210 WORKING WITH THE BIRTH THROUGH FIVE POPULATION

EFFECTIVE DATE: May 4, 2022
REFERENCES: A.R.S. §13-3620, A.A.C. R9-20-205, Division Medical Chapter 200,

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and the system of care for behavioral health services for ALTCS eligible members whose contract includes this service. It 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 using 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 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 responsible person, 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 or the Division of Developmental Disabilities. 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 AdSS, their subcontracted network, and provider agency the AdSS, their subcontracted network, and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, support coordination, and other clinical services. This may also include supervising staff that provide service delivery to children age birth through five and their families.

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 caregiver(s).

   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 AdSS policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:

a. AdSS Operations Policy 417,

b. AdSS Operations Policy 449,

c. AdSS Medical Policy 310-B,

d. AdSS Medical Policy 320-O, and

e. AdSS 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 AdSS 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 AdSS 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 aged 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).

AdSS Medical Policy 310-B and 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.

For Division eligibility criteria refer to the Division Eligibility Policy Manual.

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. 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 AdSS 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 AdSS 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 AdSS 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 AdSS 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).

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 using accepted approaches in working with children age birth through five and their caregivers.

L. DIVISION OVERSIGHT OF AdSS

The AdSS shall participate in the Division's oversight 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. Submit deliverable reports as required by the AdSS Contract with the Division.

3. Participate in Division oversight meetings for the purpose of reviewing compliance, addressing concerns with access to care or other quality of care concerns, discussing systemic issues and receiving direction or support from the Division as necessary.

4. Demonstrate ongoing monitoring and evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2022 10:33 PDT)
Anthony Dekker, D.O.

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

EFFECTIVE DATE: May 4, 2022
REFERENCES: AMPM 211

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) for ALTCS eligible members whose contract includes this service. 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 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 population includes all members enrolled with the Division who are ALTCS eligible, receive behavioral health services through an AdSS, and are age birth through five (up to age six), in collaboration with their caregiver(s) and Child and Family Teams (CFT). This policy is also applicable when working with parents and/or caregivers who have children as described above, regardless of whether the child or parent(s) 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. AdSS 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 AdSS 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 responsible person 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

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
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 paraprofes sionals
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 AdSS 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 AdSS 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

TYPE OF INTERVENTON	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
CHILD PARENT PSYCHOTHERAPY (CPP) Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principles	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 parent/guardian/ that results in increased positive interaction and reduced discordant relationship styles	Based on the 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…"
INFANT PARENT PSYCHOTHERAPY Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principles	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 Ainsworth; also based on relationship- based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*
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 AdSS 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, the Department of Child Safety, Division of Developmental Disabilities, 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 AdSS 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 responsible person about the following essential elements (Please refer to AdSS 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 and behavioral health coordinators were 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 AdSS 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, AdSS Medical Policy 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 AdSS. 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 AdSS 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 the 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 AdSS 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 BH services (Based on age, domain and 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.
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).

DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
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 10:36 PDT)
Anthony Dekker, D.O.

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

EFFECTIVE DATE: June 22, 2022

REFERENCES: A.A.C. R9-10-115, AMPM Chapter 200, AdSS 320-O

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS).This policy establishes the expectations for the implementation of support and rehabilitation services as they are used in Child and Family Team (CFT) practice.

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 (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.

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, 9 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 by improving the integration of Support and Rehabilitation Services with CFT Practice; clarifying the expectations

regarding Support and Rehabilitation Service development; and outlining responsibilities with respect to Support and Rehabilitation Services processes.

A. SERVICE DEVELOPMENT

The AdSS shall develop sufficient Support and Rehabilitation Service capacity to meet the behavioral health needs of youth and families, as identified in their CFTs. The AdSS shall ensure the following occurs in relation to service development:

1. CFTs have timely access to the full range of Support and Rehabilitation Services, in alignment with AdSS Operations Policy 417.

2. 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.

3. The AdSS shall 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).

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

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. Refer to AdSS Medical Policy 320-O. The CFT determines which of the identified needs will be met through Support and Rehabilitation Services and documents these interventions in a service plan.

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/behavioral health 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 members 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. A number of training resources have been developed as part of the MMWIA campaign to assist families, providers, and community members in using Support and 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 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 accordance with A.A.C. R9-10-115 Behavioral Health Paraprofessionals; Behavioral Health Technicians.

E. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division oversight activities including,

but not limited to the following methods to ensure compliance with this policy and associated policies:

1. Annual Operational Review of compliance with this policy and related standards, including but not limited to:
    a. Policies/procedures for, and evidence of, assessing and prioritizing identified need for MMWIA services.
    b. Policies/procedures for, and evidence of, tracking and documenting demand/unmet need for MMWI services.
    c. Policies/procedures, and evidence of, implementing strategy for addressing the lack of timely availability of MMWIA services.
    d. Policies/procedure, and evidence of, managing and documenting service utilization/length of stay for MMWIA services.
    e. Evidence of training as described in section Training and Supervision above.
2. Submit deliverable reports or other data as requested by the Division.
3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.
4. Conduct ongoing monitoring and demonstrate evidence of compliance through Behavioral Health Clinical Chart Reviews.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:30 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 Division's Administrative Services Subcontractors (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 number 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. The AdSS shall follow the procedures specified in AdSS Medical Policy 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 must 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.

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 Contractor and their subcontracted providers must ensure the young adult receives an eligibility determination at the age of 17.5, as specified in AdSS 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 AdSS Medical Policy 940.
2. 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.
3. 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 Individual Recovery 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 the AMPM, Policy 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 22. 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 AdSS shall support 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 the AMPM, Policy 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, 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. Educations 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 for attributes that should be documented, reviewed and updated, at 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 the 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 AdSS shall establish 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 AdSS shall monitor their network and provider agencies for incorporation of this policy into other supervision processes the 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. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division's oversight requirements to ensure compliance with this policy and associated policies, including but not limited to the following:

1. The Division's 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 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. Submit 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. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing any access to care concerns or other quality of care concerns.
4. Submit data demonstrating ongoing compliance monitoring of 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.

310-B TITLE XIX/XXI BEHAVIORAL HEALTH SERVICES

REVISION DATE: 8/2/2023, 3/17/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: 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. R9-22-210.01; 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 Title XIX/XXI behavioral health services available to Division of Developmental Disabilities (Division) members who are enrolled with an Administrative Services Subcontractors (AdSS) and establishes requirements for behavioral health services.

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 in Pursuant to 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:
   a. If the Behavioral Health Services were provided in a setting other than a licensed Health Care Institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and
   b. Are provided under supervision by a Behavioral Health Professional.
3. "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

4. "Behavioral Health Services" means a Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.
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:
    a. 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
    b. Health Related Services
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 "CSA" 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.

9. "Family Support Services" means home care training with Family Members 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.

10. "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.

11. "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.
12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "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.

14. "Peer Services" means support 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.
15. "Planning Team" means a defined group of individuals that shall include the Member or Responsible Adult and with the Member or Responsible Adult'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 or 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.

16. "Room and Board" means the amount paid for food or shelter. Medicaid funds can be expended for Room and Board when an individual lives in an institutional setting. Medicaid funds cannot be expended forRoom and Board when a member resides in an Alternative Home and Community Based Service (HCBS) Setting.
17. "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.
18. "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 AdSS shall provide medically necessary Behavioral Health Services to Division Members that are consistent with Arizona

Health Care Cost Containment System (AHCCCS) coverage guidelines under Title XIX/XXI Behavioral Health Services.

2. The AdSS shall ensure that 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 ADSS shall cover medically necessary outpatient Behavioral Health Services regardless of a Member's diagnosis, so long as there are documented behaviors or symptoms that will benefit from Behavioral Health Services.
4. The AdSS shall ensure that Service Plan services are provided timely and in accordance with requirements included in AHCCCS Medical, Policy Manual (AMPM) Policy 320-0.
5. The AdSS 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 AdSS shall ensure providers 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 AdSS shall establish policies and procedures 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 AdSS shall ensure that emergency Behavioral Health Services are being provided, including crisis intervention services, without prior authorization being required.
9. The AdSS shall ensure that Behavioral Health Professionals (BHP) provide supervision to Behavioral Health Paraprofessionals (BHPPs) and Behavioral Health Technicians (BHTs) that provide services in the public behavioral health system.
10. The AdSS shall ensure that BHPs providing Clinical Oversight of BHTs have demonstrated competence in delivering the same or similar services to Members of comparable acuity and intensity

of service needs as the BHTs they supervise, in addition to possessing the requisite licenses and other qualifications.

11. The AdSS shall ensure that the BHPs providing Clinical Oversight of BHTs demonstrate the following key competencies:
    a. Demonstrated knowledge of the relevant best clinical practices and policies that guide the services being provided;
    b. Demonstrated knowledge of the policies and principles governing ethical practice;
    c. Demonstrated ability to develop individualized BHT competency development goals and action steps to accomplish these goals; and
    d. Demonstrated ability to advise, coach, and directly model behavior to improve interpersonal and service delivery skills.
12. The AdSS 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.

13. The AdSS shall not require that the Member be present when the services are being provided to Family Members.
14. The AdSS 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.
15. The AdSS shall not cover Room and Board except for inpatient hospitals, Intermediate Care Facilities for individuals with Intellectual Disability (ICF/ID), and nursing facilities (NF).

16. The AdSS shall ensure that the referral process to initiate Behavioral Health Services meets the following requirements:
    a. Providers shall not require a referral to initiate Behavioral Health Services.
    b. Members may directly request assistance from their Support Coordinator or their health plan's Member services department to initiate services or to identify a contracted service provider.
    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.
    d. Providers shall make a referral to a provider who does offer the necessary service with the member's assigned health plan if Behavioral Health Services are not available within their service array.
17. The AdSS shall ensure transportation services are provided per AMPM 310-BB.

18. The AdSS shall ensure that behavioral health providers are eligible to bill for travel to and from a service location per AMPM 310-B to provide a covered behavioral health service. The AdSS 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.
19. Providers shall 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 AdSS shall cover the following treatment services 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. Refer to AMPM 320-U for Court-Ordered Evaluation responsibilities.
    b. Behavioral health counseling and therapy when provided by individuals who are qualified BHPs or BHTs supervised by BHPs when clinically appropriate.
    c. Psychophysiological therapy and biofeedback when provided by qualified BHPs.
2. The AdSS shall cover the following Rehabilitation Services:
    a. Skills training and development and psychosocial rehabilitation living skills training.
        i. Skills training includes teaching independent living, social, and communication skills to Members and/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 is highly 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 and/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 specified in AMPM Policy 1240-J.

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

iii. 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, 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.

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 AdSS shall cover medical services ordered within the scope of practice by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a Member's symptoms and improve or maintain functioning.

   a. For covered medications, the AdSS shall maintain its own formulary to meet the unique needs of Members with behavioral health disorders. At a minimum the AdSS' formulary shall include all of the medications listed on the AHCCCS formulary per AMPM Policy 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 AdSS shall cover support services to facilitate the delivery of or enhance the benefit received from other Behavioral Health Services.
5. The AdSS shall require that support services be provided by individuals who are qualified BHPs or BHTs/BHPPs supervised by BHPs.
6. The AdSS shall classify support services 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, develop skills to effectively interact or guide the Member, understand the causes and treatment of behavioral

health issues, and understand and effectively utilize the healthcare system.

ii. 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, intellectual or developmental disability, and/or substance use disorders, to provide social and personal support.

e. Therapeutic Foster Care (TFC) for Children as specified in AMPM Policy 320-W and Adult Behavioral Health Therapeutic Home as specified in AMPM Policy 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 assigned Support Coordinator, and Provider Case Manager authorizing the respite services, in addition to formal respite services.

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

iii. 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 or for longer periods of time involving overnight stays.

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

v. Community Service Agencies cannot provide respite services.

vi. Respite services may be provided in a variety of settings:

1) Habilitation Provider settings,
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..

vii. 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/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.

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

ix. Non-enrolled siblings of a child Member 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.

7. The AdSS shall cover intensive outpatient and behavioral health day programs including 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/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 Community Service Agencies (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:

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

2) Skills training and development;

3) Behavioral health prevention/promotion;

4) Medication training and support;

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

6) Home care training or Family support;

7) Medication monitoring;

8) Case management;

9) Peer and Recovery Support; and

10) Medical monitoring.

ii. Provided by an appropriately licensed ADHS DLS Outpatient Treatment Center and as specified with applicable service requirements set forth in A.A.C. R9-10-1000.

iii. Under the direction of a BHP.

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

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) Prevocational 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 appropriately licensed ADHS DLS behavioral health agency and as specified with applicable service requirements set forth in A.A.C. R9-10-1000.

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 supervised behavioral health day program shall meet the individual provider qualifications associated with those services.

8. The AdSS shall cover Behavioral Health Residential Facility Services as specified in AMPM Policy 320-V.
9. The AdSS shall cover Behavior Analysis services as specified in AMPM Policy 320-S.
10. The AdSS shall ensure timely follow up and care coordination for Members after receiving crisis services as specified in AMPM Policy 590.
11. The AdSS shall cover Inpatient Services provided by ADHS licensed inpatient facilities 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.
12. The AdSS shall ensure inpatient services 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, 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, and

b) Is licensed pursuant to A.R.S. Title 36, Chapter 4 and A.A.C. R9-10-200 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 bed hold days may not exceed 12 days, per contract year,

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. BHIF's 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 and care. Refer to the section on facility-based crisis intervention services for more information (A.A.C. R9-10-1016),

2) 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 specified in Arizona Administrative Code. The use of S&R 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.

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 meet the requirements for S&R 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 S&R.

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.

Signature of Chief Medical Officer: Anthony Dekker (Jul 26, 2023 14:47 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 service. This is different from transportation, which is provided to take a member to and from a covered behavioral health service. 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. In these circumstances, providers bill the additional miles traveled in excess of 25 miles using the HCPCS code A0160. The following examples demonstrate when to bill for additional miles:

- 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

  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.

Providers may not bill for travel for missed appointments.

Provider Travel Limitations

If a Behavioral Health Professional, Behavioral Health Technician, or Behavioral Health Paraprofessional 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 and development and psychosocial rehabilitation living skills training

Skills training includes teaching independent living, social, and communication skills to members and/or their families. Skills training and development and psychosocial rehabilitation living skills training is teaching independent living, social, and communication skills to members and/or their families. 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.

Cognitive rehabilitation

Cognitive rehabilitation is the facilitation of recovery from cognitive impairments in order to achieve independence or the highest level of functioning possible, goals of cognitive rehabilitation include relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning. Treatment may include techniques such as auditory and visual attention directed tasks, memory training, and training in the use of assistive technology, and anger management. Goals of cognitive rehabilitation include relearning of targeted mental abilities, strengthening of intact functions, relearning of social interaction skills, substitution of new skills to replace lost functioning and controlling the emotional aspects of one's functioning.

Health Promotion

Education and training about health-related topics that can be provided in single or multiple sessions shall be provided to an individual or a group of people and/or their families.

Psychoeducational Services (pre-vocational services) and ongoing support to maintain employment (post-vocational services, or job coaching)

Psychoeducational services and ongoing support to maintain employment services are 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: Rehabilitative employment support assessments when available through the federally funded Rehabilitation Act program administered by the Tribal Rehabilitation Services Administration, and preparation of a report of a member's psychiatric status for primary use with a court. Designed to assist members to choose, acquire, and maintain employment or other meaningful community activity (e.g. volunteer work). Psychoeducational Services are pre-vocational services that prepare members to engage in meaningful work-related activities, such as full- or part-time, competitive employment.

Provider Case Management

Provider case management is a supportive service provided to improve treatment outcomes. Examples of case management activities to meet member's Service Plan goals include:

- Assistance in maintaining, monitoring and modifying behavioral health services
- Assistance in finding necessary resources other than behavioral health services
- Coordination of care with the member's healthcare providers, Family, community resources, and other involved supports including educational, social, judicial, community and other State agencies,
- 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).

- 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.

Personal care services

Assisting an individual in carrying out activities of daily living such as but not limited to bathing, shopping, dressing, and other activities for living in a community.

Unskilled Respite Care (Respite)

Short term behavioral health services or general supervision that provides an interval of rest or relief to a Family Member or other individual caring for the member receiving behavioral health services as authorized under the Section 1115 Waiver Demonstration and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

310-C BREAST RECONSTRUCTION AFTER MASTECTOMY

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

PURPOSE

This policy describes covered breast reconstruction surgery services following a mastectomy for ALTCS members. This policy applies to DDD's Administrative Services Subcontractors (AdSS).

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 AdSS shall cover breast reconstructive surgery post-mastectomy per 42 U.S. Code § 300gg-52.
2. The AdSS 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 AdSS shall cover breast reconstruction surgery either immediately following the mastectomy or after the breast reconstruction, based on the choice of the member.
4. The AdSS shall cover medically necessary breast implant removal when the original implant was the result of a medically necessary mastectomy.
5. The AdSS 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.

B. LIMITATIONS

1. The AdSS 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 10:36 PDT)
Anthony Dekker, D.O.

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

REVISION DATE: 4/26/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907, A.R.S. § 14-5101; A.A.C. R9-22-207; AMPM 310-D2

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and 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 AdSS shall cover the following dental services provided by a licensed dentist 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 dentist when:
      i. The services may be performed under state law either by a physician or by a dentist, and
      ii. The services would be considered a Physician Service if furnished by a physician.
2. The AdSS shall cover services related to treatment of the following medical conditions:

a. Acute pain,

b. Infection, or

c. Fracture of the jaw.

3. The AdSS shall ensure covered services include:

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 AdSS shall not cover the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) except for reduction of trauma, under the emergent dental benefit.

5. The AdSS shall not subject services outlined in subsection (3) and (4) of this section to the $1,000 adult emergency dental limit.

6. The AdSS shall cover the following limited dental services 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.
7. The AdSS shall cover services outlined in subsection (6) of this section only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.
8. The AdSS shall cover prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head.

9. The AdSS shall not subject services outlined in subsection (3), (4), (6), and (8) of this section to the $1,000 adult emergency dental limit.
10. The AdSS shall cover cleanings for Members who are in an inpatient hospital setting and experiencing the following:
    a. Placed on a ventilator, or
    b. Physically unable to perform oral hygiene.

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

1. The AdSS shall cover medically necessary emergency dental care and extractions for Members age 21 years and older who meet the criteria for a Dental Emergency.
2. The AdSS shall cover the following services and procedures 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 or 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 AdSS shall cover follow-up procedures needed to stabilize teeth due to the emergency services and subject to the $1,000 limit.

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

1. The AdSS shall not cover the following adult dental services:

a. Maxillofacial dental services provided by a dentist, 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:

i. Non-cast fillings,

ii. Crowns constructed from pre-formed stainless steel,

iii. Pulp caps, and

iv. Pulpotomies only for the tooth causing pain or in the presence of active infection.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. AdSS and FFS PROGRAM RESPONSIBILITIES

1. The AdSS shall provide the following:

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

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

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

2. The AdSS shall ensure the annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers:

a. Between one AdSS to another, or

b. Between Fee-For-Service and an AdSS.

3. The AdSS 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 AdSS or Tribal Case Manager shall notify the accepting entity regarding the current balance of the dental benefit.
5. The relinquishing AdSS shall 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 AdSS 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 AdSS shall cover emergency dental services of $1,000 per contract year for Division Members age 21 years and older. Billing of Division Members for emergency dental services in excess of the $1000 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 AdSS 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 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 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 AdSS 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 AdSS shall ensure dentists 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 AdSS shall ensure 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 AdSS shall ensure providers complete the appropriate Informed Consents and treatment plans for Members, in order to provide quality and consistent care.
2. The AdSS shall ensure 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 the following:

i. 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. 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; and

h. Extends to all Contractor mobile unit providers.

3. The AdSS shall ensure completed consents and treatment plans are maintained in the Members chart and are subject to audit.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 15:01 PDT)
Anthony Dekker, D.O.

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

REVISION DATE: 4/26/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM 310-D2

PURPOSE

This policy applies to the Administrative Services Subcontractors (AdSS) and establishes requirements regarding the provision of medically necessary routine 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 AdSS shall cover the following medically necessary dental benefits 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 to include dentures.
2. The AdSS shall refer to AMPM 430 for dental services for Members under the age of 21.
3. The AdSS shall cover emergent services for Members as specified in AMPM 310-D1. These services do not count towards the ALTCS $1,000 limit.

B. AdSS RESPONSIBILITIES

1. The AdSS 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 AdSS shall ensure 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 AdSS shall ensure the annual dental benefit limit remains with the Member if the Member transfers to the following:

   a. Between one AdSS to another, or

   b. Between Fee-For-Service and an AdSS.

4. The transferring AdSS shall notify the receiving AdSS regarding the current balance of the Member's dental benefit.

5. The AdSS shall utilize the ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9, for reporting any dental benefit balance.

6. The AdSS shall ensure dental services provided to American Indian/Alaska Native Members within an Indian Health Service (IHS) or 638 Tribal Facility are not subject to the ALTCS dental benefit $1,000 limit.
7. The AdSS shall ensure the Member is aware they are not permitted to carry-over unused benefit from one contract year to the next.
8. The AdSS shall utilize 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 AdSS shall ensure facility and anesthesia charges are subject to the $1,000 routine dental limit when:
    a. A Member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in:

i. An ambulatory surgery center, or

ii. An outpatient hospital.

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

2. The AdSS shall ensure dentists performing General Anesthesia (GA) on Members shall bill using dental codes and the cost will count towards the $1,000 limit.

3. The AdSS shall ensure Physicians performing GA on a patient for a dental procedure shall bill medical codes and the cost shall count towards the $1,000 limit.

D. INFORMED CONSENT

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

2. The AdSS shall ensure 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. Pulpotomies.

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 AdSS shall ensure 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 AdSS shall ensure medically necessary services are provided within the $1,000 dental benefit allowable amount.

2. The AdSS shall ensure services are provided as set forth in A.A.C. R9-28-701(10) and R9-22-702, if medically necessary services are greater than $1,000.

3. The AdSS shall ensure 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 AdSS shall ensure 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 they will be responsible for the cost of the service to the extent that it exceeds the $1,000 limit.

Signature of Chief Medical Officer: Anthony Dekker (Apr 24, 2023 14:30 PDT)
Anthony Dekker, D.O.

310–G EYE EXAMINATIONS/OPTOMETRY SERVICES

REVISION DATE: 10/01/2021

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Eye and optometric services are covered for members eligible for ALTCS when provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Emergency eye care which meets the definition of an emergency medical condition is covered for all members eligible for ALTCS. For members who are 21 years of age or older treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, and for adults when medically necessary following cataract removal. Refer to Division Medical Policy Manual, Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all members eligible for ALTCS. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

A. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

B. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading

C. For the Division's DDD Tribal Health Program (Fee-For-Service) members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions, or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

A. Phacogenic Glaucoma

B. Phacogenic Uveitis.

310-I HOME HEALTH SERVICES

REVISION DATE: 10/01/2021

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-1201 et seq.

This policy applies to:

- The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS) and Qualified Vendors
- Fee-For-Services (FFS) Programs, including Tribal Arizona Long Term Care System (ALTCS), the DDD Tribal Health Program (THP), and all FFS populations.

This policy does not apply to Federal Emergency Services (FES); for information regarding FES, see Division Medical Manual Chapter 1100. This policy establishes requirements regarding Home Health Services.

Definitions

A. Home Health Agency - 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].

B. Home Health Services - Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70, when provided to a member at his/her place of residence and on his/her physician's orders as part of a written plan of care [42 CFR 440.70].

C. Place of Residence - A member's place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), except for home health services in an ICF/IID facility that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a beneficiary in an intermediate care facility for Individuals with Intellectual Disabilities during an acute illness to avoid the beneficiary's transfer to a nursing facility.

Policy

The Division covers medically necessary home health services provided in the member's place of residence as a cost-effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary medical equipment, appliances and supplies, and therapy services for Division members. Home health services are covered when ordered by the member's treating physician.

ALTCS covers home health services for members receiving home and community based services. Refer to Division Medical Policy 1240-G for additional information.

A. Home Health Nursing and Home Health Aide Services

Home health nursing and home health aide services are provided on an intermittent basis as ordered by a treating physician.

B. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

Physical therapy, occupational therapy, speech therapy, and audiology services provided by a licensed home health agency are covered for members as specified in Division Medical Policy 310-X.

C. Medical Equipment, Appliances and Supplies

Medical equipment, appliances, and supplies provided by a licensed home health agency are covered for members.

D. Face-to-Face Encounter Requirements

1. Face-to-face encounter requirements apply to FFS only.

2. For initiation of home health services, a face-to-face encounter between the member and practitioner that relates to the primary reason the individual requires home health services is required within no more than 90 days before or within 30 days after start of services.

3. The face-to-face encounter must be conducted by one of the following:

   a. The ordering physician

   b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law

   c. A certified nurse midwife as authorized by state law

   d. A physician assistant under the supervision of the ordering physician, or

   e. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The non-physician practitioner specified above who performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician.

5. The clinical findings must be incorporated into a written or electronic document in the member's' record.

6. Regardless of which practitioner performs the face-to-face encounter related to the primary reason that the individual requires home health services, the physician responsible for ordering the services must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes.

   The face-to-face encounter may occur through telehealth.

310–J HOSPICE SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, Arizona's Section 115(a) Medicaid Demonstration Extension.

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

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. Continuous home care - hospice provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or an alternative residential setting. Continuous home care is not available to members residing in a Nursing Facility (NF) Medicaid certified bed.

B. Inpatient respite care - services provided in an inpatient setting, such as an NF, on a short-term basis to relieve family members or other caregivers who provide care to

members eligible for hospice who have elected to receive hospice care and who reside in their own home or, home and community based (HCB) alternative residential setting.

C. General inpatient care - services provided, in an inpatient setting such as a hospital, to members eligible for hospice who have elected to receive hospice. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be performed in another setting.

D. Period of crisis - a period in which the hospice-eligible member requires continuous care to achieve palliation or management of acute medical symptoms.

E. Routine home care - short-term, intermittent hospice including skilled nursing, home health aide and/or homemaker services provided to a hospice-eligible member in his or her own home or an alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The member eligible for hospice must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in an NF Medicaid certified bed.

Amount, Duration and Scope

Prior to the member receiving hospice services, the physician must provide, to the Administrative Services Subcontractor (AdSS), certification stating that the member's prognosis is terminal with the member's life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician certifications are completed.

The physician certification is permitted for two 90-day periods; thereafter, an unlimited number of physician certifications for 60-day periods are permitted.

The AdSS must notify the Division's Health Care Services within five business days of any approval or denial of Hospice services. The AdSS must also notify the Support Coordinator that a referral has been made.

State licensure standards for hospice care require providers to include skilled nursing, respite, and bereavement services. 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 components are included in hospice service reimbursement, if they are provided in approved settings:

A. Bereavement services, including social and emotional support provided by the hospice provider, to the member's family both before and up to twelve months following the death of that member

B. Continuous home care (as specified in this policy), which may be provided only during a period of crisis

C. Dietary services, which include a nutritional evaluation and dietary counseling when necessary

D. Home health aide services

E. Homemaker services

F. Nursing services provided by or under the supervision of a registered nurse

G. 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

H. Hospice respite care services that are provided on an occasional basis, not to exceed more than five consecutive days at a time

(Hospice respite care services may not be provided when the member is residing in a nursing facility or is receiving services in an inpatient setting indicated above.)

I. Routine home care, as specified in the definition of hospice services

J. Social services provided by a qualified social worker

K. Therapies that include physical, occupational, respiratory, speech, music, and recreational therapy

L. Twenty-four hour on-call availability to provide services such as reassurance, information and referral, for members and their family members or caretakers

M. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee

(Under 42 CFR 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services.)

N. Medical supplies, appliances, and equipment, and pharmaceuticals used in relationship to the palliation or management of the member's terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.

310-L HYSTERECTOMY

EFFECTIVE DATE: February 7, 2024
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 who seek to obtain a medically necessary Hysterectomy. This policy applies to the Administrative Services Subcontractors (AdSS).

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 AdSS 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 IS COVERED IF DEEMED MEDICALLY NECESSARY

1. The AdSS 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 AdSS 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 AdSS shall require the provider to complete AMPM Attachment 820-A prior to performing Hysterectomy procedures.

C. MEDICAL ACKNOWLEDGEMENT AND DOCUMENTATION

1. The AdSS 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 AdSS shall require a signed, and dated written acknowledgment is kept in the Member's medical record maintained by the Primary Care Provider (PCP) if enrolled with an AdSS.

3. The AdSS shall require providers use AMPM Attachment 820-A as specified in AMPM 820.

D. EXCEPTIONS FROM INITIAL MEDICAL ACKNOWLEDGEMENT

1. The AdSS 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 shall 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 shall document in the Member's medical records and in AMPM Attachment 820-A 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 the AdSS.

E. LIMITATIONS

1. The AdSS 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 AdSS shall:
   a. Submit all approvals or denials for Hysterectomies to the Division for Second Level Review prior to the completion of the procedure, except in the event of a life-threatening

emergency situation; and

b. Submit all life-threatening emergency Hysterectomy cases to the Division for retrospective review.

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 10:26 MST)
Anthony Dekker, D.O.

310-M IMMUNIZATIONS

REVISION DATE: 05/10/2023, 10/26/2022
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 32-1974, AMPM 310-V, AMPM 430

PURPOSE

This policy applies to the Division of Developmental Disabilities (The Division) Administrative Services Subcontractors (AdSS). 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 AdSS 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 AdSS shall cover immunizations as appropriate for age, history, and health risk, for adults and children.

3. The AdSS shall follow recommendations as established by the Centers for Disease Control and Prevention (CDC) and theAdvisory Committee on Immunization Practices (ACIP).

4. The AdSS shall not require prior authorization. Prior authorization is not required for medically necessary covered immunizations when administered by an AHCCCS-registered provider.

5. The AdSS 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 and older,
    k. Human Papillomavirus (HPV) vaccine.
6. The AdSS shall cover vaccinations for children as described in AMPM 430.
7. The AdSS shall not cover immunizations for passport or visa clearance, or for travel outside of the United States.

8. The AdSS shall cover pharmacy reimbursement for adult immunizations as described in AMPM 310-V.

Signature of Chief Medical Officer: Anthony Dekker (May 8, 2023 09:53 PDT)
Anthony Dekker, D.O.

310-P MEDICAL EQUIPMENT, MEDICAL DEVICES, AND MEDICAL SUPPLIES

REVISED: 01/01/2021

EFFECTIVE DATE: October 01, 2019

REFERENCES: A.A.C. R9-28-202, A.A.C. R9-22-212, A.A.C. R9-28-101, A.A.C. R9-28-201 42 CFR 440.70, 42 U.S.C. 1396d (a), Division Medical Policy Manual, Policy 430, AdSS Medical Manual Policy Chapter 1020.

Purpose

This policy applies to the Division of Developmental Disabilities (the Division, DDD) Administrative Services Subcontractors (AdSS) that serve DDD Arizona Long Term Care System (ALTCS) members. The Division contracts with AdSS and delegates the responsibility of implementing this policy to those Subcontractors. This policy outlines the requirements for coverage of medically necessary medical equipment, medical devices, appliances, and medical supplies.

Definitions

A. Medical Equipment and Medical Devices - Any item, device, or piece of equipment (as specified in 42 CFR 440.70) is not a prosthetic or orthotic. For this policy's purposes, Medical Equipment, medical devices, and appliances are defined as Durable Medical Equipment (DME) when all the following criteria are met:

1. It is customarily used to serve a medical purpose and is generally not useful to a person in the absence of an illness, disability, or injury.

2. Can withstand repeated use

3. Can be reusable by others or removable.

B. Medical Supplies - Any healthcare-related items that are consumable or disposable or cannot withstand repeated use by more than one member required to address an individual medical disability, illness, or injury.

C. Setting in Which Normal Life Activities Take Place - A setting other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

D. Augmentative and Alternative Communication (AAC) Device Systems - An AAC device systems or speech-generating devices (SGD) represent high-technology aided forms of DME. AAC device systems and SGDs represent forms of external hardware and software systems dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a member with significant communication disorders. AAC device systems produce messages or symbols using one of the following methods:

1. Digitized audible/verbal speech output, using pre-recorded messages.

2. Synthesized audible/verbal speech output, which requires message

formulation by spelling and device access by physical contact with the device-direct selection techniques.

3. Synthesized audible/verbal speech output, which permits multiple methods of message formulation and multiple methods of device access.

4. Software that allows a computer or other electronic device to generate speech.

E. Dedicated AAC Devices - Purpose-built systems primarily designed to serve a medical purpose (e.g., solely for the purpose of expressive communication). Dedicated AAC device systems are generally not useful in the absence of disability, or illness or injury.

F. Integrated AAC Devices - Non-medical systems designed for non-medical purposes and are generally useful in the absence of disability, illness, or injury; however, they may also include functionality for use as a communication tool.

G. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - 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.

H. AAC Assessment - A comprehensive AAC assessment includes the culturally and linguistically appropriate behavioral observation and standardized and/or criterion-referenced tools; use of instrumentation; review of records, case history, and prior test results; and interview of the member and/or family to the guide decision-making process for AAC methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication. The AAC assessment process may be static (i.e., using procedures designed to describe current levels of functioning within relevant domains) or dynamic (i.e., using hypothesis testing procedures to optimize selection and use of AAC systems).

I. Treatment - Treatment services represent medically necessary skilled interventions conducted at a level of complexity and sophistication that requires the expertise, knowledge, clinical judgment, decision-making of an appropriately credentialed and trained qualified healthcare professional to perform the tasks.

J. Maintenance Plan - A maintenance plan is intended to ensure that the transition of skills achieved within isolated treatment contexts can be maintained across settings after treatment is completed to support the generalization of the achieved communication skills across settings, activities, and communicative partners. A maintenance plan and procedures support the effectiveness of the intervention, the

level of function achieved at the end of the intervention, and the appropriateness of clinical decisions and clinical recommendations. A maintenance plan may result in recommendations for continued or repeated assessment, intervention, and/or referral for other assessments or services.

K. Practitioner - For the purposes of this policy, Practitioner refers to a Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.

Medical Equipment and Medical Devices Coverage

A. The AdSS shall cover medically necessary Medical Equipment, Medical Appliances and Medical Supplies (including incontinence briefs), under the home health services benefit, that are suitable for use in any Setting in Which Normal Life Activities Take Place, as explained in this policy when the following conditions are met:

1. Provided in Settings in Which Normal Life Activities Take Place
2. Ordered by the member's practitioner or beginning March 1, 2020, ordered by the member's:
   - Nurse Practitioner
   - Physician's Assistant
   - Clinical Nurse Specialist
3. As a part of the plan of care and is reviewed by the practitioner annually.
4. Authorized as required by the Division or the AdSS.

B. Medical equipment and medical supplies cannot be limited to members who are homebound.

C. Related Services, AAC Device Systems, and Requirements:

1. Nursing, home health aide, and home health services, as specified in the Division's *Medical Policy 1240-G - Home Nursing, Medical Policy 1240-H - Home Health Aide, and AdSS Medical 310-I – Home Health Services.*
2. Therapies—Occupational, Physical and Speech-Language Pathology (Rehabilitative and Habilitative), as specified in the Division's *AdSS Medical 1250-E Therapies (Rehabilitative and Habilitative*)
3. Orthotic and Prosthetic Devices, as specified in the *AHCCCS Medical Policy Manual (AMPM) 310-JJ - Orthotic and Prosthetic Devices*
4. Prior Authorization Requirements, as specified in the *AMPM 820 - Prior Authorization Requirements*
5. Institutional Services and Settings, as specified in the Division's *AdSS Medical Policy 1210-Institutional Services and Settings*

6. AAC Device Systems, as outlined in this policy.

D. Examples of medically necessary Medical Supplies and Medical Equipment are:

1. Medical Supplies- Incontinence briefs, surgical dressings, splints, casts, and other consumable items are not reusable and explicitly designed to meet a medical purpose.

2. Medical Equipment -Wheelchairs, walkers, hospital beds, AAC device systems, SGDs, AAC software that enables dynamic symbol/language representation used with some form of dedicated hardware, and other durable items that are rented or purchased.

Medical Equipment and Medical Devices Coverage Determinations

A. Medical Equipment and Medical Supply coverage are not restricted to the items covered as DME in the Medicare program. Coverage of Medical Equipment and Medical Supplies cannot be contingent upon the member needing nursing or therapy services.

B. Absolute exclusions for coverage of medical equipment, medical appliance, and medical supplies are prohibited. A list of pre-approved medical equipment, medical appliances, and medical supplies are permissible for administrative ease. However, processes and criteria for requesting medical equipment, appliances, and supplies not on the pre-approved lists shall be made available to members and providers. The procedure shall use reasonable and specific criteria to assess items for coverage.

C. The AdSS shall make determinations of coverage in accordance with all requirements of Exhibit F1 Member Grievance and Appeal System Standards of the AdSS contract and with all requirements of the Division Administrative Service for Subcontractors (AdSS) *Medical Manual Policy Chapter 1020 - Medical Management Scope and Components*. The AdSS shall render the determination within the required timeframes regardless of the member's dual eligibility status or the providers' contract status with the AdSS.

D. To determine coverage of medical equipment and medical supplies, the following shall be used:

1. Services shall be determined to be medically necessary, cost-effective and federally, and state reimbursable.

2. Services shall be provided at the Setting in Which Normal Life Activities Take Place, be on the member's plan of care, and ordered by the member's practitioner.

3. The member's need for medical equipment, appliance, and/or supplies shall be reviewed by a practitioner as specified in this policy, annually. The frequency for further practitioner review for the member's continuing need for services is determined on an individualized, case by case basis based on the nature of the prescribed item.

4. Medical equipment and medical supplies are reasonable and necessary in amount, duration, and scope to achieve the intended purpose.

E. Medical equipment and medical supply coverage determinations are not based solely on the practitioner's prescription. Coverage decisions are based on evidence-based clinical and medical findings, about the member's condition in relation to the medical equipment or medical supplies prescribed. The member's medical record must contain sufficient documentation of the member's medical condition to substantiate the necessity for the prescribed medical equipment or medical supplies. The member's medical record is not limited to the practitioner's office records. It may include hospital, nursing home, or home health agency records and records from other professionals (if applicable) including, but not limited to, nurses, occupational therapists, physical therapists, speech-language pathologists and prosthetists, and orthotics.

F. Services shall be authorized, set up, and maintained to maximize the member's independence and functional level in the most appropriate Setting in Which Normal Life Activities Take Place as defined in this policy.

G. The AdSS shall ensure that the provider network includes a choice of vendors for customized Medical Equipment and Appliances to meet the needs of members.. Timeliness standards for the creation, repair, and delivery of customized Medical Equipment and Appliances shall be in accordance with the AdSS required Utilization, Grievance, and Appeals deliverable and included in the contract with the vendor. The AdSS shall monitor the standards and act when the vendor is found to be out of compliance.

H. Medical equipment may be purchased or rented, and the total expense of the rental cannot exceed the purchase price of the item.

I. Rental fees shall terminate no later than the end of the month in which the member no longer needs the Medical Equipment, or when the member is no longer eligible or enrolled with the AHCCCS, except during transitions as specified by the Division's Chief Medical Officer or designee.

J. Reasonable repairs or adjustments of purchased Medical Equipment are covered when necessary to make the equipment serviceable and when the repair cost is less than the cost of rental or purchase of another unit. In circumstances where the cost of replacement is less than repair, purchase is covered if medically necessary.

Incontinence Briefs

A. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. The AdSS may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered as specified in A.A.C. R9-28-202 to prevent skin breakdown when all the following are met:

1. The member is incontinent due to a documented medical condition that causes incontinence of bowel and bladder.

2. The Primary Care Provider (PCP) or attending practitioner has issued a prescription ordering the incontinence briefs.

3. Incontinence briefs, including pull-ups and incontinence pads, do not exceed 180 in any combination per month unless the prescribing practitioner presents evidence of the medical necessity for more than 180 per month.

4. The member obtains incontinence briefs from vendors within the AdSS network.

5. Prior authorization has been obtained as appropriate. The AdSS must not require a new prior authorization to be issued more frequently than every 12 months.

B. Incontinence Briefs for Members under the Age of 21 Years

1. AdSS shall cover incontinence briefs when necessary to treat a medical condition.

2. AdSS shall cover incontinence briefs for preventative purposes for members over the age of three and under 21 years of age, as described in *Division Medical Policy Manual, Policy 430,* and A.A.C. R9-22-212.

Limitations

A. Except for incontinence briefs as specified in this policy, personal care items, including items for personal cleanliness, body hygiene, and grooming, are not covered unless needed to treat a medical condition.

B. First aid supplies are not covered unless prescribed in accordance with a prescription.

Augmentative and Alternative Communication (AAC) Device Systems

This policy's AAC section provides information and requirements related to medical necessity determination and for coverage of augmentative and alternative communication (AAC), speech-generating device (SGD) systems. The Division bases this policy on generally accepted standards of practice, review of the medical literature, and federal and state policies and laws applicable to the Medicaid program.

The information in this policy is intended for AdSS qualified, licensed, and credentialed healthcare professionals involved in assessing, treating, and supporting Division ALTCS members with significant communication disorders who may benefit from AAC.

Speech-language pathologists' function as the lead professional in the assessment, treatment, monitoring, and management of members with significant communication disorders. Speech-language pathologists support members using AAC in collaboration with multi-professional (multidisciplinary, interdisciplinary, and trans-disciplinary) teams using

family and person-centered, inclusive, and rights-based approaches. The extent of involvement depends on the healthcare professional's expertise, the nature of the clinical setting, the support needs of the member, and the context of the referral.

AAC refers to all communication forms other than oral speech (e.g., pictures, symbols, writing, hand gestures). AAC systems may be unaided (e.g., signing, gestures) or aided. Aided AAC systems include non-technology assistive products (e.g., communication boards, books) and technology-based products (e.g., SGDs, mobile technologies) that compensate for the impairment and disability of a member with a significant communication disorder. AAC systems are used to establish functional communication when natural speech methods are insufficient to achieve daily communication goals and meet communication needs.

Aided AAC systems can be categorized into non-technology and technology-based products. Non-technology products are non-electronic boards or books that contain images that the member selects to convey messages (e.g., picture symbols, alphabet boards, photograph books). Technology-based systems employ hardware and software to produce visual output, that is, digitally displayed messages (i.e., dynamic, or static displays) or voice output (verbal messages [SGDs and mobile AAC software]). For this policy, the term "AAC device system" generally refers to technology-based communication systems with voice output and includes both SGDs AAC software.

Coverage

The provision of AAC systems includes coverage for all AdSS eligible members of all ages if the services, supplies, and accessories are considered medically necessary as defined in A.A.C. R9-28-101 and R9-28-201.

Prior Authorization is required for all AAC Device Systems and services. Refer to *Prior Authorization Requirements* section for requirements. For services to be considered medically necessary, the services must be reasonable and necessary to treat illness, injury, disease, disability, or developmental condition. Medical necessity is a critical factor for determining eligibility for reimbursable therapy and treatment services.

AdSS shall review requests for prior authorization based on medical necessity. If the AdSS approves the request, payment is still subject to all general conditions of the AdSS, including member eligibility, other insurance, and program restrictions.

Benefits

A. Items that are included in the AdSS covered benefits for an AAC device system and are not reimbursed separately include, but are not limited to, the following:

   1. Applicable software (except for software purchased specifically to enable a member-owned computer or a Personal Digital Assistant (PDA) to function as an AAC device system).

   2. Batteries

   3. Battery charger

   4. Power supplies

5. Interface cables
6. Interconnects
7. Sensors
8. Alternating Current (A/C) or other electrical adapters
9. Adequate memory to allow for system expansion within a 3-year time frame
10. Access device when necessary
11. Mounting device when necessary
12. Any extended warranty
13. Carrying case
14. Any medically necessary treatment services for the programming and modification or adaptation of purchased devices by the Division, the AdSS, or the primary payor.

B. Other Benefit Considerations

Replacement of applications covers the following:

1. If the application was deleted.
2. Cannot be accessed due to loss of username and password.

C. Limitations

Non-covered items that are not necessary to operate the device and are unrelated to the AAC system or software components are not covered. These items include, but are not limited to:

1. Printer
2. Wireless Internet access devices.

Medical Review Criteria

The AdSS must review the assessment and clinical documentation to determine medical necessity. The AdSS shall base its determination of the medical necessity for the coverage of AAC device hardware, software, and skilled treatment services for systems dedicated to transmitting or producing messages or symbols, based on the evidence-based clinical and medical records including, but not limited to, indicators that would affect the relative risks and medical benefits of the AAC device system, and the following criteria:

A. The member has a significant communication disorder related to a medical condition or developmental disability that significantly limits daily functional communication.

B. The member cannot meet daily functional communication needs by using unaided forms (natural modes) of communication.

C. The member has had a formal, face-to-face comprehensive speech-language assessment administered according to the generally accepted standards of practice by an appropriately credentialed and trained speech-language pathologist within one calendar year before the date of the written prior authorization request. Refer to the Division's *Medical Policy Manual*; *Policy 1250-E Therapies (Rehabilitative/Habilitative) for Therapy* assessment requirements. Refer to the American Speech-Language-Hearing Association (ASHA) Preferred Practice Patterns for the Profession of Speech-Language Pathology for "*The Fundamental Components and Guiding Principles for Comprehensive Speech-Language Assessment.*"

D. A formal AAC assessment has been conducted by an appropriately credentialed and trained speech-language pathologist to determine and recommend methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication in accordance with the " *Assessment Requirements"* section of this policy. Refer to the ASHA Preferred Practice Patterns for the Profession of Speech-Language Pathology for "*The Fundamental Components and Guiding Principles for AAC Assessment."*

E. The recommended AAC device system is the least costly and clinically appropriate.

F. The recommended AAC device system matches the cognitive, visual, language, and physical abilities of the member.

G. The viability for use, including the member's physical and behavioral health care needs, is considered for the type of AAC device system recommended. The member has demonstrated the ability to learn to use the recommended AAC device system and accessories or software for functional communication as evidenced by a data-driven AAC device system trial supporting the ability to use the AAC device system and any necessary accessories functionally for communication. Refer to Prior Authorization Requirements of this policy for device trial requirements. For a subsequent upgrade of a previously provided AAC device system or software, evidence-based clinical and medical findings including, but not limited to, indicators that would affect the relative risks and medical benefits of the AAC device system should demonstrate why the initially covered AAC device system or software is no longer clinically effective in meeting the member's medical need.

H. When the medical necessity for an AAC device system is established, coverage may include dedicated devices and—under certain circumstances, for members under 21 years old—integrated devices systems. The medical necessity for an AAC device must be met regardless of whether the member's provider recommends a dedicated or integrated AAC device system, and the AAC device system must be functional for use in all environments, including in school, in the home and in community settings.

I. Clinical documentation includes applicable descriptions that align with the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* diagnosis codes. Diagnosis descriptions must be to the highest level of specificity available. Diagnosis codes that are included must be appropriate for the

age of the member, as identified in the ICD-10-CM description of the diagnosis code.

Refer to the Official ICD-10-CM and American Speech-Language-Hearing Association (ASHA) resources for the most up-to-date information on ICD coding:

- *National Center for Health Statistics: www.cdc.gov/nchs/icd/icd10.htm*
- *Centers for Medicare and Medicaid Services: www.cms.gov/ICD10/*
- *ICD-10-CM Official Guidelines for Coding and Reporting: www.cdc.gov/nchs/icd/data/10cmguidelines-FY2020_final.pd*
- *ICD-10-CM Diagnosis Codes for Audiology and Speech-Language Pathology: www.asha.org/Practice/reimbursement/coding/ICD-10/*
- *ICD-10-CM Coding FAQs for Audiologists and SLPs: www.asha.org/Practice/reimbursement/coding/ICD-10-CM-Coding-FAQs-for-Audiologists-andSLPs/*
- *Coding Normal Results: www.asha.org/practice/reimbursement/coding/normalresults/*
- *Coding to the Highest Degree of Specificity: www.asha.org/practice/reimbursement/coding/codespecificity/*

Note: Refer to the Division's Health Plan Guide to Augmentative and Alternative Communication (AAC) Systems for further coding information.

EPSDT Criteria

Service limitations and exclusions for AAC systems, other than the requirement for medical necessity and cost-effectiveness, do not apply to members under the age of 21.

Service limitations on scope, amount, duration, frequency, or other specific criteria described in this policy may be exceeded or may not apply to members under the age of 21. Clinical documentation must include how the service, product, or procedure will correct or ameliorate defects, or improve or maintain the member's health, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems.

Refer to the Division's Health Plan Guide to *Augmentative and Alternative Communication (AAC) Systems* for EPSDT information.

Prior Authorization Requirements

Prior authorization is required for AAC systems and services provided through the AdSS. The prior authorization also includes all related accessories and supplies.

All relevant clinical and medical documentation, including the member's medical records, Practitioner's office records, therapy service records, other records from healthcare professionals, and test reports as requested by the AdSS relevant to the request should be

submitted or may be requested to support/demonstrate that the coverage criteria for an AAC device system is medically necessary and that other requirements have been met.

The AdSS shall comply with all prior authorization requirements, including timeliness standards in accordance with Exhibit F1 Member Grievance and Appeal System Standards of the AdSS contract.

If during the prior authorization review additional information is requested or the device does not meet clinical criteria, the AdSS is required to offer a peer to peer discussion and shall coordinate the discussion with the requesting provider when appropriate and comply with the Division's *Administrative Service for Subcontractors (AdSS) Medical Manual Policy Chapter 1020 - Medical Management Scope and Components.*

- Prior authorization is required for:
  - AAC device system rentals or purchases
  - AAC device system modifications
  - All AAC device system accessories
  - Replacement of AAC device system or components
  - AAC device system repairs
  - Treatment services for the programming and modification or adaptation of an AAC device system.
- Prior authorization may not be required for device trial, initial device mounting, and initial treatment units.

A. AAC Device System Purchases or Rentals

1. Prior authorization requests for AAC device system purchases must consider all projected changes in the member's communication abilities for a minimum of three years. AAC device systems that have been purchased are anticipated to last a minimum of three years.

2. An AAC device system is not approved for purchase unless the member has used the requested AAC device system for a trial period a minimum of three devices are required to be trialed.

3. Prior authorization is required for AdSS rental or loaner coverage for the trial period, as requested. All components, accessories, and switches, including mounting devices and lap trays necessary for use, may be used during the trial period before a decision to purchase can be approved. If an AAC device system is unavailable for rental, a waiver of the trial period may be granted by the AdSS with supporting documentation.

4. Prior authorization requests must include all the following information or documentation:

a. Include a detailed written order or prescription for the purchase or rental of the prescribed AAC device system by the member's practitioner. The detailed written order must:

- Be signed and dated by the licensed practitioner, familiar with the member dated within 365 days of the prior authorization request.
- Include the National Provider Identifier (NPI) numbers of the prescribing qualified health professional.
- Include an itemized description, including quantities, manufacturer's name, model, and retail price for all prescribed AAC device system accessories, components, mounting devices, modifications for the member to use the AAC device system.

b. Include a plan of care established by an appropriately credentialed and trained speech-language pathologist and prescribed by the member's practitioner for the treatment services to use the AAC device system. The plan of care must:

- Be signed and dated by the member's evaluating or treating licensed and certified speech-language pathologist.
- Include the NPI numbers of all the qualified health professionals certifying the plan of care.
- Include an itemization of the anticipated treatment service dosage (amount, frequency, and duration) necessary for the member to use the AAC device system, not to exceed a service period more than 365-days without revision and review.
- Include the Current Procedural Terminology (CPT) for the treatment services that most appropriately represent the proposed procedures or services established.
- Include the long-term and short-term goals of the treatment services based on the generally accepted standards of practice represented as functional, measurable, and time-specific objectives.
- Include the maintenance plans for discharge from treatment.
- Include a description of the member's progress, as applicable, toward the established goals, the home-programing provided, collaboration with other professionals and services, any appropriate modifications to the initial plan of care, and plans for continuing care.

c. Documentation of the appropriate ICD-10-CM medical and treating diagnoses (if applicable) and a description of how the diagnoses relate

to the member's communication needs and any significant medical information pertinent to the use of the AAC device system.

d. The written report of the member's current communication abilities and levels of function, including the results as reported on the member's most recent formal, face-to-face comprehensive speech-language assessment administered according to the generally accepted standards of practice by an appropriately credentialed and trained speech-language pathologist, within one calendar year before the date of the written prior authorization request.

Refer *to* the *Division's Medical Policy Manual; Policy 1250-E Therapies (Rehabilitative/Habilitative)*

e. Documentation to demonstrate how the prescribed AAC device system is medically necessary and the most effective form of communication to correct or improve or maintain the member's health in the best condition possible, compensate for a health problem, prevent it from worsening or prevent the development of additional health problems, with a comparison of benefits versus alternative communication forms.

f. The written AAC assessment report is conducted by a speech-language pathologist individually, or in collaboration with the multidisciplinary, which may include the member being assessed, family/caregivers, and other relevant professionals (e.g., educational, vocational, and medical personnel).

g. The current Individual Support Plan/Individualized Family Services Plan/Person-Centered Plan (Planning Documents), including long-term communication goals.

B. AAC Device System Repairs

All repairs require prior authorization. Non-Warranty repairs of an AAC device system require documentation from the manufacturer explaining why the repair is not covered by warranty and medical necessity documentation. During the repair process period, a short-term rental of a device may be allowed.

The following prior authorization documentation for AAC device system repairs is required:

1. A prescription from the treating Practitioner

2. A statement that describes the needed repair

3. Justification of medical necessity

4. The estimated cost of repairs is determined by the DME supplier.

C. AAC Device System Replacement

Replacement of AAC device system or components require prior authorization and is considered in the following circumstances:

1. When loss or irreparable damage has occurred

2. It has been three (3) years since the initial prescription, and the AAC device system is no longer functional.

3. Documentation supports medical necessity or appropriateness of replacing the current AAC device system.

4. The following prior authorization documentation for AAC device system replacement is required:

   A joint statement from the prescribing practitioner's and a licensed speech-language pathologist that includes:

   a. The cause of loss or damage and what measures have been taken to prevent recurrences.

   b. Information stating the member’s abilities or communication needs are unchanged if the device replacement is greater than three years of initial device order, or no other AAC device systems currently available are better suited to the member’s needs.

   c. A new evaluation if requesting a different AAC device system from one that has been lost or damaged.

D. AAC Device System Treatment

1. The authorization and provision of AAC device system treatment and intervention includes four-unit of initial treatment services for the member in the appropriate use of the AAC device system by the speech-language pathologist.

2. The treating speech-language pathologist is responsible to coordinate, schedule, and confirm the services for the member. The initial services must include the following interventions:

   a. Treatment services for the use of AAC device system

   b. Programming and modification

   c. Established on the member’s plan of care by a qualified speech-language pathologist.

3. The intervention must include, but not be limited to:

   a. The provision of appropriate information related to set up, features, routine use, troubleshooting, cleaning, infection control practices, and

other issues related to the use and maintenance of all devices and accessories provided.

i. Treatment and instruction materials tailored to the needs, abilities, learning preferences, and language of the member and appropriate.

ii. Confirmation that the member can use all devices and accessories provided safely and effectively in the settings of anticipated use.

iii. Written description of the instruction and the provision of such instruction in the member's clinical treatment and progress report record to include, but not be limited to:

- Instructions commensurate with the risks, complexity, and manufacturer's instructions and specifications for the device.
- Instruction provided to the member, or the member's caregiver, in the appropriate use of the AAC device system provided to the member.

Assessment Requirements

A. AAC assessment is provided to determine and recommend methods, devices, aids, techniques, symbols, and/or strategies to represent and/or augment spoken and/or written language in ways that optimize communication. These components, in any combination, are known collectively as an AAC system.

B. AAC assessments are conducted by appropriately credentialed and trained speech-language pathologists. AAC evaluations shall be completed and submitted to AdSS within 65 days of the initiating referral, including the device trial period of up to 30 days.

C. Speech-language pathologists may perform these assessments individually or as members of collaborative teams that may include the individual being assessed, family/caregivers, and other relevant persons (e.g., educational, vocational, and medical personnel).

D. AAC assessment is conducted to identify, measure, and describe these expected outcomes:

1. Structural/functional strengths and deficits related to speech and language factors that affect communication performance and justify the need for AAC devices, equipment, materials, strategies, and/or services to augment speech production or comprehension, to support and promote spoken and written language learning, or to provide an alternative mode of communication.

2. Effects of speech-language and communication impairments on the individual's activities and participation (capacity and performance in everyday

communication contexts), and how an AAC system would support such activities and participation.

3. Contextual factors that serve as barriers to or facilitators of successful communication and participation for individuals who need AAC systems.

4. Assistance to members in selecting and obtaining components (e.g., aids, techniques, symbols, strategies) to optimize communication and activity/participation.

5. Recommendations for AAC systems, for AAC intervention, for follow-up, and for a referral for other examinations or services.

E. Clinical Indications:

1. AAC assessment services are provided to members as needed, as requested, or mandated or when other evidence suggests that individuals have communication impairments associated with their body structure/function and/or activities/participation that might justify the need for an AAC system.

2. An assessment is prompted by referral, by the individual's speech-language, communication, educational, vocational, social, and/or health needs, or following completion of a speech-language assessment that is sensitive to cultural and linguistic diversity.

F. Clinical Assessment:

A comprehensive assessment is sensitive to cultural and linguistic diversity. The assessment may be static (i.e., using procedures designed to describe current levels of functioning within relevant domains) or dynamic (i.e., using hypothesis testing procedures to optimize selection and use of AAC systems), and includes the following:

1. Review of auditory, visual, neuromotor, speech-language, and cognitive status, including observation of posture, gross and fine motor coordination, and any existing adaptive and/or orthotic devices currently used by the patient/client (e.g., wheelchair, neck braces, communication devices and/or techniques, other specialized equipment).

2. Relevant case history information, including medical status, education, vocation, socioeconomic, cultural, and linguistic background regarding activities in which the person needs an AAC system to support communication.

3. Standardized and/or non-standardized methods for assessing the individual's use and acceptance of a range of AAC devices, aids, symbol systems, techniques, and strategies.

4. Examination of specific aspects of voice, speech, language (e.g., spoken, written language samples, and reading level), cognition, and existing communication options and abilities.

5. Methods for identifying associated barriers and facilitators that are addressed in an intervention plan.

6. Varied parameters of the AAC assessment(e.g., tests, materials) that depend on levels of severity, whether the patient/client is a child or an adult, and whether the expressive or receptive communication disorder is congenital or acquired.

7. Selection of measures for AAC assessment with consideration for ecological validity, environments in which AAC systems routinely will be used, technology and device features, and preferences of the patient/client and communication partners (e.g., family/caregivers, educators, service providers).

8. The assessment of a range of potential AAC systems in multiple controlled and natural contexts.

9. Follow-up services to monitor individuals with identified speech-language and communication disorders justifying the need for AAC systems.

10. Cognitive-communication and language status

11. Appropriate intervention and support

12. Optimal use of the recommended AAC system

13. Adjustments in the AAC system as necessary

14. Assessment of the member's ability to use the AAC system effectively in various contexts, with adjustments made to the system, as necessary.

G. Assessment Report:

A written AAC assessment report by a licensed speech-language pathologist is required with the request for prior authorization and may include the following information:

1. Communication status and limitations, including prognosis for speech or written communication and documentation of previous use of low technology devices such as picture boards. Sensory functioning

   a. Hearing ability

   b. Visual abilities

   c. Postural abilities

   d. Physical status

2. A description of the member's cognitive readiness

3. Behavioral and learning abilities observed, evaluated, or gathered from

records of assessments:

a. Executive function skills, including:

i. Attention span

ii. Memory

iii. Problem-solving skills

iv. Ability to understand cause and effect.

v. Presence of significant behaviors, such as physical aggression and property destruction.

b. Motor abilities and assessments, if applicable:

Gross motor abilities (e.g., ambulatory, or walks with crutches/walker, or uses a wheelchair; seating and positioning/posture; head control and trunk mobility; ability to use a head stick).

c. Fine motor and upper-extremity abilities and function (e.g., ability to point, type, write, access a device via direct selection).

d. Ability to access via gaze, head mouse, single-switch or multiple-switch scanning, or other alternative access methods.

e. Treatment options considered, including types of communication support used in the past to meet goals, and why each is or is not appropriate.

4. The results of the data driven AAC device or software trials, including the following information for each device or software trialed:

a. Length of trial

b. Data collected during the trial

c. The environment in which the AAC device system and/or software trial took place (e.g., home, school, community).

d. The manner in which the device or software was accessed (e.g., gaze, direct selection, scanning).

e. Member's ability to learn to use the device or software functionally for communication.

f. A sampling of messages communicated, including frequency, level of cueing, and communication partner(s).

g. Number of messages expressed in a time period and level of cueing required for expression of such messages.

h. The degree to which the member was able to move beyond the exploratory phase and use the device or software to communicate intentionally, whether such progress occurred in both structured and unstructured settings, and with what level of proficiency progress beyond the exploratory phase occurred.

5. Description of the recommended device/accessory/software, the rationale for selection (including cost comparisons among the devices or software trialed), and how the recommended option meets the communication needs of the member.

Durable Medical Equipment Service Delivery Reporting

The AdSS shall provide reporting for timeliness of DME service delivery for specified DME as required in the Medical Equipment Service Delivery deliverable in accordance with the AdSS contract.

310-R NURSING FACILITY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division of Developmental Disabilities (Division) covers medically necessary services rehabilitative services provided in Nursing Facilities (NF) for members who are eligible for Arizona Long Term Care System (ALTCS) with acute medical needs and who need nursing care 24 hours a day but who do not require hospital care under the daily direction of a physician. NF service providers must be state licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements. Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

See Chapter 1210 of this manual regarding Institutional Services for members who are ALTCS eligible.

The Division covers services for members who have acute medical needs and are eligible for ALTCS. The following requirements apply:

A. The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting (i.e., home with home health services).While convalescent care should be considered short-term, the Contractor shall extend NF coverage as medically necessary. The AdSS must contact the Division by Day 45 of the member's placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in Chapter 1210 of this manual, the AdSS must obtain approval from the Division.

B. For members enrolled in the ALTCS Transitional Program whose health status indicates that the member will likely require NF placement for longer than 90 days, the AdSS shall provide notification to the Division's assigned Support Coordinator. The Support Coordinator shall notify AHCCCS for consideration of continued enrollment in the Transitional Program or a change to ALTCS status.

Services that are not covered <u>separately</u> when provided in an NF include:

A. Nursing services, including:

1. Administration of medication
2. Tube feedings
3. Personal care services
4. Routine testing of vital signs and blood glucose monitoring
5. Assistance with eating
6. Maintenance of catheters.

B. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

C. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

D. Administrative physician visits made solely for meeting state certification requirements

E. Non-customized durable equipment and supplies such as manual wheelchairs, geriatric chairs, and bedside commodes

F. Rehabilitation therapies ordered as a maintenance regimen

G. Administration, Medical Director Services, plant operations, and capital

H. Over-the-counter medications and laxatives

I. Social activity, recreational and spiritual services

J. Any other services, supplies or equipment that are state or county regulatory requirements or are included in the NF's room and board charge.

310-V PRESCRIPTION MEDICATION PHARMACY SERVICES

REVISION DATE: 1/24/2024, 1/10/2024, 09/21/2022, 6/22/2022, 3/1/2022, 10/1/2021, 9/30/2020
REVIEW DATE: 9/21/2022
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.52; 42 CFR 438.3(s); 42 USC 1396A(OO); A.R.S. § 32-1974; A.R.S. § 32-3248.01; 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. 4-23-402; 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; A.A.C. § 9-22-203; Social Security Act Section 1927 (g) Drug Use Review; AMPM 310-DD, AMPM 310-M, AMPM 320-N, AMPM 320-Q; AMPM 320 T-1; AMPM 320 T-2; AMPM 660; AMPM Attachment 310-V (A); AMPM Attachment 310-V (B); AMPM Attachment 310-V (C); AMPM Exhibit 300-1; AMPM 510; AHCCCS Fee For Service Billing Manual Chapter 12; ACOM 111; ACOM 201; ACOM 414 ACOM 432.

PURPOSE

This policy specifies the medication, device, and pharmacy coverage requirements and limitations of the Arizona Health Care Cost Containment System (AHCCCS) pharmacy benefit for Division of Developmental Disabilities (Division) Members enrolled in health plans managed by Administrative Services Subcontractors (AdSS) and for Members enrolled in the Tribal Health Program 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 AdSS 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 THP 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 AdSS utilize 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 written or electronic order for a short-acting opioid medication that the Member has not previously filled any prescription for 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, 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 AdSS shall maintain its own drug list to meet the unique needs of the Members they serve. The AdSS drug list shall include all the drugs listed on the AHCCCS Drug List.

2. The AdSS shall 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 AdSS shall maintain Preferred Drug lists that include every drug exactly as listed on the AHCCCS Drug List.

4. The AdSS shall not 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 AdSS shall inform their Pharmacy Benefit Managers (PBM) of the Preferred Drugs and shall require the 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 AdSS shall cover 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 AdSS shall 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 AdSS shall not disadvantage one Preferred Drug over another Preferred Drug when AHCCCS has approved Preferred Drugs or supplemental rebates for a therapeutic class.

9. The AdSS shall not require Prior Authorization (PA) criteria to require a trial and failure of one preferred agent when there are others that are also preferred and have the same indication.

10. The AdSS shall require PA for the Non-Preferred Drug when the prescribing clinician is not in agreement with transition to the Preferred Drug.

11. The AdSS shall not provide a Notice of Adverse Benefit Determination when the prescribing clinician agrees with the change to the First Line or Preferred Drug.

12. The AdSS shall 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 AdSS shall Grandfather Members on medications that AHCCCS has communicated to the Division and AdSS as approved for Grandfathering.

14. The AdSS 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 AdSS shall 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 AdSS shall be prohibited 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 AdSS shall be prohibited 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall develop Step Therapy requirements for therapeutic classes when there are no Preferred Drugs identified on the AHCCCS Drug List.

24. The AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall not 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 AdSS shall provide the Division with the Generic Drug substitution policy during the Operational Review.

C. ADDITIONAL INFORMATION FOR MEDICATION COVERAGE

1. The AdSS shall 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
    b. 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 AdSS shall 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 AdSS shall obtain PA for antipsychotic medication class based on age limits depending on the form of the medication.

4. The AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall not charge Non-Title XIX/XXI eligible Members copayments for Guest Dosing.

D. OVER THE COUNTER MEDICATION

The AdSS shall 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 AdSS shall 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 AdSS shall provide prescription drugs for covered transplant services in accordance with AdSS Medical Policy Manual Policy 310-DD.
3. The AdSS shall 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 AdSS shall not 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 AdSS shall not allow pharmacies to split-bill the cost of a prescription claim to the AdSS PBMs for Members.

6. The AdSS PBMs pharmacies shall not 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 AdSS shall communicate to the pharmacies that they are prohibited from auto-filling prescription medications.

8. The AdSS shall not 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 AdSS shall 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 AdSS shall 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 AdSS shall require pharmacies that purchase drugs at a Nominal Price outside of 340B or the FSS to bill their Actual Acquisition Cost (AAC) of the drug.

F. PA REQUIREMENTS FOR LONG-ACTING OPIOID MEDICATIONS

1. The AdSS, AdSS' PBM or AHCCCS' PBM, as applicable, shall 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 AdSS, AdSS' PBM or AHCCCS' PBM as applicable, shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 MONITORING REQUIREMENTS

1. The AdSS shall 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 AdSS shall report Drug Utilization Review management activities annually to the Division.

3. The AdSS shall 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 AdSS shall cover and consider Naloxone as an essential prescription medication to reduce the risk and prevent an opioid overdose death.

2. The AdSS shall 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 AdSS shall 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. Members 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 Adss shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall require the return of unused prescription medication in accordance with Federal and State laws.

4. The AdSS shall maintain documentation and include the quantity of medication dispensed and utilized by the Member.

5. The AdSS shall 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 MEDICATION

1. The AdSS shall be billed for the 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.

2. The AdSS shall ensure prescribers use the most cost-effective product(s) for the required dose to be administered.

3. The AdSS shall 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 AdSS shall ensure that for multidose products, prescribers only bill for the actual amount of drug that was used and the AdSS shall only reimburse the actual amount of used drug.

N. PA CRITERIA FOR SMOKING CESSATION AIDS

The AdSS shall 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 AdSS shall 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 AdSS shall ensure pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a pharmacist, within their scope of practice, shall only administer influenza and COVID immunizations to Members who are at least three years of age through 18 years of age.

3. The AdSS shall 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 AdSS shall ensure the pharmacies providing the vaccine are an AHCCCS registered provider.

5. The AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall comply with any changes to reimbursement methodology for 340B entities.

Q. PHARMACEUTICAL REBATES

1. The AdSS, including the THP PBM and AdSS' PBM, shall 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 AdSS or its PBM's shall 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 AdSS shall ensure the prescriber obtains informed consent from the Responsible Person for each psychotropic medication

prescribed.

2. The AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall ensure the prescribers obtain informed consent

for a minor through the minor's authorized Responsible Person unless the minor is emancipated.

5. The AdSS shall ensure prescribers discuss the youth can give consent for medications when they turn 18.

6. The AdSS shall 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 AdSS shall 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 AdSS shall 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 AdSS shall 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.

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 AdSS covers 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, may 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-BB TRANSPORTATION FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: February 22, 2023
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211, A.A.C.n A.A.C. R9-22-211, AMPM 310, AMPM 310-BB, AMPM 320-I, AMPM 700

PURPOSE

This policy describes requirements for coverage of transportation services for Division of Developmental Disabilities (DDD) members who are eligible for Arizona Long Term Care System (ALTCS). This policies applies to DDD's Administrative Services Subcontractors (AdSS)

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 AdSS shall cover Emergency Transportation in emergent situations in which ambulance transportation (specially staffed and equipped) is required to safely manage the member's condition.

2. The AdSS may cover basic life support, advanced life support, and air ambulance services are covered, depending upon the member's medical needs.
3. The AdSS shall cover emergency transportation for a 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 AdSS shall not require prior authorization for emergency transportation.
5. The AdSS shall cover Emergency Transportation that coverage also 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 AdSS shall cover emergency medical transportation only to the nearest appropriate AHCCCS-registered facility capable of meeting the member's physical and behavioral health needs.
7. The AdSS shall cover Emergency Transportation to obtain immediate treatment for acute conditions including, but not limited to the following:
    a. Untreated fracture or suspected fracture of spine or long bones;
    b. Severe head injury or coma;
    c. Serious abdominal or chest injury;
    d. Severe hemorrhage;
    e. Serious complications of pregnancy;
    f. Shock, heart attack or suspected heart attack, stroke or unconsciousness;
    g. Uncontrolled seizures; or
    h. Condition warranting use of restraints to safely transport to medical care.

B. AIR AMBULANCE

1. Prior Authorization is not required of any non-emergent medically necessary air ambulance transport services, regardless of the miles.
2. The Division shall cover air ambulance services under the any of 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.

3. The Division shall ensure that air ambulance companies are licensed by the Arizona Department of Health Services (ADHS) and be 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 Emergency Transportation to an appropriate AHCCCS-registered provider 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 telehealth/telemedicine when medically indicated.

D. EMERGENCY TRANSPORTATION PROVIDER REQUIREMENTS FOR EMERGENCY TRANSPORTATION SERVICES PROVIDED TO MEMBERS LIVING ON TRIBAL LANDS

1. The Division shall require that, in addition to other requirements specified in this policy, Emergency Transportation providers

rendering services on tribal lands must meet the following requirements:

a. The Division shall cover Emergency Transportation services to manage an emergency physical or behavioral health condition at the emergency scene and in transport to the nearest appropriate facility capable of meeting the member's health care needs.

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 medically necessary Non-Emergency Transportation 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 Non-Emergency Transportation services are also covered under the following circumstances:
    a. Transport a member to obtain their Medicare Part D covered prescriptions.
4. The Division shall cover medically necessary Non-Emergency Transportation services furnished by all providers who offer transportation for members residing within the State of Arizona

limited to trips within 100 miles of the pick-up location when 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. Trips over 100 miles require authorization from the Division. 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 NEMT for members residing within the State of Arizona limited to trips within 100 miles of the pick-up location when 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. Trips over 100 miles require authorization from the Division. NEMT trips for members traveling to Multi-Specialty Integrated Clinics (MSIC) or IHS/638 facilities are exempt from this limitation.
6. 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.

7. The Division shall covers medically necessary Non-Emergency Transportation provided by ambulance providers when:
   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 member must not require medical care enroute;
      ii. Passenger occupancy must not exceed the manufacturer's specified seating occupancy;
      iii. Members, companions, and other passengers must follow state laws regarding passenger restraints for adults and children;

iv. Vehicle must be driven by a licensed driver, following applicable State laws;

v. Vehicles must be insured;

vi. Vehicles must be in good working order;

vii. Members, companions, and other passengers must be transported inside the vehicle; and

viii. School-based providers should follow the school-based policies in effect.

8. 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/tribal

terrain.

9. The Division shall cover Non-Emergency Transportation when medically necessary and furnished by ambulance providers when the following conditions are met:
   a. 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 and/or therapeutic services, such as chemo, MRI, Cobalt therapy.
   b. The Division shall cover the cost of the transportation if the services are not available in the hospital in which the member is hospitalized.
10. The Division shall ensure public transportation is available 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, 10/1/2019
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907; A.R.S. § 36-850.01; A.A.C. R9-22-101; A.A.C. R9-22-202; A.A.C. R9-22-203; A.A.C. R9-22-206; 42 U.S.C. 1396b (i) and 42 CFR 441.35; AHCCCS Medical Policy 310-DD, Attachment A

PURPOSE

The purpose of this policy is to outline the coverage for transplants, related services, and immunosuppressant medications for Division members who are enrolled with an Administrative Services Subcontractors (AdSS).

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. "Close Proximity" means within the geographic service area.

3. "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.

4. "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.

5. "Experimental Service" 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.
6. "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.
7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
8. "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.

9. "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" (A.A.C. R9-22- 101).
10. "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.
11. "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.

12. "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 AdSS shall follow all Federal, State and Arizona Health Care Cost Containment System (AHCCCS) requirements for coverage of transplants, related services, and immunosuppressant medications.

B. COVERED TRANSPLANTS

1. The AdSS shall ensure coverage of 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. Allogeneic related Hematopoietic Stem Cell Transplants:

i. Allogeneic related,

ii. Allogeneic unrelated,

iii. Autologous, and

iv. Tandem Hematopoietic Stem Cell Transplant.

2. The AdSS shall ensure Members under the age of 21 under the EPSDT Program are referred or put on the Waiting List for medically necessary services 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 the AHCCCS State Plan.

3. The AdSS 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 AdSS shall ensure 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 AdSS 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 AdSS shall cover corneal transplants and bone grafts when medically necessary, cost effective and non-experimental as specified in AMPM Exhibit 300-1.

7. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant medications prior to denying services.
8. 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.

C. COVERED TRANSPLANT SERVICES

1. The AdSS 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

d. Transplantation

e. Inpatient or outpatient post-transplant care, which may include, but is not limited to, the following:

   i. Laboratory studies

   ii. Radiology and diagnostic imaging or procedures

   iii. Biopsies

   iv. Home health

   v. Skilled nursing facility services

f. All related medications, including transplant related immunosuppressants medications, as specified in AMPM 310-V.

g. Transportation, and room and board for the transplant candidate, donor and, if needed, one adult caregiver as identified by the transplant facility.

i. 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.

ii. Coverage includes the periods of evaluation, on-going testing, transplantation, and post-transplant care by the transplant center.

2. The AdSS shall ensure the Living Donor Coverage which 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 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. Behavioral Health Treatment Plans are developed with a BHP for Members with prior or ongoing adherence issues that might impact their ability to adhere to the transplantation care plan, based on a BHP assessment.

g. 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 AdSS shall cover solid organ transplant services 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 AdSS shall cover hematopoietic stem cell transplant services 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 AdSS shall ensure reimbursement is only available for transplant centers that meet the above requirements.

F. ADDITIONAL REQUIREMENTS

1. The AdSS shall ensure coverage of 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. The AdSS reviews the quality and outcome data published for the out-of-network facility as part of secondary review.

2. The AdSS shall cover solid organ living donor-related costs for pediatric kidney and liver transplants and adult kidney transplants.

3. The AdSS shall cover 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.

4. The AdSS shall ensure limited coverage for medically necessary and non-Experimental Services following the discharge from the

acute care hospital where the non-covered transplant procedure was performed, 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.

5. The AdSS 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.
6. The AdSS shall utilize the AHCCCS Reinsurance Processing Manual for transplantation reinsurance standards.
7. The AdSS 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 AdSS Transplant Coordinator shall coordinate with the Division’s 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 AdSS shall submit Division specific transplant logs on a quarterly basis for review and tracking.
3. The AdSS Transplant Coordinator shall ensure continuity of care for Members receiving care through Indian Health Services (IHS) who are being considered for transplant services.

H. ORGAN TRANSPLANT ELIGIBILITY

1. The AdSS 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, and

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 AdSS 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.

Signature of Chief Medical Officer: Anthony Dekker (Apr 21, 2023 12:34 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, 6/7/2023
REVIEW DATE: 7/25/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 20-2327, AMPM Policy 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). This policy applies to DDD's Administrative Services Subcontractors (AdSS).

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 AdSS 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 AdSS shall cover the 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).

3. The AdSS shall cover nutritional assessment services provided by a registered dietitian when ordered by the Member's PCP.

4. The AdSS shall cover 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.

5. The AdSS shall be responsible for the procurement of and the primary funding source for any other nutritional supplementation medically necessary for Women, Infants, and Children (WIC) exempt formula.

6. The AdSS shall implement protocols for transitioning a Member who is receiving nutritional therapy to or from subcontractors or

providers.

B. PRIOR AUTHORIZATION

1. The AdSS 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 AdSS shall require the Member's PCP or specialty provider to determine medical necessity for commercial oral nutritional supplements on an individual basis, using the criteria specified in this policy.

2. The AdSS shall require the PCP or specialty provider to use AMPM Attachment 310-GG (A) to obtain authorization from the Division.

3. The AdSS shall follow specific criteria utilizing AMPM Attachment 310-GG (A) when assessing the medical necessity of providing commercial oral nutritional supplements.

4. The AdSS 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 AdSS shall require the provider submit AMPM Attachment 310-GG (A) from the AdSS' Medical Director or designee's consideration, along with supporting documentation 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 AdSS shall ensure supporting documentation

accompanies AMPM Attachment 310-GG (A) 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 AdSS shall cover metabolic formulas and Medical Foods for Members diagnosed with metabolic conditions that are screened for using the Newborn Screening Panel authorized by the Arizona Department of Health Services.

2. The AdSS shall cover metabolic formulas and medical foods as specified in A.R.S. § 20-2327 and within the following limitations:

   a. The AdSS are responsible for the initial and follow-up consultations by a genetics physician or a metabolic nutritionist;

b. The AdSS are responsible for all medically necessary laboratory tests and other services related to the provision of medical formulas or foods for Members diagnosed with an inherited metabolic disorder;

c. 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.

d. 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;

e. The AdSS shall ensure the member's medical and nutritional status is supervised by the member's PCP, attending physician or appropriate specialist;

f. 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;

g. Foods that are available in the grocery store or health food store are not covered as a metabolic food; and

h. 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 AdSS shall follow Medicare requirements for the provision of Total Parenteral Nutrition (TPN) services.

2. The AdSS shall cover TPN for Members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

3. The AdSS shall cover TPN when medically necessary, for Members receiving EPSDT.

F. 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 16:00 MST)

Anthony Dekker, D.O.

310-HH END OF LIFE CARE AND ADVANCE CARE PLANNING

REVISION DATE: 6/22/2022

EFFECTIVE DATE: October 1, 2019

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 AdSS shall provide End of Life (EOL) care that is member-centric, includes Advance Care Planning, and the delivery of appropriate health care services and practical supports in conjunction with 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 Manual 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 AdSS Medical Manual 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 are 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. REPORTING REQUIREMENTS TO THE DIVISION

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 17:50 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 the Administrative Services Subcontractors (AdSS).

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 AdSS 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 AdSS 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 AdSS 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 AdSS 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.

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 10:15 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 Administrative Services Subcontractors (AdSS).

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 AdSS shall cover medically necessary non-experimental Biomarker Testing 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 AdSS shall cover Biomarker Testing with the same scope, duration, and frequency as the system otherwise provides to Members pursuant to A.R.S. § 36-2907.03.

3. The AdSS shall ensure that coverage is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples.

4. The AdSS shall require prior authorization for Biomarker Testing.

5. The AdSS shall have a clear and readily available process to accept electronic requests from providers for exceptions to a coverage policy.

Signature of Chief Medical Officer: Anthony Dekker (Dec 7, 2023 10:16 MST)

Anthony Dekker, D.O.

320-B MEMBER PARTICIPATION IN EXPERIMENTAL SERVICES AND CLINICAL TRIALS

EFFECTIVE DATE: May 17, 2023
REFERENCES: AMPM 320-B

PURPOSE

This policy describes the responsibilities related to Experimental Services and Qualifying Clinical Trials. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "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.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "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 nationally recognized medical research organizations or institutions.

4. "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 AdSS shall ensure that Members may participate in clinical trials, but shall not reimburse for the Experimental Services.

2. The AdSS 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 AdSS shall not block or attempt to block an Eligible Patient's access to an Individualized Investigational Treatment.

B. COVERAGE DETERMINATION

1. The AdSS shall expedite and complete a determination of coverage for a Member to participate in a Qualifying Clinical Trial within 72 hours regardless of the geographic location or if the provider is in network.

2. The AdSS shall not deny coverage of a routine member's costs based on:
    a. Where the clinical trial is conducted, including out of state; or
    b. Whether the provider treating the Member is outside of the network.
3. The AdSS Chief Medical Officer, Medical Director, or designee shall describes the responsibilities related to Experimental Services and Qualifying Clinical Trials. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).using the following criteria:
    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 has no financial interest in the clinical trial.

4. The AdSS shall submit a Second Level Review to the Division for any Member to participate in Experimental Services or Qualifying Clinical Trial prior to approving or denying services.

5. The AdSS shall ensure Members rights are being protected when approved to participate in a clinical trial.

Signature of Chief Medical Officer: Anthony Dekker (May 10, 2023 11:12 PDT)
Anthony Dekker, D.O.

320-I TELEHEALTH AND TELEMEDICINE

REVISION DATE: 12/21/2022
EFFECTIVE DATE: October 1, 2019
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). This policy applies to DDD's Administrative Services Subcontractors (AdSS).

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 AdSS shall cover medically necessary, non-experimental, and cost-effective services delivered via Telehealth for Division covered services.

2. The AdSS shall cover services delivered via Telehealth in rural and urban regions; there are no geographic restrictions for Telehealth.

3. The AdSS 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 AdSS shall not permit services delivered via Telehealth to replace member or provider choice for healthcare delivery modality.

5. The AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS shall cover both synchronous and asynchronous remote patient monitoring.

2. The AdSS shall limit coverage of equipment and/or supplies for remote patient monitoring to when:

   a. The service being provided is an AHCCCS covered service eligible for remote monitoring, and

   b. The equipment and/or supplies are AHCCCS covered items.

F. AUDIO-ONLY SERVICES

1. The AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS shall ensure all Telehealth reimbursable services are provided by an AHCCCS-registered provider within their scope of practice.

1. The AdSS shall cover Non-Emergency Transportation (NEMT) to and from the Originating Site where applicable.

2. The AdSS 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.

3. The AdSS shall ensure informed consent standards for Telehealth services adhere to all applicable statutes and policies governing informed consent.

4. The AdSS 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).

5. The AdSS shall not place POS restrictions for a Distant Site.

6. The AdSS 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-M MEDICAL MARIJUANA AND CBD OIL PRODUCTS

REVISED DATE: 7/13/2022
EFFECTIVE DATE: January 15, 2020
REFERENCES: 9 A.A.C. 22, Article 2, 42 CFR 440.120, AMPM 320-M Medical Marijuana

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division contracts with Administrative Services Subcontractors (AdSS) and delegates the responsibility of implementation of this policy. 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 and AdSS cover medically necessary federally or 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 or state reimbursable medications.

The Division and AdSS do not cover medical marijuana or CBD Oil. AdSS shall 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 owner, director, principal, agent, employee, subcontractor, volunteer, or staff of the AdSS' 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 12:05 PDT)
Anthony Dekker, D.O.

320-O BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

REVISION DATE: March 3, 2021

EFFECTIVE DATE: October 1, 2019

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

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy describes the provisions for behavioral health assessment and treatment/service planning for Division members enrolled with a DDD subcontracted health plan.

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.

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.

4. 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 member's 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, DDD, 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 Medical Policy 520.

5. 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.

6. The AdSS shall require subcontractors and 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>

1. General Requirements for behavioral health assessments and treatment/service planning shall comply with the Rules set forth in A.A.C. Title 9, Chapters 10 and 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 Plan, 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 AdSS Medical Policies 310-B, 320-P, 320-Q and 320-R; AdSS Operations Policies 444 and 446.

4. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) must 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 AdSS 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 AdSS 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 AdSS Medical Policy 320-P.

11. For members determined SMI:

    a. Assessment and treatment/service planning must 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 AdSS 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 AdSS 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 (Refer to AdSS Medical Policy 541), and

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.

C. 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).

320-P SERIOUS EMOTIONAL DISTURBANCE AND SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATIONS

REVISION DATE: 2/7/2024, 7/14/2021
REVIEW DATE: 9/19/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. 36-550, A.A.C. R9-21-101(B), Division Medical Policy 320-P

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and establishes requirements for eligibility determinations for individuals with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). The Division contracts with the AdSS and delegates the responsibilities of implementing this policy. The Division provides oversight and monitoring of delegated duties.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday or Friday, excluding State and Federal Holidays.

2. "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.

3. "Determining Entity" means an entity designated by AHCCCS and authorized to make SED and SMI eligibility determinations.

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 individual'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 AdSS shall ensure all Members from birth to 18 years of age are evaluated for SED eligibility by a qualified clinician and

referred to the Determining Entity if the Responsible Person or Designated Representative makes such a request.

2. The AdSS shall ensure all Members ages 17.5 or older are evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and are referred to the Determining Entity if:
   a. The Responsible Person or Designated Representative makes such a 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 AdSS shall ensure the SED and SMI eligibility evaluation records contain all documentation considered during the review,

including current and historical treatment records.

4. The AdSS shall develop and make available to providers any requirements or guidance on SED and SMI eligibility evaluation record location and or maintenance.

5. The AdSS shall computate time 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 SED or SMI determination, but the final SED or SMI determination must be completed no later than day three; and
   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 INITIAL SED OR SMI ASSESSMENT

1. The AdSS shall require behavioral health providers, upon receipt of a referral or identification of the need for an SED or SMI Eligibility Determination, to schedule an assessment with the Member and a qualified clinician, if one has not been completed within the past six months, within seven business days of receipt of the referral or request, or as expeditiously as the Member's health condition requires.

2. For urgent eligibility determination referrals for members admitted to a hospital for psychiatric reasons, the AdSS shall allow the hospital to complete the assessment if it meets the criteria needed to render a decision.

3. The AdSS shall ensure that the qualified clinicians complete the following during the assessment meeting with the Member:

   a. Make a clinical judgment as to whether the Member is

competent to participate in the assessment;

b. Obtain written consent to conduct the assessment from the Member or Responsible Person unless the Member is under court order to undergo an evaluation as part of court-ordered treatment proceedings;

c. Provide the Member or Responsible Person with 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 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 AdSS shall ensure the final determination of SED includes both a qualifying SED diagnosis and functional impairment because of the qualifying SED diagnosis.

2. The AdSS shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. The AdSS shall ensure the functional criteria for SED, due to a qualifying SED diagnosis, includes 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 disorder;

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 AdSS 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 AdSS shall ensure the final determination of SMI includes both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis.

2. The AdSS shall refer to the Medical Coding Page on the AHCCCS website for a list of qualifying diagnoses.

3. The AdSS shall ensure the functional criteria for SMI status, due to a qualifying SMI diagnosis, includes dysfunction in at least one of the following four domains for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:

    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 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 or 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; or

vi. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

d. Risk of deterioration:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Comorbidities including developmental and intellectual disability, substance use and personality disorders;

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors;

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 AdSS 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 AdSS shall ensure, for purposes of SED or SMI eligibility determination, presumption of functional impairment is as follows for Members with co-occurring substance use:
   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.

iii. In order 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 and determination process. Some Members will not meet the 30-day period of abstinence. This does not preclude them from the SED or SMI eligibility assessment and determination process.

F. PROCESS FOR COMPLETION OF FINAL SED OR SMI ELIGIBILITY DETERMINATION

1. The AdSS shall develop policies and procedures that describe the providers' requirements for submitting the evaluation packet and providing additional clinical information for the Determining Entity to make the final SED or SMI eligibility determination.

2. The AdSS shall ensure the evaluating agency responds to the Determining Entity within three business days of a request for additional information to make a final SED or SMI eligibility determination.

G. ISSUES PREVENTING TIMELY COMPLETION OF ELIGIBILITY DETERMINATION AND EXTENSION OF TIME

1. The AdSS shall allow an extension of up to 20 calendar days to initiate or complete the SED or SMI eligibility determination if the Responsible Person agrees to the extension and:

a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;

b. The Member fails to keep an appointment for assessment, evaluation, or any other necessary meeting;

c. The Member is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;

d. The Member or Designated Representative 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.

2. The AdSS shall ensure "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).

H. RE-ENROLLMENT OR TRANSFER

1. The AdSS shall adhere to the following:
    a. If a Member's status is SED or SMI at disenrollment, while incarcerated, or transition to another health plan, 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 the criteria.

I. REMOVAL OF SED OR SMI DESIGNATION

1. The AdSS shall indicate in policies and procedures made available to providers, the process for reviewing an SED or SMI designation, including:
    a. A review of the eligibility determination may not be requested within the first six months from the date a Member has been designated as SED or SMI eligible.

b. A review of the Member's SED or SMI designation from the Determining Entity may be requested:

   i. As part of an instituted, periodic review of all Members designated to have an SED or SMI;

   ii. When there has been a clinical assessment that supports the Member no longer meets the functional and or diagnostic criteria; or

   iii. As requested by a 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.

2. The AdSS shall ensure services are continued in the event of a timely filed appeal, and that services are appropriately transitioned.

SUPPLEMENTAL INFORMATION

The information contained in Sections J through M of this policy are AHCCCS requirements for the Determining Entity authorized by AHCCCS to make the final SED and SMI designation determinations.

J. DETERMINING ENTITY RESPONSIBILITY FOR COMPLETION OF FINAL ELIGIBILITY DETERMINATION

1. A licensed psychiatrist, psychologist or nurse practitioner designated by the Determining Entity will 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 must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement must be documented in the Member's comprehensive clinical record.

b. Disagreement regarding functional impairment: Determination that the Member does not meet eligibility requirements must 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 Member shall be provided written notice of the eligibility determination within three business days of the initial meeting with the qualified clinician.

K. 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 must 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 will be notified of their appeal rights and the option to reapply in accordance with this policy.

L. 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 or Responsible Person 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 individuals 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

M. DETERMINING ENTITY RESPONSIBILITY FOR REMOVAL OF SED OR SMI DESIGNATION

1. Upon removal of an SED or SMI designation, the Determining Entity is responsible for the following:
   a. Inform the Member of changes that may occur as a result of the designation removal.

b. Provide written notice of the determination and the Member's right to appeal within 30 calendar days from the date of the written notice of determination is issued.

Signature of Chief Medical Officer: Anthony Dekker (Jan 30, 2024 15:43 MST)

Anthony Dekker, D.O.

320-Q GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-514.05(C), A.R.S. § 15-104, A.R.S. § 36-501 et seq, A.R.S. § 36-2272; A.A.C. R9-21-206.01(c); AMPM Policy 310-V; AMPM 310-V, Attachment A; AMPM Exhibit 320-Q, Attachments A and B

This policy applies to the Division's Administrative Services Subcontractors (AdSS). Each member of the Division of Developmental Disabilities (Division) has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services, be made aware of the service options and alternatives available to them, and to be aware of the specific risks and benefits associated with these services.

Definitions

General Consent - a one-time agreement to receive certain services, including but not limited to behavioral health services, that is usually obtained from a member during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from the member/ responsible person.

Informed Consent - permission granted in the knowledge of the possible consequences; typically consent that is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits. Informed consent is required to be obtained from a member/responsible person prior to the provision of the following services and procedures:

A. Complementary and Alternative Medicine (CAM)

B. Psychotropic medications

C. Electro-Convulsive Therapy (ECT)

D. Use of telemedicine

E. Application for a voluntary evaluation

F. Research

G. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness)

H. Procedures or services with known substantial risks or side effects.

Overview

The Division and AHCCCS recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in A.A.C. R9-21-206.01(c), must present the facts necessary for a

member/responsible person to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the member/responsible person agrees or does not agree to the specific treatment, and the member's/responsible person's signature when required, must be included in the comprehensive clinical record.

In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

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

General Requirements

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

B. For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. § 8-514.05[C]) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.

C. Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

D. Any member aged 18 years and older or the member's legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

E. Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. § 36-501 et seq.

F. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per Policy 940 of this Policy Manual.

G. The Administrative Services Subcontractor (AdSS) must develop and make available to providers policies and procedures that include any additional information or forms.

H. A foster parent, group home staff, foster home staff, relative, or other person or

agency in whose care a child is currently placed may give consent for:

1. Evaluation and treatment for emergency conditions that are not life threatening, and

2. Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. § 8-514.05[C]).

I. To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS), whomever is available to do so immediately upon request (A.R.S. § 8-514.05[C]).

J. Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services for which foster or kinship caregivers can consent include:

1. Assessment and service planning

2. Counseling and therapy

3. Rehabilitation services

4. Medical Services

5. Psychiatric evaluation

6. Psychotropic medication

7. Laboratory services

8. Support Services

9. Case Management

10. Personal Care Services

11. Family Support

12. Peer Support

13. Respite

14. Sign Language or Oral Interpretive Services

15. Transportation

16. Crisis Intervention Services

17. Behavioral Health Day Programs.

K. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed must not consent to:

1. General anesthesia

2. Surgery

3. Testing for the presence of the human immunodeficiency virus

4. Blood transfusions

5. Abortions.

L. Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires DCS consultation and agreement.

M. If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

General Consent

Administrative functions associated with a member's enrollment do not require consent, but before any services are provided, general consent must be obtained.

The AdSS must develop and make available to providers any form used to obtain general consent to treatment.

Informed Consent

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

1. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions

2. Information about the member's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment

3. The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding

4. The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects

5. The ability of any consent given to be withheld or withdrawn in writing or orally at any time (when this occurs, the provider must document the member's choice in the medical record)

6. The potential consequences of revoking the informed consent to treatment

7. A description of any clinical indications that might require suspension or termination of the proposed treatment.

B. Documenting Informed Consent

1. Members, or if applicable, the member's parent, guardian or custodian, must give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

2. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established.

   If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the responsible person, refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner must document in the member's record that:

   a. The information was given

   b. The member refused to sign an acknowledgment

   c. The member gives informed consent to use psychotropic medication or telemedicine.

C. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

1. Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court

2. Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience.

   It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

D. Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

1. Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in the medical record. Informed consent is required prior to:

   a. Initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see Division Medical Policy Manual Policy 310-V)

      The use of Informed Consent/Assent for Psychotropic Medication Treatment Form *(*AMPM 310-V Attachment A) is recommended as a tool to review and document informed consent for psychotropic medications.

   b. Delivery of behavioral health services through telemedicine.

2. Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, prior to:

   a. Provision of Electro-Convulsive Therapy (ECT)

      ECT includes research activities, voluntary evaluation, and procedures or services with known substantial risks or side effects.

   b. Involvement of the member in research activities

   c. Provision of a voluntary evaluation for a member

      The use of Application for Voluntary Evaluation *(*AMPM 320-Q, Attachment A) is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations.

   d. Delivery of any other procedure or service with known substantial risks or side effects.

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

F. If informed consent is revoked, treatment must be promptly discontinued, except when abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

G. Informed Consent for Telemedicine

1. Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or legally authorized health care decision maker must be obtained. Refer to this Policy Manual, Policy 320-I.

2. Information regarding informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing information regarding informed consent, it must be communicated in a manner that the member and/or legal guardian can adequately understand.

3. Exceptions to this consent requirement include:

a. If the telemedicine interaction does not take place in the physical presence of the member

b. In an emergency situation in which the member or the member's legally authorized health care decision maker is unable to give informed consent

c. The transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

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

B. Non-Emergency Situations

1. When the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

a. Lawfully authorized legal guardian

b. Foster parent, group home staff or other person with whom the DCS has placed the child, or

c. Government agency authorized by the court.

2. If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

INDIVIDUAL/ENTITY	**DOCUMENTATION**
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other person/agency	Copy of court order assigning custody
DCS Placements (for children removed from the home by DCS), such as: Foster parents Group home staff Foster home staff Relatives Other person/agency in whose care DCS has placed the child	None required (see note)

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

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

a. Evaluation and treatment for emergency conditions that are not life threatening, and

b. Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

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

C. Emergency Situations

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

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

Special Requirements for Children

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or un-able to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment, and such consent should be obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

A. Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.

B. Substance Abuse Prevention Program and Evaluation Consent *(*AMPM 320-Q, Attachment B) must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of the Division and AHCCCS. The consent must satisfy all of the following requirements:

1. Contain language that clearly explains the nature of the screening program and when and where the screening will take place

2. Be signed by the child's parent or legal guardian

3. Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.

C. Completion of Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

320-R SPECIAL ASSISTANCE FOR MEMBERS WITH SERIOUS MENTAL ILLNESS

REVISION DATE: 9/15/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM Policy 1040; A.R.S. §§ 14-5304, 36-107, 36-501, 36-504, 36-509, 36-517.01, 41-3803, 41-3804; 9 A.A.C 21

PURPOSE

This policy applies to the Division's Administrative Services Subcontractor(s) (AdSS). The Division's AdSS must identify, document, notify and report members determined to have a serious mental illness (SMI) and meet the criteria for Special Assistance.

DEFINITIONS

Behavioral Health Residential Facility (BHRF) - as stated in A.A.C. R9-10-101, is a health care institution that provides treatment to an individual experiencing a behavioral health issue that limits the individual's ability to be independent or causes the individual to require treatment to maintain or enhance independence.

Designated Representative - is a parent, guardian, relative, advocate, friend, or other person, designated orally or in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs.

Independent Oversight Committee (IOC) - is established by state statute (A.R.S. § 41-3804) to promote the rights of individuals who receive behavioral health services pursuant to Title 36, Chapters 5 and 34. There is one IOC established for each region, as well as the Arizona State Hospital, with each IOC providing independent oversight and review within its respective jurisdiction as defined in A.R.S. §§ 41-3803 and 41-3804, and A.A.C. R9-21-105.

Office of Human Rights (OHR) - is established within AHCCCS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates 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.

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

Special Assistance - is 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 Planning, grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

POLICY

The AdSS and subcontracted providers, if applicable, shall identify and submit notification to the Division of Developmental Disabilities (Division) and AHCCCS, Division of Community

Advocacy and Intergovernmental Relations, Office of Human Rights (OHR) of members who meet criteria for Special Assistance. The provider shall submit a notification whether or not the member's Special Assistance needs appear to be met by an involved guardian or

designated representative (e.g., family member or friend). The AdSS and subcontracted providers shall ensure that the individual designated to provide Special Assistance is involved at key stages of the grievance and appeals process.

A. GENERAL REQUIREMENTS

1. Criteria to deem a member to be in need of Special Assistance are as follows:

    a. A member is in need of Special Assistance if the member is unable to do any of the following:

        i. Communicate preferences for services;

        ii. Participate effectively in service planning or Inpatient Treatment and Discharge Planning (ITDP) development;

        iii. Participate effectively in the appeal, grievance, or investigation processes as specified in A.A.C R9-21, Article 4; and

    b. The member's inability to communicate preferences and participate effectively shall be due to at least one of the following:

        i. Cognitive ability/intellectual capacity (i.e., cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);

        ii. Language barrier (an inability to communicate, other than a need for an interpreter/translator); and/or

        iii. Medical condition including, but not limited to, traumatic brain injury, dementia, or severe psychiatric symptoms.

    c. A member who is subject to general guardianship has been found to be incapacitated as specified in A.R.S. § 14-5304 and automatically satisfies the criteria for Special Assistance.

    d. The existence of any of the following circumstances should prompt the AdSS or subcontracted provider to more closely review whether the member is in need of Special Assistance:

        i. Developmental disability involving cognitive ability;

        ii. Residence in a 24-hour BHRF setting;

        iii. Limited guardianship, or the AdSS or subcontracted provider is recommending and/or pursuing the establishment of a limited guardianship; or

iv. Existence of a serious medical condition that affects the member's intellectual and/or cognitive functioning, such as dementia or traumatic brain injury.

2. The following criteria shall not be considered when making a determination as to whether a member is in need of Special Assistance. The member:

   a. Needs things explained in more basic terms;

   b. Is able but not willing to participate in treatment, service planning, ITDP, the appeal, grievance, or investigation processes;

   c. Can speak and advocate for themselves but presents with interpersonal issues that make working with the member challenging;

   d. Needs more regular and effective engagement from the treatment team; or

   e. Has a special need (e.g., unable to read or write, needs an interpreter).

3. The following individuals or entity may deem a member to be in need of Special Assistance:

   a. A qualified clinician providing treatment for the member,

   b. A Support Coordinator as specified in A.A.C. R9-21-101,

   c. A member of the clinical team as specified in A.A.C. R9-21-101,

   d. An AdSS,

   e. A program director of an AdSS' subcontracted provider,

   f. The Deputy Director of AHCCCS or designee; or

   g. A hearing officer assigned to an SMI appeal or grievance.

4. The AdSS and subcontracted providers shall, on an ongoing basis, assess whether members are in need of Special Assistance in accordance with the criteria set out in this policy. At a minimum this shall occur at the following stages:

   a. Assessment and annual updates,

   b. Development of or update to the service plan,

   c. Admission to a psychiatric inpatient facility,

   d. Development of or update to an ITDP,

   e. Initiation of the grievance or investigation processes,

f. Filing of an appeal, and

g. Existence of circumstances and/or other contributing factors which may be a basis for a grievance, an investigation, or an appeal.

5. The AdSS and subcontracted providers shall document in the member's medical record (e.g., on the assessment, service plan, ITDP, face sheet) each time a member is assessed for the need of Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the member is in need of Special Assistance, notification shall be provided to AHCCCS OHR by completing the notification form, Part A, in the AHCCCS QM Portal, at QMportal.azahcccs.gov, in accordance with the procedures below.

6. The AdSS shall also submit notification to the Division on a monthly basis by submitting members determined to have SMI receiving Special Assistance.

B. PROCESS FOR NOTIFICATION TO THE OFFICE OF HUMAN RIGHTS DIVISION

1. The AdSS and subcontracted providers shall submit a notification to AHCCCS OHR by completing Part A of the notification within five business days of identifying a member who is in need of Special Assistance and shall include:

   a. If the member requires immediate support (e.g., ITDP, active SMI appeal or grievance); the notification shall be submitted immediately.

   b. Notation if the member was or was not informed of the notification. If the member was not informed of the notification then it shall be documented with an explanation of why not, and

   c. A copy of the court-ordered guardianship and contact information of the appointed guardian if the member is under full legal guardianship.

      i. If guardianship documentation is not available at the time the member is identified as in need of Special Assistance, the notification is required to be submitted within the required timeframes, followed by submittal of the required documentation. The notification shall remain in pending status until the documentation is received. The AdSS shall ensure that the documentation is submitted timely.

2. The AdSS shall review the completed Part A section of the notification and:

   a. Verify the accuracy of all demographic information,

   b. Verify criteria and/or documentation submitted,

   c. Request additional information or missing information from the provider, if needed, and

   d. Move the notification forward in the process by submitting to AHCCCS OHR.

3. AHCCCS OHR will review the notification to ensure it contains all required information and respond within five business days of receipt. After review, AHCCCS OHR will:

    a. Contact the AdSS submitting the form for clarification, if needed.

    b. Designate which agency/individual will provide Special Assistance by completing Part B of the notification.

    c. Change the status of the notification to active.

4. The AdSS and subcontracted providers requesting an updated Part B, to change the individual/agency assigned to meet Special Assistance needs, shall submit a notification to AHCCCS OHR by updating the guardian/advocate information section on Part A of the notification and including any new documentation required (e.g., guardianship documentation). Requests to update Part B shall be submitted when any of the following changes occur:

    a. The individual or entity currently identified as providing Special Assistance is no longer actively involved or is unable to continue to meet the member's needs,

    b. There is a change in guardianship status,

    c. The member requests a change in the individual/agency meeting Special Assistance needs.

5. Notification to the Division

    a. The AdSS shall submit the monthly deliverable, Members Determined to have SMI Receiving Special Assistance, to the Division's Compliance Department as required in their Contract.

C. NOTIFICATION REQUIREMENTS FOR MEMBERS NO LONGER IN NEED OF SPECIAL ASSISTANCE

1. The AdSS or their subcontracted providers shall notify AHCCCS OHR within 10 days of an event or determination that a member receiving Special Assistance no longer meets criteria by completing Part C of the notification form within the portal noting:

    a. The reason(s) why Special Assistance is no longer required;

    b. The effective date;

    c. The name, title, phone number and e-mail address of the staff person completing the form; and

    d. The date the form is completed.

2. The following are instances that should prompt the AdSS or their subcontracted providers to submit a Part C:

a. The original basis for the member meeting Special Assistance criteria is no longer applicable and the member does not otherwise meet criteria. This includes when it is determined that the SMI designation is no longer appropriate and the designation as been removed.

b. A Part C due to change in SMI designation shall not be completed until after the period to appeal has expired.

c. The member passes away.

d. The member enters a Department of Corrections facility.

e. The member moves out of state and no longer receives behavioral health services in Arizona.

f. The member elects not to receive services from the AdSS or TRBHA and the member is not transferred to another AdSS or TRBHA.

3. The AdSS or their subcontracted providers shall perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, in accordance with the Division AdSS Medical Manual Policy 1040, Outreach, Engagement, Re-engagement and Closure for behavioral health. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.

4. Submission of a Part C is not needed when a person transfers to another AdSS, as the Special Assistance designation follows the person and will be included in medical record during the transfer.

5. Upon receipt of Part C, AHCCCS OHR will review the content to confirm accuracy and:

a. Sends additional follow up questions to the AdSS or subcontracted provider, or

b. Changes the status of the notification to closed.

D. REQUIREMENTS TO ENSURE THE PROVISION OF SPECIAL ASSISTANCE

1. The AdSS and subcontracted providers must maintain open communication with the person (e.g., guardian, family member, designated representative) assigned to meet the member's Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

a. Behavioral health service planning and review, including any instance when the member makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, and physician and behavioral health case manager assignment).

b. Behavioral health service plan development and update shall be in accordance with AdSS Medical Policy 320-O, Service Planning, Assessments, and Discharge Planning.

c. ITDP, including any time a member is admitted to a psychiatric inpatient facility and involvement throughout the stay and discharge.

d. Appeal process, including in circumstances that may warrant the filing of an appeal, so all Notices Adverse Benefit Determination or Notices of Decision issued to the member/guardian shall also be copied to the person designated to meet Special Assistance needs; and

e. Investigation or grievance, including when an investigation/grievance is filed and circumstances when initiating a request for an investigation/ grievance may be warranted.

2. If procedures described in the section above are delayed to ensure the participation of the person providing Special Assistance, the AdSS and subcontracted providers shall document the reason for the delay in the clinical record or in the investigation, grievance, or appeal file. If an emergency service is needed, the AdSS and their subcontracted providers shall ensure that the member receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.

3. The AdSS shall provide timely, relevant details and a copy of the original notification to the receiving entity and, when applicable, the support coordinator when a member in need of Special Assistance is:

   a. Admitted to an inpatient facility,

   b. Admitted to a BHRF setting, or

   c. Transferred to a different AdSS.

4. The AdSS and subcontracted providers shall ensure that Special Assistance member demographic information is updated within five business days of a change in any of the following sections of Part A:

   a. Member residence information; residence type, address, city, state, zip code, and phone number;

   b. Provider information; assigned provider agency, treatment team names, phone numbers and email addresses;

   c. Clinical information: diagnosis and clinical basis for Special Assistance (e.g., guardianship is assigned to a member who previously met criteria due to a cognitive barrier); or

   d. Guardian/advocate information; relationship to member, name, address, and phone number.

5. The AdSS shall periodically review whether the member's needs are being met by the person or agency designated to meet the member's Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they shall take further action to address the issue, which may include contacting the Division or AHCCCS OHR for assistance.

G. ADMINISTRATIVE REQUIREMENTS

1. The AdSS and subcontracted providers must clearly document in the member's medical record and in the behavioral health case management/client tracking system if a member is identified as in need of Special Assistance. This documentation should also include identification of the individual/agency currently assigned to provide Special Assistance, the relationship, and contact information including phone number and mailing address.

2. The AdSS must implement quality management measures to ensure the subcontracted providers implement requirements of this policy.

3. The AdSS must ensure that all applicable staff is trained regarding Special Assistance requirements.

4. The AdSS must share Special Assistance data with its subcontracted providers that provide behavioral health case management to members determined to have an SMI designation and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly).

5. The AdSS must also establish a process with its providers to obtain quarterly updates on persons currently identified as Special Assistance.

320-S BEHAVIOR ANALYSIS SERVICES

EFFECTIVE DATE: March 17, 2021
SUPERCEDES: 12/04/19

This policy applies to the Division's Administrative Services Subcontractors (AdSS).This Policy establishes requirements for Behavior Analysis Service delivery and treatment.

DEFINITIONS

1) 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.

2) 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.

3) Behavior Analyst - A person who is licensed pursuant to A.R.S §32-2091 to practice behavior analysis.

4) Behavioral Health Professional –

    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:

    h) A psychiatric-mental health nursing certification, or

        i) One year of experience providing behavioral health services

ii) Behavioral 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).

Program Descriptions

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. ABA 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, modifiers for Behavior Analysis Trainee billing, or other billing/coding information.

Provider Qualifications

Behavior Analysis Services are 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 is 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 is 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.

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.

A. Standardized instruments and procedures include, but are not limited to, 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).

B. 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.

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, DCS, 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).

   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 ABA as well as Arizona Medicaid laws and regulations and Arizona state behavior analyst licensure laws and regulations (A.R.S. §32-2091).

320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

REVISION DATE: 10/01/21, 6/16/2021
EFFECTIVE DATE: October 1, 2019

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) 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.

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. Responsibilities

may vary for Pre-Petition Screening and COE based on contractual arrangements between AHCCCS, Contractors, and Arizona counties. AdSS shall ensure providers responsible for the COE/COT process adhere to requirements of this policy. When necessary, as specified in A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible individual may submit an application requesting an agency conduct a pre-petition screening 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 as specified in A.R.S. 36-524 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 shall 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 shall 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 AdSS may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the AdSS 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 AdSS 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 shall immediately refer the application for Pre-Petition Screening and petitioning for COE to the AdSS-designated Pre-Petition Screening agency or county facility.

   The AdSS 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 AdSS is responsible through an IGA with a county for Pre-Petition

Screening and petitioning for COE, the AdSS 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 AdSS. 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 AdSS' Medical Director 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 AdSS 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 AdSS 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 AdSS must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see AdSS Medical Policy 940):

a. A copy of the application for Voluntary Evaluation

b. A completed informed consent form (see AdSS 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 AdSS 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 AdSS 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 AdSS must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the AdSS 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 AdSS 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 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 AdSS 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 AdSS 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. AdSS are 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 appropriate AdSS. This clinical communication and coordination with the AdSS 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 AdSS are 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.

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 DDD THP 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 AdSS 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 shall be the responsibility of the AdSS of enrollment.

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

EFFECTIVE DATE: March 24, 2021

PURPOSE

This Policy establishes requirements for the provision of care and services to members in Adult Behavioral Health Therapeutic Homes (ABHTH).

DEFINITIONS

A. 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.

B. 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.

C. Assessment **-** An analysis of a patient's need 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

D. 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, or
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.

E. 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:

1. 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

2. 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.)

F. 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.

G. 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.

H. 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.

I. 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.

J. 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

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 CHI. Care and services provided in an ABHTH are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board (Arizona State Plan for Medicaid). The Administrative Services Subcontractors (AdSS) shall refer to ACOM Policy 414 for information on timeframes and requirements regarding prior authorizations.

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 AdSS shall develop admission criteria for medical necessity, which at a minimum includes the below elements. The AdSS shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the AdSS website.

1. Criteria for Admission:
    a. The recommendation for ABHTH shall come through the ART process,
    b. Following an Assessment by a licensed 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 disorder behaviors.

3. As a means of providing safe housing, shelter, supervision or permanent placement.

4. 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 AdSS 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 AdSS shall develop medically necessary criteria for continued stay which, at a minimum, include the below elements. The AdSS shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria on the AdSS 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

e. 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 AdSS shall develop medical necessity criteria for discharge from an ABHTH setting which, at a minimum, includes the below elements. The AdSS shall submit discharge criteria to The Division for approval, as specified in Contract, and publish the approved criteria on the AdSS 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. AdSS Reporting Requirements

1. The AdSS shall monitor and report ABHTH bed utilization as specified in ACOM Policy 415, Attachment G or as requested by The Division or AHCCCS.
2. The AdSS 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. § 11-58; A.R.S. § 13- 3991; A.R.S. §§ 13-3994 through 13-4000; AMPM 320-Z.

PURPOSE

This Policy establishes requirements for the oversight of individuals who have been granted conditional release from the Arizona State Hospital (ASH) by the Superior Court. This policy applies to the Division's Administrative Services Subcontractors (AdSS).

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. "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.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. AdSS RESPONSIBILITIES

1. The AdSS shall develop and implement policies and procedures to provide monitoring or other behavioral health and related services to Members on conditional release from the ASH consistent with the Conditional Release Plan (CRP) issued by the Superior Court.

2. The AdSS shall provide 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.

3. The AdSS shall establish relationships with the Superior Court and ASH to support streamlined communication and collaboration between the AdSS, the Division, outpatient

treatment team, ASH, and the Superior Court.

4. The AdSS shall develop and implement policies and procedures to proactively coordinate care for Members on conditional release awaiting admission to and discharge from ASH.

B. REPORTING REQUIREMENTS

The AdSS shall monitor and ensure the behavioral health outpatient providers complete the Conditional Release Monthly Monitoring Report for members on conditional release, and submit the form as directed by the Contractor Chart of Deliverables.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:02 PDT)
Anthony Dekker, D.O.

400 CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Pregnancy Termination
2. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
3. Sterilization Reporting
4. Stillbirth Supplement Request
5. AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination requests
6. Dental Plan and Evaluation
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Adult Monitoring Report
8. EPSDT Plan and Evaluation
9. Maternity Care Plan and Evaluation
10. Number of Pregnant Women who are HIV/AIDS Positive.

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 the Administrative Services Subcontractors (AdSS) requirements for providing Maternity Care Services to Division of Developmental Disabilities (Division) Members.

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. "High-Risk Pregnancy" means a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the American College of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.
3. "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.
4. "Maternity Care" means identification of pregnancy, prenatal care, labor and delivery services, and postpartum care.

5. "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.
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "Perinatal Services" means medical services for the treatment and management of obstetrical patients and neonates as specified in A.A.C. R9-10-201.
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 or 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 the 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 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.
16. "Work Plan" means a document that identifies goals and methodology for improvement utilizing the Plan-Do-Study-Act

(PDSA) method, and monitoring efforts related to the program requirements.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall cover Maternity Care Services for all eligible, enrolled ALTCS Members of childbearing age. Maternity Care services include:
    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 such as:

2. The AdSS shall ensure 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 AdSS 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 AdSS shall ensure all cesarean sections include medical documentation surrounding medical necessity.
    a. The AdSS shall ensure all inductions and cesarean sections done prior to 39 weeks shall follow the ACOG guidelines.
    b. The AdSS shall ensure any inductions performed prior to 39 weeks or cesareans sections performed at any time that are found not to be medically necessary are not eligible for payment.
5. The AdSS shall cover related services such as outreach and Family Planning Services and Supplies, whenever appropriate,

based on the Member's current eligibility and enrollment as specified in AMPM 420.

B. AdSS REQUIREMENTS FOR PROVIDING MATERNITY CARE SERVICES

1. The AdSS shall establish and operate a Maternity Care program with program goals directed at achieving optimal birth outcomes. The following are the minimum requirements of the Maternity Care program:
    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 AdSS 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 AdSS shall 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 AdSS shall report the number of pregnant women who are HIV or AIDS positive, as specified in contract, see 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 AdSS shall ensure programs include protocols for service providers to notify the AdSS promptly when Members have tested positive for pregnancy.

ii. The AdSS shall notify the Division at maternalandchildhealth@azdes.gov and

dddcctreferral@azdes.gov when Members have tested positive for pregnancy.

iii. The AdSS shall have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all pregnant women. If activities prove to be ineffective, the AdSS shall implement different activities.

e. Participation in community and quality initiatives, 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 AdSS shall allow for freedom of choice, while not compromising the continuity of care.

ii. The AdSS shall allow Members who transition to a different AdSS or become newly enrolled with an

AdSS during their third trimester shall be allowed 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:

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 established timeframes and as specified in ACOM Policy 417. The established timeframes are as follows:

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 or 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 AdSS shall ensure Providers adhere to the following Maternity Care requirements:
   a. Maternity Care Providers shall 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 AHCCCS policy, procedures, and contracts.
2. The AdSS shall require all Maternity Care Providers ensure:
   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. For those Members receiving opioids,

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;

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 healthy behaviors during pregnancy, including:
   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 AAP to increase the initiation and duration of breastfeeding.

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 the birthing mother regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the AdSS for behavioral health services, 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:

   a. Special Supplemental Nutrition Program for WIC,

   b. Strong Families AZ home visiting programs,

   c. Arizona Department of Health Services breastfeeding hotline,

   d. Birth to Five Helpline, and

   e. Other community-based resources.

j. Members are notified that, in the event they lose eligibility for services, they may contact Arizona Department of Health Services (ADHS) Hotline for referrals to low-cost or no-cost services.

k. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the Member had with the provider, are recorded on all claim forms submitted to the AdSS regardless of the primary payer or payment methodology used, and

l. Postpartum services as clinically indicated are provided to Members within the postpartum period and adhere to current AHCCCS minimum performance measures as specified in Contract.

3. The AdSS shall ensure Maternity Care Providers utilize a separate zero-dollar claim for the postpartum visit.

D. PREGNANCY TERMINATION

1. The AdSS 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 AdSS shall ensure the following requirements regarding Prior Authorization (PA) are met except in cases of medical emergencies:
   a. The Provider obtains a prior authorization for all covered pregnancy terminations from the AdSS Medical Director;
   b. The attending physician submits a request for review of the pregnancy termination qualifying diagnosis and condition to the AdSS Medical Director or designee for enrolled pregnant women with clinical information that supports the medical necessity or other criteria met for the procedure;
   c. The AdSS Medical Director 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; and
   d. The attending physician submits all documentation of medical necessity to the AdSS, within two working days of

the date on which the pregnancy termination procedure was performed, in cases of medical emergencies.

3. The AdSS shall ensure that any decision to deny a service authorization request or to authorize a service amount is made by a Healthcare Professional who has appropriate clinical expertise in treating the Member's condition or disease.
4. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
   a. Hysterectomy;
   b. Sterilization; or
   c. Termination of pregnancy.
5. The AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven business days, for review and response for standard service authorization requests, and two business days for expedited service authorization requests.

6. The AdSs shall ensure expedited requests are clearly labeled as expedited.
7. The AdSS may request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.
8. The AdSS shall ensure:
    a. A written consent obtained by the provider and filed 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 of 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 medication(s) used,

   ii. Duration of pregnancy in days,

   iii. The date medication was given,

iv. The date any additional medications were given, and

v. Documentation that pregnancy termination occurred.

8. The AdSS shall submit the following reporting requirements 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,

   b. Pregnancy Termination Report and the required documentation as listed in AMPM 410 Attachment E, as specified in Contract.

9. The AdSS shall ensure procedures are developed to identify and monitor all claims and encounters with a primary diagnosis of pregnancy termination.

E. REQUIREMENTS FOR THE MATERNITY AND FAMILY PLANNING SERVICES ANNUAL PLAN

1. Each AdSS shall have a written Maternity and Family Planning Services Annual Plan that includes the following requirements:

a. Addresses minimum AdSS requirements, as well as the objectives of the AdSS' program that are focused on achieving Division and AHCCCS requirements;

b. Incorporates monitoring and evaluation activities as specified in AMPM Exhibit 400-2A Maternity and Family Planning Services Annual Plan Checklist;

c. The Maternity and Family Planning Services Annual Plan shall be submitted to the Division Health Care Services Unit through the Division Compliance Unit;

d. The Maternity and Family Planning Services Annual Plan shall contain, at a minimum, the following:

    i. Maternity and Family Planning Services Care Plan which provides a written, narrative description of all planned activities to address the AdSS minimum requirements for Maternity Care and Family Planning Services and Supplies, including participation in community and quality initiatives within the communities served by the AdSS.

a) The narrative description shall also include AdSS activities to identify Member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

ii. Maternity and Family Planning Services Work Plan Evaluation which provides an evaluation and assessment of the previous year's Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

iii. Maternity and Family Planning Services Work Plan that includes specific measurable objectives.

a) These objectives shall be based on Division and AHCCCS established minimum performance standards.

b) In cases where Division and AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue

the AdSS improvement efforts shall be used including:

1) National Committee on Quality Assurance (NCQA),
2) CMS Core Measures, and
3) Healthy People 2030 standards.

c) The AdSS may also develop additional specific measurable goals and objectives aimed at enhancing the Maternity Program when Division and AHCCCS Minimum Performance Standards have been met.

d) Strategies and specific measurable interventions specific to Division Members to accomplish objectives including:

1) Member outreach,
2) Provider education, and

3) Provider compliance with mandatory components of the Maternity and Family Planning Services program.

e) Targeted implementation and completion dates of Work Plan activities.

f) Assigned local staff position(s) responsible and accountable for meeting each established goal and objective specific to the Division Members.

g) Identification and implementation of new interventions and continuation of or modification to existing interventions specific to Division Members, based on analysis of the previous year's Work Plan evaluation.

h) Relevant policies and procedures, referenced in the Maternity and Family Planning Services Annual Plan, submitted as separate attachments.

F. ADDITIONAL RELATED SERVICES

1. The AdSS 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 AdSS shall cover home uterine monitoring technology 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 AdSS shall cover labor and delivery services provided in Free Standing Birthing Centers.

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 is considered 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 AdSS shall cover labor and delivery services provided in a home setting by the Member's maternity provider.

a. For members who meet medical criteria, AHCCCS covers labor and delivery services provided in the home by:

i. 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 shall initially be 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 shall be 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 shall 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. For each anticipated home labor and delivery, LMs who render home labor and delivery services shall 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.

g. Referral information to an AHCCCS registered physician who can be contacted immediately, in the event that management of complications is necessary, shall be included in the plan of action.

h. Upon delivery of the newborn, the physician, CNM or LM is responsible for conducting the following newborn examination procedures, including:

i. A mandatory Bloodspot Newborn Screening Panel

ii. 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. Second newborn hearing screening.

i. The Maternity Care provider shall notify the birthing mother's AdSS no later than three days after the birth in order to enroll the newborn with AHCCCS.

5. The AdSS shall cover licensed midwife services by LMs for Members, if LMs are included in the AdSS' provider network.

a. The AdSS shall ensure Members who choose to receive maternity services from this provider type shall meet eligibility and medical criteria specified in this policy.

b. The AdSS shall ensure risk status initially be 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. The AdSS shall ensure 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. The AdSS shall ensure documentation certifying the risk status of the Member's pregnancy is submitted to the AdSS, before providing midwife services.

e. The AdSS shall ensure a consent form signed and dated by the Member shall be submitted, indicating that the Member has been informed and understands the scope of services that shall be provided by the LM, including the risks to a home delivery.

f. The AdSS shall ensure Members are immediately referred 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. The AdSS shall ensure Labor and delivery services provided by a LM are not 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 shall be submitted to the AdSS Medical Director or designee.

h. The AdSS shall ensure the LM notifies the birthing mother's AdSS of the birth no later than one day from the date of birth, in order to enroll the newborn with AHCCCS.

Signature of Chief Medical Officer: Anthony Dekker (Oct 21, 2023 09:06 PDT)
Anthony Dekker, D.O.

411 WOMEN'S PREVENTIVE CARE SERVICES

REVISION DATE: 6/08/2022
EFFECTIVE DATE: May 27, 2016
REFERENCES: AMPM Exhibit 400-3, AMPM Policy 420, AMPM Policy 310-BB, AMPM Chapter 300, ACOM Policy 431, ACOM Policy 406. ACOM Policy 405.

PURPOSE

This policy establishes AdSS 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. The AdSS shall develop policies and procedures to monitor, evaluate, and improve women's participation in preventive care services. Contractors shall:

1. Inform all participating primary care providers (PCPs), including Obstetrician/Gynecologist (OB/GYN) providers of the availability of women's preventive care services, detailing the covered services included as part of the well-woman preventive care visit, as outlined in this policy.

2. Develop and implement a process for monitoring compliance with well-woman preventive care services provider requirements.

3. Develop, implement, and maintain a process to inform members about women's preventive health services as specified in this policy, in AMPM Exhibit 400-3, and that align with the requirements in ACOM Policy 406. This information shall be provided as specified in ACOM Policy 405.

    a. This information shall include:

        i. The benefits of preventive health care,

        ii. A complete description of the services available as described in the provider requirements,

        iii. A statement that provides assistance with information on how to obtain medically necessary

transportation as specified in AMPM Policy 310-BB including scheduling appointments to obtain well-woman preventive care services, and

iv. A statement that there is no copayment or other charge for women's preventive care visit as specified in ACOM Policy 431.

c. Provider requirements for Well-woman preventive care services include at a minimum the following covered services at each service:

1. A physical exam (Well Exam) that assesses overall health,

2. Clinical Breast Exam,

3. Pelvic exam (as necessary, according to current recommendations and best standards of practice),

4. Review and administration of immunizations, screenings, and testing as appropriate for age and risk factors as specified in AMPM Chapter 300.

5. Screening and counseling focused on maintaining a healthy lifestyle and minimizing health risks and addresses at a minimum the following:

a. Proper nutrition,

b. Physical activity,

c. Elevated BMI indicative of obesity,

d. Tobacco/substance use, abuse, and/or dependency,

e. Depression screening,

f. Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems,

g. Sexually transmitted infections,

h. Human Immunodeficiency Virus (HIV),

i. Family Planning Services and Supplies, (refer to AMPM Policy 420),

j. Preconception Counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:

i. Reproductive history and sexual practices,

ii. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake,

iii. Physical activity or exercise,

iv. Oral health care,

v. Chronic disease management,

vi. Emotional wellness,

vii. Tobacco and substance use (caffeine, alcohol, marijuana, and other drugs), including prescription drug use, and

viii. Recommended intervals between pregnancies, and

ix. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified. Screenings as specified in AMPM Chapter 300 and AMPM Policy 430. Genetic screening and testing are not covered, except as specified in AMPM Policy 310-II.

D. Well-Woman Preventive Care Service Standards

1. Immunizations:

   a. AHCCCS covers the HPV vaccine for members, as specified in AMPM Policy 310-M.

   b. Providers shall coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Providers shall enroll and re-enroll annually with the VFC program, as specified in AMPM Policy 430.

   c. Immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule as specified on the CDC website https://www.cdc.gov/vaccines/schedules/index.html, and

   d. Contractors shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

Signature of Chief Medical Officer: Anthony Dekker (Jun 1, 2022 17:25 PDT)

Anthony Dekker, D.O.

420 FAMILY PLANNING SERVICES AND SUPPLIES

REVISION DATE: 1/10/2024, 9/6/2023, 6/8/2022
REVIEW DATE: 9/14/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36.2904(L), 42 CFR 50.203 and 204, AMPM 420, AMPM 420 Attachment A and B

PURPOSE

This policy establishes requirements and describes covered services regarding Family Planning Services and Supplies for the Administrative Services Subcontractors (AdSS).

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 AdSS shall cover Family Planning Services and Supplies when provided by the appropriate Family Planning Providers or Maternity Care Providers for Members, regardless of gender, who voluntarily choose to delay or prevent pregnancy.
2. The AdSS shall ensure that services provided are within each provider's training and scope of practice.
3. The AdSS shall cover the provision of accurate information and counseling to allow Members to make informed decisions about specific Family Planning methods available.

4. The AdSS 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 AdSS shall allow pregnant or postpartum Members whose AHCCCS eligibility continues, remain with their assigned maternity provider, or may select another provider for Family Planning Services and Supplies.

B. SECOND LEVEL REVIEW

1. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
   a. Hysterectomy,
   b. Sterilization, or
   c. Termination of pregnancy.
2. The AdSS shall submit a request to the Division for prior authorization with clinical documentation that supports medical necessity for the required service and includes the following:

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 AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven Business Days, for review and response for standard service authorization requests.

4. The AdSS shall submit expedited service authorization requests within two Business Days and clearly label these requests as expedited.

5. The AdSS shall request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization prior to approval or denial being communicated to the Member or provider.

6. The AdSS shall allow the Division to make the final decision on prior authorization requests elevated for Second Level Review.

C. AMOUNT, DURATION, AND SCOPE

1. The AdSS shall ensure that Members whose eligibility continues maintain the option to remain with their assigned maternity provider or select another provider for Family Planning Services and Supplies.
2. The AdSS shall cover the following Family Planning Services and Supplies for Members:
    a. Contraceptive counseling, medication, or 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 AdSS shall ensure the provider counsels and recommends the Member continue another form of birth control to prevent pregnancy for up to three months following the Hysteroscopic Tubal Sterilization or Vasectomy.

ii. The AdSS shall ensure the provider performs 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.

3. The AdSS shall cover the following Family Planning Services:
   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 specified in this policy, for sterilization services are met; and
   e. Pregnancy termination only as specified in AMPM Policy 410.
4. The AdSS shall not cover the following 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. Hysterectomies for the purpose of sterilization.

D. AdSS REQUIREMENTS FOR PROVIDING FAMILY PLANNING SERVICES AND SUPPLIES

1. The AdSS shall plan and implement an outreach program 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 AdSS shall ensure the following Family Planning Services and Supplies information are provided to Members:
   a. A complete description of available covered services;
   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 AdSS shall ensure policies and procedures are 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 AdSS 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 AdSS shall ensure providers incorporate medical audits for Family Planning Services and Supplies within Quality Management activities to determine conformity with acceptable medical standards.
6. The AdSS shall establish quality or utilization management indicators to effectively measure and monitor the utilization of Family Planning Services.
7. The AdSS shall have written practice guidelines that detail specific procedures for the provision of LARC or IPLARC and are written in accordance with acceptable medical standards.
8. The AdSS shall ensure 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 AND SUPPLIES AND AdSS REPORTING REQUIREMENTS

1. The AdSS shall establish processes to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions.
2. The AdSS shall ensure the following minimum requirements are met for notification of covered Family Planning Services and Supplies:
    a. Members of Reproductive Age be notified either directly or through the parent or Health Care Decision Maker, whichever is most appropriate, 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 include 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 and are completed by November 1st. For Members who enroll with the AdSS after November 1st, notification is sent at the time of enrollment;

f. Notification of all 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 monitor compliance to ensure the Maternity Care Providers verbally notify Members of the availability of Family Planning Services during office visits;

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 AdSS 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 AdSS 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 AdSS 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 AdSS shall ensure the Member receives a copy of the consent form and offered factual information prior to signing the consent form that includes all of 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; and

i. Notification that sterilization cannot be performed for at least 30 days post consent.

5. The AdSS 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.

SUPPLEMENTAL INFORMATION

Sterilization

Hysteroscopic tubal sterilization and other sterilization methods are not immediately effective upon completion. It is expected that the procedure will be an effective sterilization procedure three (3) months following completion. Therefore, during the first (3) three months, the Member shall continue using another form of birth control to prevent pregnancy.

At the end of the 3 months, it is expected that a Hysterosalpingogram or sperm count will be performed confirming that the Member is sterile.

Signature of Chief Medical Officer: Anthony Dekker (Jan 5, 2024 13:01 MST)

Anthony Dekker, D.O.

430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATES: 6/08/2022, 10/01/2019
EFFECTIVE DATE: June 30, 1994
REFERENCES: 42 U.S.C. 1396d (a), Division Medical Policy Manual, 310-P

PURPOSE

This policy establishes Division 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

EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. All members age out of Oral Health & EPSDT services at age twenty-one (21). Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described in this policy and as referenced in

AMPM 430 Attachment A and AMPM431 Attachment A. The Division has adopted AMPM Policy 430 Attachment E , which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Providers shall use AMPM Policy 430 Attachment E referenced above or electronic equivalent that includes all components found in the hard copy form, at every EPSDT visit.

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan." This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of "Medical Assistance", as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law, even when they are not listed as covered services in the

AHCCCS State Plan, statutes, rules, or policies, as long as the services are medically necessary and cost effective.

A. EPSDT Services

EPSDT includes, but is not limited to, coverage of:

1. Inpatient and outpatient hospital services
2. Laboratory and x-ray services
3. Physician and nurse practitioner services
4. Medications and medical supplies
5. Dental services
6. Therapy services
7. Behavioral health services
8. Orthotics and prosthetic devices
9. Eyeglasses
10. Transportation
11. Family planning services
12. Diagnostic, screening, preventive, and rehabilitative services.

EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of 42 CFR 441.58. The Administrative Services Subcontractor (AdSS) shall ensure members receive required health screenings in compliance with AMPM Policy 430 Attachment A and the AMPM Policy 430 Attachment F, which are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life. The service intervals are minimum requirements, and any services determined by a primary care provider (PCP) to be medically necessary shall be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this policy. EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

B. EPSDT Visit Shall Include

1. A comprehensive health and developmental history, including growth and development screening [42 CFR 441.56(B)(1)] that includes physical, nutritional, and behavioral health assessments.

   Refer to the Centers for Disease Control and Prevention website for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Assessment provided by a PCP

   a. Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention.

   b. Nutritional assessment is a separately billable service by PCPs who care for EPSDT age members.

   c. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings and on an inter-periodic basis, as determined necessary by the member’s PCP.

d. Division also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT members who are underweight or overweight.

e. To initiate the referral for a nutritional assessment, the PCP shall use the AdSS' referral form in accordance with AdSS protocols, and

f. If a member qualifies for nutritional therapy due to a medical condition, the following is covered:

i. For medically necessary WIC-exempt formula

ii. Refer to Arizona WIC Programs Food List,

iii. For medically necessary WIC-exempt formula, the AdSS shall also be responsible for procurement of and the primary funding source for any other nutritional supplementation that is medically necessary.

3. Behavioral Health Screening and Services provided by a PCP

The AdSS covers behavioral health services for members eligible for EPSDT. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment or behavioral health assignment.

4. Developmental Screening Tools used by a PCP

   a. Developmental screening is a separately billable service by PCPs who care for EPSDT age members.

   b. PCPs who bill for developmental screening shall be trained in the use and scoring of the developmental screening tools as indicated by the American Academy of Pediatrics (AAP).

   c. Any abnormal developmental screening finding shall result in referrals for appropriate follow-up.

   d. As specified in AMPM Behavioral Health Practice Tools 210 and AMPM Policy 320-O, a copy of the developmental screening tool shall be kept in the medical record.

e. General Developmental Screening at nine months, 18 months, and 30 months EPSDT visits

i. General developmental screening shall occur at the 9 months, 18 months, and 30 months EPSDT visits.

ii. Accepted tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life. AHCCCS approved tools include the Ages and Stages Questionnaire, Third Edition (ASQ-3), and the Parents' Evaluation of Developmental Status (PEDS), Birth to Age Eight.

iii. The CPT code 96110 shall be used with EP modifier.

f. Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 months and 24 months EPSDT visits:

i. ASD specific developmental screening should occur at the 18 months and 24 months EPSDT visits. The Modified Checklist for Autism in Toddlers (M-CHAT-r) shall be used.

5. A comprehensive unclothed physical examination

6. Immunizations

   a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood as specified in the CDC recommended childhood immunization schedules and as specified in AMPM Policy 310-M, according to age and health history, and

   b. For members under age 19 years, unless otherwise noted in AMPM Policy 310-M, providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

   c. For adult immunizations, refer to AMPM Policy 310-M.

7. Laboratory tests

   a. Laboratory including anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test),

   b. EPSDT covers blood lead screening and testing appropriate to age and risk. Blood lead testing is required for all members at 12 months and 24 months of age and for

those members between the ages of 24 months through 6 years 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 responsible person's concerns. Additional screening for children through 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.

8. Health education, counseling, and chronic disease self-management

9. Oral Health Screening

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.

Fluoride varnish is limited in a PCPs office to once 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.

10. Appropriate vision, hearing, and speech screenings

    a. EPSDT covers eye examinations as appropriate to age according to 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 by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices, and

    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.

11. Tuberculin skin testing, as appropriate to age and risk

Children at increased risk of tuberculosis (TB) include those who have contact with persons who have been:

a. Confirmed or suspected as having TB

b. In jail or prison during the last five years

c. Living in a household with an HIV-infected person or the child is infected with HIV

d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

C. 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.

D. AdSS Specific Requirements

The AdSS Shall

1. Implement processes to ensure age-appropriate Screening and care coordination, as specified in Contract, when member needs are identified.

2. Ensure providers utilize AHCCCS approved standard developmental screening tools and complete training in the use of these tools, as indicated by the AAP. The AdSS shall monitor providers and implement interventions for non-compliance.

3. Develop policies and procedures to identify the needs of EPSDT age members, inform members of the availability of EPSDT services, coordinate member care, provide care management, conduct appropriate follow-up, and ensure members receive timely and appropriate treatment.

4. Develop policies and procedure to monitor, evaluate, and improve EPSDT participation.

5. Ensure members receive required health screenings in compliance with AMPM 430 Attachment A and AMPM Policy 431 Attachment A.

6. Ensure that the Bloodspot Newborn Screening Panel hearing and, if indicated, bilirubin screening tests are conducted, including initial and secondary screenings, in accordance with 9 A.A.C. 13, Article 2.

7. Ensure that in-office capillary blood draws utilizing validated CLIA waived testing equipment will be covered for in-network point of care EPSDT visits.

8. Ensure that providers report blood lead levels to Arizona Department of Health Services (ADHS) as required under (A.A.C.

R9-4-302). The AdSS shall implement protocols for the following:

a. Care coordination for members with elevated blood lead levels (e.g., parents/ HCDM, DR, PCP and ADHS) to ensure timely follow-up and retesting,

b. Case management is required for all children with elevated blood lead levels per current CDC recommendations. Case management shall align with CDC's recommendations for actions based on blood lead level and ADHS recommendations,

c. Appropriate care coordination for an EPSDT child who has an elevated blood lead level and is transitioning to or from another AHCCCS Contractor, and

d. Referral of members who lose AHCCCS eligibility to low-cost or no-cost follow-up testing and treatment for those members who have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood.

9. Develop, implement, and maintain a process to provide appropriate access to and timeliness of blood lead testing and follow-up care for members who have abnormal blood lead test results.

10. Ensure that:

    a. Each hospital or birthing center screens all newborns using a physiological hearing Screening method prior to initial hospital discharge.

    b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening shall be scheduled at the time of the initial discharge and completed between 2 and 6 weeks of age.

    c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination and referral(s).

11. All infants with confirmed hearing loss receive services before turning 6 months of age. Implement protocols for care and

coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

12. Employ a sufficient number of appropriately qualified local personnel in order to meet the health care needs of members and fulfill Federal and State EPSDT requirements, as well as achieve contractual compliance.

13. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements. This shall include informing PCPs of Federal, State and AHCCCS policy requirements for EPSDT and updates of new information as it becomes available and ensuring PCPs providing care to children are trained to use implemented developmental screening tools. This shall also include a process to monitor the utilization of AHCCCS approved developmental screening tools.

14. Provide EPSDT member outreach, including oral health member outreach as specified in this policy, in AMPM Policy 431 and AMPM Exhibit 400-3. This information shall include:

a. Develop, implement, and maintain a process to inform members about EPSDT services that align with the enrollment and annual requirements in ACOM Policy 406. This information shall include:

i. The benefits of preventive health care,

ii. Information that an EPSDT visit is a Well Child visit,

iii. A description of the services listed in section A (of this policy), Covered Services During an EPSDT Visit,

iv. Information on how to obtain these services and assistance with scheduling appointments,

v. Availability of care management assistance in coordinating EPSDT covered services,

vi. A statement that there is no copayment or other charge for EPSDT Screening and resultant services as specified in ACOM Policy 431, and

vii. A statement that assistance with medically necessary transportation as specified in AMPM Policy 310-BB is available to obtain EPSDT services.

b. Conduct written and other member educational outreach related to immunizations, available community resources (including but not limited to WIC, AzEIP, CRS, Behavioral Health, Home Visiting Programs, Head Start, Birth to Five Helpline), lead poisoning prevention (dangers of and sources of lead exposure in AZ populations, lead poisoning prevention measures and recommended/mandatory testing), age appropriate weight gain, childhood obesity and prevention measures, how to recognize asthma signs and symptoms, reduce triggers, and improve maintenance, age appropriate risk prevention efforts (addressing development, injury and suicide prevention, bullying, violence, drug and alcohol use, social media and sexual behavior), education on importance of utilizing primary care provider in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other AdSS selected topics at a minimum of 1 every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period. EPSDT related outreach material shall include a statement

informing members that an EPSDT visits is synonymous to a Well Child visit. Refer to AMPM Exhibit 400-3, AMPM Policy 431 and ACOM Policy 404 for additional member information requirements.

c. Develop, implement, and maintain a procedure to notify member/responsible person of visits recommended by the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM 430 Attachment A and AMPM Policy 431 Attachment A). This procedure shall include:

i. Notification to member's responsible parties/responsible person regarding suggested dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice shall be sent,

ii. Notification to member's or responsible person regarding suggested dates of biannual (one-visit every six months) dental visits. If a dental visit has not taken place, a second notice shall be sent,

iii. Inform members of appropriate immunizations according to age and health history,

iv. Refer to AMPM Policy 431 and AMPM Exhibit 400-3 for additional Oral Health required written notifications, and

v. Processes other than mailings shall be pre-approved by AHCCCS as outlined in ACOM 404.

15. Develop and implement processes to educate, refer and assist members and their families regarding community health resources, including but not limited to WIC (and ensure medically necessary nutritional supplements are covered), AzEIP, Home Visiting Programs and Head Start as specified in 42 CFR 441.61.

16. Develop and implement processes to ensure the identification of members needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

17. Participate in community and/or quality initiatives, to promote and support best local practices and quality care, within the communities served by the AdSS.

18. Coordinate with other entities when the AdSS determines a member has third party coverage.

19. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, as a result of examination, Screening, and diagnosis. Treatment, if required, shall occur on a timely basis, generally initiating services no longer than 6 months beyond the request for Screening services, unless stated otherwise in this policy.

20. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Policy 430 Attachment A and AMPM Policy 431, Attachment A) by all contracted providers.

21. Develop and implement a process for monitoring that providers use the most current EPSDT Periodicity Schedule at every EPSDT visit and that all age-appropriate Screenings and services are conducted during each visit.

22. Develop and implement processes to reduce no-show appointment rates for EPSDT services.

23. Encourage providers to schedule the next EPSDT Screening at the current office visit, particularly for children 24 months of age and younger.

24. Ensure providers enroll and re-enroll annually with the VFC program, in accordance with AHCCCS Contract requirements.

    1. AdSS shall not utilize AHCCCS funding to purchase vaccines covered through the VFC program for members younger than 19 years of age, and

    2. AdSS shall ensure providers document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, AdSS shall ensure providers maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Chapter 135. AdSS are required to monitor provider's compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.

25. Participate in a review of EPSDT requirements conducted by AHCCCS, including but not limited to: AdSS results of on-site visits to providers and medical record audits.

26. Include language in PCP contracts that requires PCPs to:

    a. Provide EPSDT services for all assigned members from birth up to 21 years of age. Services shall be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Policy 430, Attachment A and AMPM Policy 431, Attachment A),

    b. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements,

    c. Implement protocols to ensure that health problems are diagnosed and treated Early, before they become more complex and the treatment more costly (including follow-up related to blood lead Screening and tuberculosis Screening),

    d. Have a process for assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal

health outcomes, to ensure that members receive appropriate support services,

e. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes,

f. Refer eligible members to Head Start and the special supplemental nutrition program for WIC, for WIC approved formula and support services. Ensure that medically necessary nutritional supplements are covered by the AdSS. For more information, refer, EPSDT Service Standards, Nutritional Assessment and Nutritional Therapy of this Policy),

g. Utilize the criteria specified in this Policy when requesting medically necessary nutritional supplements,

h. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children birth up to 3 years of age with Developmental disabilities needing services, including

family education and family support needs focusing on each child's natural environment, to optimize child health and development (EPSDT services, as defined in 9 A.A.C. 22, Article 2, shall be provided by the AdSS). Refer to AMPM 430 Attachment D, and

i. Require providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member's AzEIP enrollment. Refer to AMPM 430 Attachment C for more information related to the coordination and referral process for Early interventions services.

27. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services.

Behavioral health services are delivered in accordance with guidelines that incorporate evidence-based "best practices". AHCCCS has implemented 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. AdSS and providers are required to

integrate these principles in the provision of behavioral health services for EPSDT age members. Refer to AMPM Policy 100.

28. Develop guidelines for use by the PCP in providing the following:

    a. Information necessary to obtain Prior Authorization (PA) for commercial oral nutritional supplements,

    b. Encouragement and assistance to the parent/responsible person in weaning the member from the necessity for supplemental nutritional feedings, and

    c. Education and training, if the member's responsible person elects to prepare the member's food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

29. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another AdSS or another service program (e.g. WIC).

30. Implement a process for verifying medical necessity of nutritional therapy through the receipt of supporting medical documentation dated within 3 months of the request, prior to

giving initial or ongoing authorizations for nutritional therapy. Documentation shall include clinical notes or other supporting documentation from the member's PCP specialty provider, or registered dietitian, including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on AMPM 430 Attachment B.

E. AdSS Requirements For The EPSDT Program Plan Checklist

AdSS shall have a written EPSDT Program Plan Checklist that addresses minimum AdSS requirements as specified above as well as the objectives of the AdSS' program that are focused on achieving AHCCCS requirements. The Checklist shall also incorporate monitoring and evaluation activities for these minimum requirements. Refer to Attachment F. The EPSDT Program Plan Checklist shall be submitted as specified in Contract and is subject to AHCCCS approval. The EPSDT Program Plan Checklist shall contain, at a minimum, the following: Provider Requirements

1. EPSDT Narrative Plan

A written description of all planned activities to address the AdSS' minimum requirements for EPSDT services, as specified above, including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral health problems for members under the age of 21. The narrative description shall also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

2. EPSDT Plan Evaluation - An evaluation of the previous year's Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. EPSDT Plan that includes:

    a. Specific measurable objectives. These objectives shall be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS Minimum 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, current Healthy People standards). The AdSS may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program when Minimum Performance Standards have been met.

b. Strategies and specific measurable interventions to accomplish objectives (e.g. member outreach, provider education and provider compliance with mandatory components of the EPSDT program).

c. Targeted implementation and completion dates of plan activities.

d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective, and

e. Identification and implementation of new interventions, continuation of, or modification to existing interventions, based on quarterly analysis of the previous year's Plan Evaluation.

4. All relevant current EPSDT policies and procedures shall be submitted as separate attachments

F. Provider Requirements

EPSDT services shall be provided according to community standards of practice in accordance with Section 42 USC 1396d(a) and (r), 1396a(a)(43), 42 CFR 441.50 et seq. and AHCCCS rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Policy 430, Attachment A and AMPM Policy 431, Attachment A).

Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of Screening services.

Providers are required to provide health counseling/education at initial and follow-up visits.

Refer to the specific AdSS regarding PA requirements.

A PCP referral is not required for Naturopathic services.

Additionally, providers shall adhere to the below specific standards and requirements for the following covered services:

1. Breastfeeding Support per AAP recommendation, PCPs will ensure that families receive evidence-based breastfeeding information and support.

2. Immunizations:

a. All appropriate immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule as specified in the CDC recommended immunization schedules and AMPM Policy 310-M.

Refer to the CDC website: www.cdc.gov/vaccines/schedules/index.html for current immunization schedules. The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed on www.AZDHS.gov. If appropriate, document in the member's medical record the member/responsible person's decision not to utilize EPSDT services or receive immunizations, and

b. Providers shall coordinate with the ADHS for the VFC program in the delivery of immunization services.

3. Blood Lead Screening

a. The ADHS Parent Questionnaire, which was formerly used as part of Screening, is no longer required in this population. However, the questionnaire may be utilized to

help determine if a lead test should be performed outside of the required testing ages. Screening efforts should focus on assuring that these children receive blood lead testing,

b. Anticipatory guidance to provide an environment safe from lead, shall still be included as part of each EPSDT visit from 6 months through 6 years of age, and

c. A blood lead test result equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick shall be confirmed using a venous blood sample.

4. Organ and Tissue Transplantation Services Refer to Division Medical Policy 310-DD for information regarding AHCCCS-covered transplants.

5. Metabolic Medical Foods

If an AHCCCS covered 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 Division Medical Policy 310-GG.

6. Nutritional Therapy

   a. AHCCCS 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,

   b. PA is required from the AdSS for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy,

      i. Medical necessity for commercial oral nutritional supplements shall be determined on an individual basis by the member's PCP or specialty provider, using the criteria specified in this policy. An example of a nutritional supplement is an amino acid based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty

provider shall use the AHCCCS approved form, AMPM Policy 430 Attachment B, to obtain authorization from the AdSS.

1) Attachment B shall indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

   a) The member has been diagnosed with a chronic disease or condition,

   b) The member is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the AAP, and

   c) There are no alternatives for adequate nutrition

   OR

a) The member had met at least two of the following criteria to establish medical necessity:

- Is at or below the 10th percentile for weight-for- length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.
- Reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age.
- Demonstrated a medically significant decline in weight within the 3 month period prior to the assessment.

- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

c. Additionally, each of the following requirements must be met:

i. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems).

ii. 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 of no less than 30 days in duration. 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, the provider may submit the Certificate of Medical Necessity for Commercial Oral Nutritional

Supplements located in the AMPM Policy 430 Attachment B), along with supporting documentation demonstrating the risk posed to the member, for the AdSS Medical Director or Designee's consideration in approving the provider's prior authorization request.

iii. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater - Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria, and it includes:

1) Initial Requests

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.

Clinical notes or other supporting documentation dated within 3 months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity (The physical assessment must include the member's current/past weight-for-length and BMI percentiles (if member is two years of age or older.)

Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, and as member adherence to the prescribed dietary plan/alternatives attempted.

2) Ongoing Requests

Subsequent submissions shall include a clinical note or other supporting documentation dated

within three months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

Note: Members receiving nutritional therapy must be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually. Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

5. 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 AdSS Medical Policy 431.

6. Cochlear and Osseointegrated Implantation

a. Cochlear implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for individuals who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or post-lingual. AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members' candidates for cochlear implants shall meet criteria for medical necessity, including but not limited to, the following indications:

i. A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation,

ii. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation,

iii. No known contraindications to surgery,

iv. Demonstrated age-appropriate cognitive ability to use auditory clues, and

v. The device shall be used in accordance with the FDA approved labeling.

b. Coverage of cochlear implantation includes the following treatment and service components:

i. Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist, or audiologist,

ii. Pre-surgery inpatient/outpatient evaluation by a board-certified otolaryngologist,

iii. Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability,

iv. Pre-operative psychosocial assessment/evaluation by psychologist or counselor,

v. Prosthetic device for implantation (shall be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions),

vi. Surgical implantation and related services,

vii. Post-surgical rehabilitation, education, counseling, and training,

viii. Equipment maintenance, repair, and replacement of the internal/external components or both if not operating effectively. Examples include but are not limited to the device is no longer functional or the used component compromises the member's safety. Documentation which establishes the need to replace

components not operating effectively shall be provided at the time prior authorization is sought,

ix. Cochlear implantation requires PA from the AdSS Medical Director, and

c. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA]) AHCCCS coverage of medically necessary services for Osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss, or surgery. Osseointegrated implantation requires PA from the AdSS Medical Director. Maintenance of the Osseointegrated implants is the same as described above for cochlear implants.

d. Conscious Sedation

The AdSS covers conscious sedation for members receiving EPSDT services.

7. Behavioral Health Services

The AdSS 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.

8. Religious Non-Medical Health Care Institution Services

The AdSS covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

9. Care Management Services

The AdSS 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.

10. Chiropractic Services

The AdSS 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.

11. Personal Care Services

The AdSS covers personal care services, as appropriate, for members eligible for EPSDT services.

12. Incontinence Briefs

Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable

participation in social, community, therapeutic and educational activities under the following circumstances:

a. The member is over 3 years and under 21 years of age,

b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder,

c. The PCP or attending physician has issued a prescription ordering the incontinence briefs,

d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder,

e. The member obtains incontinence briefs from vendors within the AdSS' network, and

f. PA has been obtained as required by the Division, AdSS, or AdSS' designee. The AdSS may require a new PA to be issued no more frequently than every 12 months. PA for a renewal of an existing prescription may be provided by the physician through telephone contact with the member

rather than an in-person physician visit. PA will be permitted to ascertain that:

i. The member is over 3 years and under twenty-one (21) years of age,

ii. The member has a disability that causes incontinence of bladder and/or bowel,

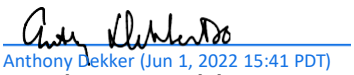
iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the AdSS, and

iv. The prescription is for 240 briefs or fewer per month unless evidence of medical necessity for over 240 briefs is provided.

13. Medically Necessary

Therapies AHCCCS 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.

Signature of Chief Medical Officer: 
Anthony Dekker (Jun 1, 2022 15:41 PDT)
Anthony Dekker, D.O.

431 DENTAL/ORAL HEALTH SERVICES FOR EPSDT ELIGIBLE MEMBERS

REVISION DATE: 2/7/2024, 6/8/2022
REVIEW DATE: 7/26/2023
EFFECTIVE DATE: October 1, 2019
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 AdSS 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 AdSS shall require an oral health Screening to be conducted by a PCP as part of an EPSDT Screening.
2. The AdSS 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 AdSS 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 AdSS 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 AdSS 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 three days of request; or
    b. Routine referrals within 45 calendar days of request.
6. The AdSS shall reimburse 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 AdSS shall reimburse PCPs according to AHCCCS-approved fee schedules for additional fluoride applications occurring every three months during an EPSDT visit until the Member's fifth birthday.
8. The AdSS shall not permit the application of fluoride varnish by the PCP to take the place of an oral health visit.

9. The AdSS 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 AdSS shall require 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 dental/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 gingivae, 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 AdSS shall require Members to be assigned a Dental Home by six months of age or upon enrollment and seen by a dentist for routine preventative care according to the AMPM 431 Attachment A.

3. The AdSS shall require Providers to refer Members with identified additional oral health care concerns for evaluation or treatment.

4. The AdSS shall inform PCPs 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 professional.

5. The AdSS shall inform EPSDT Members that they are allowed to self-refer to a dentist who is included in the AdSS provider network.

C. COVERED SERVICES

1. The AdSS shall cover the following dental/oral health services:
   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 and symptomatic 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 AMPM430.

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 to21 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 dentist or dental hygienist 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 process.

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, root planning, 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 determined to be the primary treatment of choice or an essential part of an overall Treatment Plan developed by both the PCP and the dentist in consultation with each other.

ix. Conditions that may 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 AdSS shall not cover services or items furnished solely for cosmetic purposes.

D. PROVIDER REQUIREMENTS

1. The AdSS shall require that dental/oral health services are provided by AHCCCS-registered dental Providers.
2. The AdSS 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 month follow-up appointment.
3. The AdSS shall require a separate written consent is completed for any irreversible or invasive procedure.
4. The AdSS shall require Providers review and sign a written Treatment Plan with the Member or Responsible Person receiving a copy of the complete Treatment Plan.

5. The AdSS shall require all 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 AdSS shall require consents and Treatment Plans to be in writing, signed and dated by both the 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 AdSS shall require Providers maintain completed consents and Treatment Plans in the Member's chart which are subject to audit.

E. AdSS REQUIREMENTS

1. The AdSS shall:

a. Conduct annual outreach efforts to Members receiving oral health care through school-based or mobile unit Providers in or out of network, to:
   i. Ensure Members are aware of their Dental Home Provider and contact information; and
   ii. Let Members know when school-based or mobile unit Providers are not accessible, they can receive ongoing-access to care through the Dental Home Provider.

b. Conduct the following written Member educational outreach topics at least once every 12 months, addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period, as specified in AMPM Chapter 400, Exhibit 400-3:
   i. Dental Home,
   ii. Importance of oral health care,
   iii. Dental decay prevention measures,
   iv. Recommended dental periodicity schedule, and

v. Other AdSS-selected topics.

c. Educate Providers in the importance of offering continuously accessible, coordinated, family-centered care.

d. Develop processes to:

i. Ensure Members are enrolled into a Dental Home by six months of age, to allow for an ongoing relationship providing comprehensive oral health care;

ii. Allow Members the choice of Dental Providers from within the AdSS' Provider network and provide Members with instructions on how to select or change a Dental Home Provider;

iii. Automatically assign a Provider if the Member does not select a Dental Home Provider.

iv. Connect all Members to a Dental Home before one year of age or upon assignment to the AdSS;

v. Inform Members of selected or assigned Dental Home Provider contact information and recommended dental visit schedule;

vi. Monitor Member participation with the Dental Home and provide outreach to Members who have not completed visits as specified in AMPM 431 Attachment A;

vii. Notify all Members or Responsible Person of visit as specified in AMPM 431 Policy Attachment A and AMPM 430 Attachment A.

viii. Notify the Member or Responsible Person regarding due dates of biannual dental visits and sending a second notice if a dental visit has not taken place. a second notice shall be sent.

ix. Monitor Provider engagement related to scheduling and follow-up of missed appointments to ensure care consistent with AMPM Policy 431 Attachment A for assigned EPSDT Members.

e. Develop and implement processes to reduce no-show appointment rates for dental/oral health services;

f. Provide targeted outreach to those Members who did not show for appointments;

g. Encourage all dental/oral health Providers to schedule the next dental/oral health Screening at the current office visit, particularly for children 24 months of age and younger;

h. Advise Members about:

   i. How to obtain medically necessary transportation, as specified in AMPM Policy 310-BB, including

   ii. Scheduling appointments to obtain EPSDT services, and

i. No copayment or other charge for EPSDT Screening and resultant services.

j. Require the use of AMPM Policy 431 Attachment A by all contracted dental/oral health Providers.

k. Adhere to the Dental Uniform Prior Authorization List (List) as specified on the AHCCCS website under Resources: Guides-Manuals-Policies and:

i. Submit all requests for changes to the List to the AHCCCS Division of Health Care Services (DHCS) designated Operations and Compliance Officer for review; and

iii. Include supporting documentation and rationale for requests to propose changes to the List.

l. Adhere to the Dental Uniform Warranty List as specified on the AHCCCS website under Resources-Guides-Manuals-Policies and:

i. Submit all requests for changes to the list to the AHCCCS DHCS designated Operations and Compliance Officer for review; and

ii. Include supporting documentation and rationale for request to propose changes to the List.

iii. The AdSS shall provide Oral Health Care Member Outreach as outlined in AMPM Exhibit 400-3.

F. REQUIREMENTS FOR THE DENTAL ANNUAL PLAN

1. The AdSS shall have a written Dental Annual Plan that:
   a. Addresses minimum requirements as specified in this policy;
   b. Addresses the objectives of the AdSS' program that are focused on achieving Division and AHCCCS requirements; and
   c. Incorporate monitoring and evaluation activities for these minimum requirements as outlined in AMPM 431 Attachment B.
2. The AdSS 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 AdSS 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 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

b. Follow-up activities to ensure appropriate treatment is received in a timely manner.

c. 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;

d. Dental Work Plan that includes:

i. Specific measurable objectives based on AHCCCS established Performance Measure Performance Standards (PMPS) as adopted by the Division;

iii. 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 AdSS 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 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 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. Provider agreement; and

   iv. 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 Providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

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 (Feb 1, 2024 13:51 MST)
Anthony Dekker, D.O.

450 OUT-OF-STATE PLACEMENTS FOR BEHAVIORAL HEALTH TREATMENT

REVISION DATE: 8/4/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Behavioral Health Covered Services Guide, AMPM Exhibit 450-1
DELIVERABLES: Out of State Placements

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

The purpose of this policy is to provide criteria and procedures for the Division's AdSS in the event that an out-of-state placement for behavioral health treatment is clinically necessary and supported by the Child and Family Team (CFT) or Adult Recovery Team (ART).

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 the 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

AdSS and made after the CFT, ART, or TRBHA 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. AdSS 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 AdSS, 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, AdSS 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 AdSS, 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 AdSS 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, 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 second-level 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. IHS/638 tribally operated facilities coordinating out-of-state placement for an AdSS enrolled member shall coordinate efforts with AdSS of Enrollment prior to placement, including coordinating with any IHS/638 providers located out of state. In addition, the Chief Medical Officer or their designee of the Division must be notified.

8. Coordination shall occur between the member's primary care provider and the AdSS 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, 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 AdSS 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)/Division

1. The AdSS and Fee-For-Service providers shall notify AHCCCS and the Division through the AHCCCS QM Portal, prior to or upon notification of a member being placed in an out-of-state placement.

2. The Division shall review the information to ensure all of the requirements in this Policy have been met. The Division shall acknowledge receipt within one to three business days. If the information is incorrect or incomplete, the Division shall notify the AdSS provider to correct the submission within three business days.

3. The AdSS shall report progress updates to the Division 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. The Division 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: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; A.R.S. Title 32, Chapter 13 or Chapter 17; A.R.S. Title 32, Chapter 25; A.R.S. Title 32, Chapter 15, 42 CFR 457.1230(c), 42 CFR 438.208(b)(1).

PURPOSE

This policy establishes requirements regarding Primary Care Providers participating in Arizona Health Care Cost Containment System (AHCCCS) programs. This policy applies to the Administrative Services Subcontractors (AdSS).

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 AdSS shall ensure 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 AdSS shall ensure PCPs are rendering and providing 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 AdSS shall ensure 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 AdSS shall ensure 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 AdSS shall cover medically necessary, cost-effective, Federal and State reimbursable behavioral health services provided by a PCP within their scope of practice including monitoring and adjustments of behavioral medications.
2. The AdSS shall ensure prior authorization is obtained for antipsychotic class of medications, if required, to include monitoring and adjusting behavioral health medication as specified in AMPM 310-V.
3. The AdSS shall ensure PCPs coordinate and collaborate with behavioral health providers.

D. PRIMARY CARE COORDINATION RESPONSIBILITIES

1. The AdSS shall ensure 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 to ensure coordinated quality care that is efficient and cost effective.
2. The AdSS shall ensure the following PCP's coordination responsibilities are met:
    a. Referring Members to Providers or hospitals within the AdSS's network;
    b. Referring Members to Non-Contracting specialty Providers and non-contracting community benefit organizations if necessary;
    c. Coordinating with the AdSS, or the appropriate entity for Fee-for-service (FFS) members. Appropriate entities for coordination of services for FFS Members include:
        i. Division of Fee-For-Service Management (DFSM) for Members enrolled with a Tribal Regional Behavioral Health Authority (TRBHA),

ii. Tribal Arizona Long Term Care System (ALTCS) for physical and behavioral health services for enrolled FFS members,

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; and

iv. TRBHA for behavioral health services for enrolled FFS Members.

d. Coordinating with a Member's:

i. AdSS care manager,

ii. Provider case manager,

iii. Division Support Coordinator,

iv. Behavioral Health Complex 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 prevent negative interactive effects;
   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) Therapies including:

1) Occupational,

2) Physical, and

3) Speech language pathology.

e) Durable Medical Equipment,

f) Home health,

g) Palliative care, and

h) 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. Requiring and ensuring 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 AdSS shall ensure newly enrolled Members are assigned to a PCP and notified after the assignment within 12 Business Days of the enrollment notification.
2. The AdSS shall ensure that AHCCCS-registered PCPs receive an AHCCCS Provider ID number.

3. The AdSS shall maintain a current file of Member PCP assignments and accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data.
4. The AdSS shall 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.
5. The AdSS shall allow Members to choose PCPs available within their network.
6. The AdSS shall automatically assign a PCP if a Member does not select a PCP.
7. The AdSS shall ensure the network of PCPs is sufficient to provide Members with available and accessible service within the time frames specified in ACOM Policy 417.
8. The AdSS shall provide information to the Member on how to contact the Member's assigned PCP.

9. The AdSS shall develop procedures to ensure enrolled pregnant Members are assigned to and are receiving appropriate care from: a qualified physician, a PCP who provides obstetrical care, or referred to an obstetrician as specified in AMPM Policy 410.
10. The AdSS shall assign Members with complex medical conditions who are age 12 and younger to board certified pediatricians.
11. The AdSS shall develop a methodology 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 AdSS shall ensure referral procedures are in place for PCPs for the appropriate availability and monitoring of health care services that include the following:

a. Utilization of the AdSS specific referral process.
b. Definition of who is responsible for initiating referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral.

c. Specifications addressing the timely availability of appointments as specified in ACOM Policy 417.

d. Specifications and procedures for linking specialty and other referrals to the claims management system, such as through the Prior Authorization process.

G. PHYSICIAN ASSISTANT (PA) AND NURSE PRACTITIONER (NP) VISITS IN A NURSING FACILITY

The AdSS shall cover initial and any subsequent visits to a Member in a nursing facility made by 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. MEDICAL RESIDENT VISITS UNDER SPECIFIC CIRCUMSTANCES

1. The AdSS shall ensure Resident Physicians providing service without the presence of a Teaching Physician have completed six months of post graduate work in an approved residency program.

2. The AdSS shall allow medical residents to provide low-level evaluation and management services to Members in designated settings without the presence of the Teaching Physician as specified in AMPM 510 Section H.

SUPPLEMENTAL INFORMATION

Refer to AMPM Chapter 600 for information regarding specific AHCCCS requirements for participating providers.

Refer to ACOM Policy 325 for additional information related to Contractor responsibilities and PCP assignments pertaining to providers participating in Targeted Investments 2.0

Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

FFS members have freedom of choice and are not required to have an assigned PCP. FFS members may receive services from any AHCCCS registered PCP and any IHS/638 facility.

Signature of Chief Medical Officer: Anthony Dekker (Apr 10, 2024 10:42 PDT)
Anthony Dekker, D.O.

520 MEMBER TRANSITIONS

REVISION DATE: 5/10/2023, 1/27/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.300; 42 CFR 438.62; 42 CFR 440.70; 42 CFR 457.1216; 42 CFR 431.300 et seq; A.R.S. §§ 36-2931; A.R.S. §§ 36-2901.01; A.R.S. §§ 36-2981; AMPM 520; AMPM 1620-H; AMPM 1620-M; AMPM Exhibit 1620-9; AdSS 310-P

PURPOSE

This policy establishes requirements for Division of Developmental Disabilities (Division) Member Transitions between the Administrative Services Subcontractors (AdSS), Fee-for-Service (FFS) programs, and other AHCCCS contractors. It applies to the Administrative Services Subcontractors.

DEFINITIONS

1. "Enrollment Transition Information" or "ETI" means Member specific information the relinquishing contractor shall complete and transmit to the receiving contractor or Fee-For-Service program for those Members requiring coordination of services as a result of transitioning to another contractor or FFS program.
2. "Member" means an individual who is receiving services from the

Division of Developmental Disabilities (Division).

3. "Member Transition" means the process during which Members change from one contractor or Fee-for-Service (FFS) program to another.
4. "Medical Equipment and Appliances" means an item as specified in 42 CFR 440.70, that is not a prosthetic or orthotic; and
    a. Is customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness, disability, or injury,
    b. Can withstand repeated use, and
    c. Can be reusable by others or is removable
5. "Special Health Care Needs" or "SHCN" means a 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 AdSS 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 AdSS shall work collaboratively with Members with special circumstances which may require additional or distinctive assistance during a period of transition to ensure Members do not experience a gap in services.
3. The AdSS shall develop policies or protocols to address the transition of Members with the following medical conditions or special circumstances:
   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 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 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 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 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 or 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;

4. The AdSS shall ensure members have received prior authorization or approval for the following at the time of transition:

a. Scheduled elective surgery(ies);

b. Procedures 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 relinquishing AdSS shall provide relevant information regarding Members who transition to a receiving AdSS.
2. The relinquishing AdSS shall utilize the ALTCS Enrollment Transition Information (ETI) for those Members with special circumstances who are transitioning enrollment to another AdSS.
3. The relinquishing AdSS shall complete and electronically transmit the appropriate ETI Form to the receiving AdSS or FFS program no later than 10 business days from the date of receipt of AHCCCS notification.
4. The relinquishing AdSS shall be responsible for covering the Member's care for up to 30 calendar days if they fail to notify the receiving AdSS of transitioning Members with special circumstances, or fail to send the completed ALTCS Enrollment Transition Information.
5. The AdSS shall have protocols for the transfer of pertinent medical records and the timely notification of Members,

subcontractors, or other providers, as appropriate during times of transition.

6. The receiving AdSS shall provide new Members with its Member Handbook, provider directory, and emergency numbers as specified in ACOM Policy 460.
7. The receiving AdSS shall follow up with the Member to address the needs of the Member identified on the ETI form.
8. The receiving AdSS shall extend previously approved prior authorizations for a minimum 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.
9. The receiving AdSS shall provide at a minimum a 90 calendar day transition period, for children and adults with Special Health Care Needs who have an established relationship with a PCP that does not participate in the receiving AdSS provider network.

C. TRANSITION TO ALTCS

1. The relinquishing AdSS shall coordinate transition with the receiving AdSS or Tribal ALTCS if a Member is approved for ALTCS enrollment.
2. The AdSS shall ensure applicable protocols are followed for any special circumstances of the Member and that continuity and quality of care is maintained during and after the transition.

D. TRANSITION FROM CHILD TO ADULT SERVICES

1. The AdSS 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 AdSS shall ensure any 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 AdSS shall provide a smooth transition of care for Members who are hospitalized on the day of an enrollment change with the following steps:

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 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 relinquishing and receiving AdSS shall coordinate care and coverage for Members who have been approved for major organ or tissue transplant if there is a change in AdSS or FFS enrollment.

2. Each AdSS shall cover 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 AdSS shall have protocols for ongoing care of Members with active or chronic health care needs during the transition period.
2. The receiving AdSS shall have protocols to address the timely transition of the Member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.
3. The AdSS 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 included in the all-inclusive maternity care as specific in AMPM 410.

H. MEDICALLY NECESSARY TRANSPORTATION

1. The AdSS shall provide information to new Members on what and how medically necessary transportation can be obtained.
2. The AdSS shall provide information to providers on how to order medically necessary transportation for Members.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

1. The relinquishing AdSS shall:
    a. Cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment; and
    b. Not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100 unit doses.
2. The receiving AdSS shall extend previously approved prior authorizations 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 AdSS shall ensure Member's transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP for behavioral health medication management continue on the

medication(s) prescribed by the BHMP until the Member can transition to their PCP.

4. The AdSS 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 receiving 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 AdSS shall transition 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. OUT OF SERVICE AREA PLACEMENT REFERRALS

1. The AdSS shall initiate a referral for placement of a Member with SMI to a service provider for the purposes of obtaining behavioral health services when:
    a. The resulting relocation of the Member may result in the eligibility source making corresponding changes to a Member's address in the Pre-paid Medicaid Management Information System (PMMIS), or
    b. A change of address to another Geographic Service Area (GSA) will cause the Member with SMI to become enrolled with a RBHA Contractor in the other GSA for both behavioral health and physical health services.

2. The AdSS shall provide services out of state when medically necessary services are not available in state.

Signature of Chief Medical Officer: Anthony Dekker (May 3, 2023 15:22 PDT)
Anthony Dekker, D.O.

530 MEMBER TRANSFERS BETWEEN FACILITIES

EFFECTIVE DATE: April 17, 2024
REFERENCES: AMPM 530

PURPOSE

This policy establishes requirements for the Administrative Services Subcontractors (AdSS) regarding Division of Developmental Disabilities (Division) Member transfers 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 AdSS shall ensure coordination activity and data sharing is required when a Member transitions between facilities and levels of care. The methodology for data sharing is determined based on the capability of each entity.
2. The AdSS shall ensure the following criteria are met when a transfer is initiated by the AdSS between inpatient hospital facilities following 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. Such determination is binding on the AdSS responsible for coverage and payment;

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.

3. The AdSS shall comply with Medicaid Managed Care guidelines regarding the coordination of post stabilization care as specified in 42 CFR 438.114 and 42 CFR 422.113.

4. The AdSS shall ensure the following criteria are met when a Member transfers to a lower level 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 the 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.

5. The AdSS shall ensure 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 the type of transport, the training level of the transport crew and the level of life support; and

d. A transfer summary accompanies the Member.

6. The AdSS shall ensure 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.

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 10, 2024 08:05 PDT)
Anthony Dekker, D.O.

540 OTHER CARE COORDINATION ISSUES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915(k).

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Problem Resolution

The AdSS must establish policies that address problem resolution.

Members Presenting for Care Outside the AdSS's Provider Network

The AdSS must establish procedures for assisting members when they present to a non-contracted provider that include, but are not limited to:

A. Identification of a specific AdSS contact person for assistance

B. Identification of a telephone number to obtain AdSS information

C. Electronic and hard copy (if requested) provider directories.

Members with Special Health Care Needs

A. Members with special health care needs includes all members eligible for the Division.

B. The AdSS must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions requiring treatment or regular care monitoring. The assessment mechanism must identify appropriate health care professionals.

C. The AdSS must share, with other entities providing services to that member, the results of its identification and assessment of that member's needs.

D. For members requiring a specialized course of treatment or regular care monitoring, the AdSS must have procedures in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.

Coordination of Urgent Response for Children Involved With DCS

When a child is removed from his/her home, to the protective custody of the Department of Child Safety (DCS), the AdSS must consider this to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The urgent response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

In cases where DCS notifies the AdSS within five days of physical removal of the child, the AdSS must implement the urgent response process within 72 hours from initial contact by

DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. If notification is received after the fifth day of removal, the AdSS, in collaboration with the DCS Specialist, has the discretion to initiate an urgent response or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services through the Arizona Department of Health Services (ADHS) Behavioral Health System, the Children's Rehabilitative Services (CRS) Contractor may authorize continued services with the behavioral health provider that has established a treatment relationship with the child until a safe transition to a contracted behavioral health provider can be completed.

The urgent response process must include:

A. Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, current disposition of siblings, any known needs of the new caregiver, etc.

B. Conduct a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child's removal.

C. Stabilization of behavioral health crises and offering of immediate services.

D. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term.

E. The provision of needed behavioral health services to the child's caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health provider network.

F. Provide the DCS Case Manager and DDD Support Coordinator with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child's removal.

G. If the child is placed with temporary caregivers, services should support the child's stability by addressing the child's behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child's life. Transitions may include changes in placement, educational setting, and/or reaching the age of majority.

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, A.R.S. § 8-271-273, Division Medical Policy 541

PURPOSE

This policy outlines how the Division's Administrative Services Subcontractors (AdSS) develop and maintain collaborative relationships with other government entities that deliver services to Members and their families, ensuring access to services, and coordinating care with consistent quality.

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, 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. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, or other places of worship and faith, agents from other service systems like 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 when a child first enters into DCS custody.

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 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 AdSS shall develop policies, protocols, and procedures that describe how the AdSS coordinates and manages Member care with other governmental entities.

2. The AdSS shall ensure collaboration through involving other

government agencies to participate in the Member's:

a. Planning Team

b. Child and Family Team (CFT)

c. Adult Recovery Team (ART)

3. The AdSS shall ensure all required protocols and agreements with state agencies are specified in provider manuals.

4. The AdSS shall develop and maintain mechanisms and processes to identify barriers to timely services for Members served by other governmental entities.

5. The AdSS shall work collaboratively to remove barriers to Member care and to resolve any quality of care concerns.

B. ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)

1. The AdSS shall work in collaboration with DCS as outlined below:

a. Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS, including support to providers for awareness and adherence to A.R.S. § 8-271-273;

b. Coordinate development of the Service Plan with the DCS case plan to avoid redundancies and inconsistencies;

c. Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings;

d. Ensure a behavioral health assessment is performed that identifies the behavioral health needs of the child, the child's parents, and family or caregivers, that is based on the Arizona Vision - 12 Principles as specified in AMPM Policy 100;

e. Provide necessary behavioral health services, including support services to caregivers, based on needs identified within the behavioral health assessment and service plan;

f. Engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the CFT;

g. Attend team meetings such as Team Decision Making

(TDM) providing input about the child and family's behavioral health needs.

h. Combine the TDM and CFT meetings, when it is possible;

i. Coordinate behavioral health services in support of family reunification or other permanency plans identified by DCS;

j. Coordinate activities and service delivery that supports the CFT ServicePlan and facilitates adherence to the timeframes established in the following:

i. AdSS Operations Manual Policy 417,

ii. AdSS Operations 449,

iii. AHCCCS Behavioral Health System Practice Tools: AMPM Chapter 200

k. Coordinate activities including coordination with the adult service providers rendering services to adult family members.

2. The AdSS shall coordinate with a Tribal Regional Behavioral Health Authority (TRBHA) for Members receiving behavioral

health services through a TRBHA.

3. The AdSS shall consider the removal of a child from the home to the custody of the DCS to be an urgent behavioral health situation.

4. The AdSS shall consider any child who has experienced a removal by DCS to be at risk for negative emotional consequences and future behavioral health disorders.

5. The AdSS shall implement the Rapid Response process to identify the immediate behavioral health needs of children and address the trauma of the removal itself as outlined below:

    a. The AdSS shall implement the Rapid Response process within 72 hours from initial contact by DCS, in all cases where DCS notifies the AdSS of physical removal of the child, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child.

    b. The AdSS shall collaborate with the DCS Specialist to initiate a Rapid Response when a notification is received

after 72 hours of removal as outlined below:

i. The AdSS shall identify if the DCS Specialist or another entity has referred the child for a behavioral health assessment prior to the AdSS receiving notification.

ii. The AdSS shall authorize continued services with the behavioral health provider that has established a treatment relationship with the child, if the the DCS Specialist has initiated behavioral health services prior to the AdSS being notified.

iii. The AdSS shall assist DCS in identifying members already receiving physical and behavioral health services.

c. The AdSS shall ensure the Rapid Response process includes:

i. Contacting the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how, when, and where the removal occurred, any known

medical, behavioral, or special needs of the child, any known medications, any known supports for the child, current disposition of siblings, and any known needs of the new caregiver, and any other information impacting the health of the child or caregiver's ability to support the child;

ii. Conducting a comprehensive assessment identifying immediate safety needs and presenting problems of the child;

iii. Assessing and addressing needs related to trauma, grief and loss;

iv. Conducting an extended assessment period to accurately identify any emerging or developing behavioral health needs that are not immediately apparent following the child's removal;

v. Stabilization of behavioral health crises and offering of immediate services;

vi. The AdSS shall require its Rapid Response providers to distribute the most recent Foster and Kinship Care Resources Packet to the caregivers of children in DCS

out of home dependencies during the Rapid Response visit. The Resource Packet is available on the AHCCCS website.

vii. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term, including need for and information to support initiation of the Intake Assessment and CFT process;

viii. The provision of needed behavioral health services to the child's caregiver.

ix. Guidance about how to respond to the child's immediate needs in adjusting to foster care,

x. Explanation of physical and behavioral health symptoms to watch for and report,

xi. Assistance in responding to any behavioral health symptoms the child may exhibit, and

xii. Identification of contacts within the behavioral health

system;

xiii. Provision to the DCS Specialist of findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child's removal; and

xiv. If the child is placed with temporary caregivers, services shall support the child's stability by addressing the child's behavioral health needs, identifying any risk factors for placement disruption, and anticipating crises that might develop.

xv. Ensure behavioral health services shall proactively plan for transitions in the child's life. Transitions include changes in placement, educational setting, or reaching the age of majority.

C. DCS ARIZONA FAMILIES F.I.R.S.T. (FAMILIES IN RECOVERY SUCCEEDING TOGETHER-AFF) PROGRAM

1. The AdSS shall ensure that behavioral health providers coordinate with parents, Responsible Persons, families, and caregivers referred through the Arizona Families F.I.R.S.T. (AFF)

Program and that the providers participate in the family's CFT and planning team to coordinate services for the family and temporary caregivers.

2. The AdSS shall ensure behavioral health providers coordinate the following:

   a. Accept referrals for Members and families referred through the AFF Program.
   b. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments.
   c. Develop procedures for collaboration in the referral process to ensure effective service delivery through the AdSS behavioral health system.
   d. The AdSS shall ensure substance use disorder treatment for families involved with DCS are family-centered, provide for sufficient support services and shall be provided in a timely manner, as outlined in Section B in this Policy, to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.

D. ARIZONA DEPARTMENT OF EDUCATION (ADE), SCHOOLS, OR OTHER LOCAL EDUCATIONAL AUTHORITIES

1. The AdSS shall work in collaboration with the ADE and assist with resources and referral linkages for children with behavioral health needs.

2. The AdSS shall ensure that behavioral health providers collaborate with schools and help a child achieve success in school as follows:

    a. Work with the school and share information to the extent permitted by law and authorized by the child's parent or Responsible Person. Refer to AdSS Operations Manual Policy 940;

    b. The AdSS shall include information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning process for children who receive special education services.

    c. The AdSS shall ensure the Behavioral health providers participate with the school in developing the child's IEP and

partner in the implementation of behavioral health interventions, ensuring appropriate coordination of care occurs;

d. The AdSS shall ensure the behavior health provider communicates with and involves the DCS Specialist with the development of the IEP for children in the custody of DCS;

e. The AdSS shall ensure behavioral health providers invite teachers and other school staff to participate in the CFT if agreed to by the child and Responsible Person;

f. The AdSS shall ensure behavioral health providers understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;

g. The AdSS shall ensure the behavioral health providers support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973; and

h. The AdSS shall ensure that transitional planning occurs

prior to and after discharge of an enrolled child from any out-of-home placement.

i. The AdSS shall ensure behavioral health providers collaborate with schools to provide the appropriate behavioral health services in school settings, identified as Place of Service (POS) 03 and submit reports as specified in Contract.

j. The AdSS 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.

E. ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1. The AdSS shall ensure behavioral health providers coordinate Member care with the Arizona Early Intervention Program (AzEIP). The AdSS shall ensure:

   a. Children birth to three years of age are referred to AzEIP when information obtained in the child's behavioral health assessment reflects developmental concerns,

   b. Children found to require behavioral health services as part

of the AzEIP evaluation process receive appropriate and timely service delivery, and

c. If an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems.

2. The AdSS shall ensure behavioral health providers work collaboratively with the DES Rehabilitation Services Administration (DES/RSA) with the goal of increasing the number of employed Members who are successful and satisfied with their vocational roles.

F. COURTS AND CORRECTIONS

1. The AdSS shall collaborate,and coordinate care, and ensure that behavioral health providers collaborate and coordinate care for Members with behavioral health needs and for Members involved with:

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.

2. The AdSS shall collaborate with courts or correctional agencies to coordinate Member care as outlined in AHCCCS AMPM Policy 1021 and 1022. The AdSS shall:

a. Work in collaboration with the appropriate staff involved with the Member;

b. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with approval from the Responsible Person;

c. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan; and

d. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible Members.

e. Ensure the behavioral health provider manages and coordinates care upon the Member's release.

Signature of Chief Medical Officer: Anthony Dekker (Aug 29, 2023 14:58 PDT)
Anthony Dekker, D.O.

542 ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: September 22, 2021
REFERENCES: AMPM Policy 540, Electronic Visit Verification

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and the DD THP providers.

This Policy establishes requirements for Contractors and providers regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. 1396b(l).

DEFINITIONS

Aggregator - A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.

AHCCCS Electronic Visit Verification (EVV) Vendor - The AHCCCS selected Statewide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

Alternate Electronic Visit Verification (EVV) System - Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected Statewide EVV vendor.

Designee - For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.

Direct Care Worker (DCW) - For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.

Electronic Visit Verification (EVV) - 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.

Electronic Visit Verification (Evv) System Chapter 500 – Care Coordination Requirements - The AHCCCS procured system or an AHCCCS approved alternate EVV system.

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.

Manual Edit - Any change to the original visit data. All edits shall include an appropriate audit trail.

Prior Authorization – For the purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

Service Confirmation - A notification to AHCCCS through an online portal by a provider a service that does not require Prior Authorization will be provided to a member that is medically necessary.

Service Plan - 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.

POLICY

The Division is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. 1396(b)(l). AdSS and providers are required to utilize AHCCCS's single statewide EVV System for data collection or providers may choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS and the Division are using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that will be mandated to use EVV can be found on the AHCCCS website.

A. Service Verification

1. AdSS shall ensure that all providers who are subject to EVV utilize the AHCCCS procured system or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.

3. If a member/Health Care Decision Maker is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/Health Care Decision Maker is required to sign a standardized AHCCCS attestation specified in AHCCCS AMPM 540 Attachment A Designee Attestation form ("Attachment A") found on the AHCCCS website, at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change

decisions about verification delegation at any time by completing a new attestation. The Qualified Vendor shall keep the attestation on file, following the Divisions record retention requirements outlined in the Qualified Vendor Agreement.

4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the Attachment A Designee Attestation form prior to the delegation of service delivery verification responsibility.

5. Neither the Health Care Decision Maker nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or Health Care Decision Maker shall document in Attachment A.

B. Paper Timesheets

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.

2. Individuals for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.

3. Individuals electing not to use other visit verification modalities on the basis of moral or religious grounds.

4. Individuals with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Members who need to have their address and location information protected for a documented safety concern (i.e., witness protection or domestic violence victim or members in the Address Confidentiality Program as outlined in DES Policy VR-2.2-v1).

The member/Health Care Decision Maker and provider are required to sign a standardized AHCCCS attestation as specified in AHCCCS AMPM 540 Attachment B ("Attachment B") and utilize the standardized paper timesheet specified in AHCCCS AMPM 540 Attachment C ("Attachment C"). Attachment B is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. AdSS must review the records of the provider annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for providers to utilize their own paper timesheet as long as AHCCCS minimum data elements are captured.

The provider shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in ACOM Policy 203 (Claims Processing) or the provider's contract with the AdSS, are also met. The signature does not have to be recorded in the EVV System, but Agencies shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. EVV Modalities

1. The member/Health Care Decision Maker is able to choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. AdSS shall ensure that providers have at least two different types of visit verification modalities available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The AdSS shall ensure that the provider assists the member/Health Care Decision Maker to make an informed decision about the choice of data collection modality. The member/Health Care Decision Maker shall be permitted to change the modality at any time.

2. It is allowable for provider agencies to allow DCWs to utilize personal devices such as a smartphone. The AdSS shall ensure that if the provider elects this option, the provider is responsible to have a back-up plan for EVV if the device becomes inoperable.

3. The AdSS shall ensure that if the provider chooses to allow for GPS tracking while the DCW is on the clock, the provider shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.

4. Members shall be afforded the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. EVV Prior Authorizations and Service Confirmation Portal

Some EVV services require Prior Authorization, and some do not. To ensure all EVV services have an authorization record in the EVV System, AHCCCS has instituted and will require the use of Service Confirmations for EVV services that currently do not require Prior Authorization. Service Confirmation is simply a notification to AHCCCS for any EVV services not Prior Authorized by a provider that a service will be provided to a member that is medically necessary. AHCCCS has created an online web-based Service Confirmation portal for providers to enter the required data for the service (service code, units, and dates of service). The Service Confirmation Portal is available on the AHCCCS website.

The medical necessity determination date is an additional element required for EVV Services on the Prior Authorization or Service Confirmation. The medical necessity

determination date is the date the need for a new service was determined as specified in guidance documents available on the AHCCCS website.

E. Contingency/Back-Up Plan

The AdSS shall ensure that Provider agencies shall use the standardized AHCCCS Contingency/Back-Up Plan form as specified in Attachment D to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the provider is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Provider with the member at least annually, and a current copy provided to the assigned Support Coordinator. In the event a visit is late or missed, the provider is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/Health Care Decision Maker can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference may be applied based upon the service.

F. Reporting

At a minimum, AdSS shall utilize EVV data to monitor and analyze the following to support provider compliance with EVV as well as inform network adequacy and workforce development planning:

1. Member access to care, including:

    a. Late and missed visits and adherence to contingency planning preferences, and

    b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AMPM Policy 1620-A (Initial Contact/Visit Standard), AMPM Policy 1620-D (Placement/Service Planning Standard), AMPM Policy 580 (Behavioral Health Referral and Intake Process), and AMPM Policy 310-B (Title XIX/XXI Behavioral Health Service Benefit).

2. Provider Performance, including:

    a. Unscheduled visits,

    b. Manual Edits,

    c. Device utilization,

    d. EVV modality types in use,

    e. Visits that follow the member's Contingency/Back-Up Plan, and

f. Monitoring of service hours authorized compared to service hours actually provided.

3. The AdSS contracted provider shall self-monitor and analyze the following:

a. Performance, including:

i. Location discrepancies, and

ii. Visit exceptions.

b. Devices

i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider.

c. Service Delivery

i. Monitor service hours authorized compared to service hours actually provided.

G. Provider Requirements and Contractor Oversight

The AdSS shall monitor all provider responsibilities specified in this Policy as part of annual monitoring to ensure compliance for the following roles and responsibilities of providers required to utilize EVV, including but not limited to:

1. Notifying the AHCCCS EVV Vendor of all new users and user terminations and all data security incidents.

2. Collecting and maintaining records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation, paper timesheet allowances, and contingency/back-up plans as specified in this Policy.

3. Counseling the member/Health Care Decision Maker on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.

4. Developing a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in or onsite caregivers.

5. Ensuring that all associated EVV System users have access to training on the EVV System.

6. For providers using an Alternate EVV System, submitting data timely to AHCCCS as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Comply with member responsiveness including requirements that provider agencies shall answer the phone 24/7 or return a phone call within 15 minutes for members who are reporting a missed or late visit.

8. For providers using the AHCCCS procured EVV System, developing and implementing policies to account for and ensure the return of devices issued by providers to DCWs.

9. Ensuring the provider has at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.

10. Ensuring any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.

11. Ensuring any providers that permit DCWs to utilize personal devices, such as a smartphone, have an alternate verification method or option if the device becomes inoperable.

12. Ensuring that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g., landline telephone).

13. Contacting the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements for addendums to records. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

14. Documenting Manual Edits to visits within the system and/or maintaining hard copy documentation.

H. Provider Attestation

The AdSS shall ensure that new providers complete an attestation verifying agreement to comply with the requirements of Electronic Visit Verification. This attestation shall be incorporated as a requirement of the AdSS credentialing process.

560 CRS CARE COORDINATION AND SERVICE PLAN MANAGEMENT

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. 36-2912, A.A.C. R9-22-1303, A.A.C. R9-22-101

This policy applies to the Administrative Services Subcontractors (AdSS).

This policy establishes requirements regarding Children's Rehabilitative Services (CRS) care coordination for ALTCS members designated as having a CRS condition and defines the process for development and management of the member's service plan.

The AdSS is responsible for ensuring that:

- Every member has a Service Plan initiated upon notice of enrollment; and updating the Service Plan as the member's health condition or treatment plans change.
- Care is coordinated according to the Service Plan and in cooperation with other State Agencies, AHCCCS Contractors, or Fee-For-Service (FFS) programs with which the member is enrolled, and Community Organizations.

AHCCCS identifies members who meet a qualifying condition(s) for CRS and who require active medical, surgical, or therapy treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-22-1303. 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 determination process. DMS may also provide information received for purposes of a CRS designation regarding care, services or procedures that may have been approved or authorized by the member's current health plan or FFS program.

Service delivery must be provided in a family-centered, coordinated and culturally competent manner in order to meet the unique physical, behavioral and holistic needs of the member.

Members with a CRS designation may receive care and specialty services from an MSIC or community based provider in independent offices that are qualified to treat the member's condition. The AdSS must ensure availability of alternative methods for providing services such as field clinics and telemedicine in rural areas.

The AdSS must ensure the development and implementation of a Service Plan for members designated as having a CRS Condition and are responsible for coordination of the member's health care needs and collaboration as needed with providers, communities, agencies, service systems, and members/guardians/designated representatives in development of the Service Plan.

The AdSS must ensure the Service Plan is accessible to all service providers and contains the behavioral health, physical health, and administrative information necessary to monitor a coordinated and integrated treatment plan implementation.

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 lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care

provider.

B. 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.

C. Designated Representative - parent, guardian, relative, advocate, friend, or other person, designated in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member's rights and voicing the member's service needs. See A.A.C. R9-22-101.

D. Field Clinic - "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

E. Multi-Specialty Interdisciplinary Clinic (MSIC) - established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

F. Multi-Specialty Interdisciplinary Team (MSIT) - team of specialists from multiple specialties who meet with members and their families for the purpose of determining an interdisciplinary treatment plan.

G. Service Plan - 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.

Care Coordination

The AdSS must establish a process to ensure coordination of care for members that includes:

A. Coordination of member health care needs through a Service Plan

B. Collaboration with members/guardians/designated representatives, other individuals identified by the member, groups, providers, organizations and agencies charged with the administration, support or delivery of services that is consistent with federal and state privacy laws

C. Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements or makes the decision to transition to another Division Contractor after the age of 21 years

D. Service coordination to ensure specialty services related to a member's CRS condition(s) care completed, as clinically appropriate prior to the member's 21st birthday. Appropriate service delivery and care coordination must be provided regardless of the member's CRS designation ending.

Service Plan Development and Maintenance

A. The AdSS is responsible for ensuring that:

- Each member designated to have a CRS Condition has a member-centric Service Plan and that the member's first provider visit occurs within 30 days of designation.

- Services are provided according to the Service Plan.

The Service Plan serves as a working document that integrates the member's multiple treatment plans, including behavioral health, into one document in a manner and format that is easily understood by the member/guardian/designated representative, and shared with the member/guardian/designated representative upon request or as part of the Multi-Specialty Interdisciplinary Team (MSIT), Child Family Team (CFT), or Adult Recovery Team (ART) meetings. The Service Plan identifies desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives. The Service Plan must identify the immediate and long-term healthcare needs of each newly enrolled member and must include an action plan. The AdSS is responsible for ensuring that every member has an initial Service Plan developed by the AdSS within 14 days of the notice of designation utilizing information provided by AHCCCS DMS. The Service Plan must be monitored regularly and updated when there is a change in the member's health condition, desired outcomes, personal goals or care objectives.

B. A comprehensive Service Plan must be developed within 60 calendar days from date of the first appointment for the CRS qualifying condition and must include, but is not limited to, all the following required elements:

a. Member demographics and enrollment data

b. Medical diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies

c. Action plan

d. The member's current status, including present levels of functioning in physical, cognitive, social, behavioral, and educational domains

e. Barriers to treatment, such as member/guardian/designated representative's inability to travel to an appointment

f. The member/guardian/designated representative's strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the member

g. Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes.

C. The AdSS must identify an interdisciplinary team to implement and update the Service Plan as needed.

D. The AdSS must modify and update the Service Plan when there is a change in the member's condition or recommended services. This will occur periodically as determined necessary by the member/guardian/designated representative, or provider(s).

E. The AdSS must identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur, and who identifies organizations and providers with whom treatment must be coordinated.

Specialty Referral Timelines

The AdSS must have a policy and procedure that ensures adequate access to care through scheduling of appointments as specified in ACOM Policy 417.

570 BEHAVIORAL HEALTH PROVIDER CASE MANAGEMENT

EFFECTIVE DATE: November 9, 2022
REFERENCES: A.R.S § 36-551; ACOM 407; AMPM Chapter 200; AMPM 320-O; AMPM 570; AMPM 570 Attachment A

PURPOSE

The purpose of this policy is to outline the requirements for Behavioral Health Provider Case Management services for Administrative Services Subcontractors (AdSS) whose contract includes this service.

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 Early 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 AdSS shall provide Provider Case Management services concurrently with DDD support coordination when the member/responsible person requests them and when determined medically necessary to coordinate services.

B. The AdSS 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. The AdSS shall refer to the Arizona Health Care Cost Containment System (AHCCCS) Behavioral Health Services Matrix for billing and coding requirements for case management services.

C. The AdSS 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 AdSS shall ensure that the frequency and type of contact for case management services are determined by the Child and Family Team (CFT) or Adult Recovery Team (ART) during the treatment planning

process, and adjusted as needed, considering clinical need and member preference.

E. The AdSS shall ensure that one of the following intensity levels for Provider Case Management services is determined by the CFT or ART:

1. Connective Case Management
2. Supportive Case Management
3. High Needs Case Management
4. Assertive Community Treatment Case Management

F. The AdSS shall ensure that Provider Case Managers coordinate care on behalf of DDD members and 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 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 behavioral health service/treatment 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 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. Assessing for, providing, and coordinating additional supports and services as needed to accommodate the 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 development of the crisis and safety plan.

G. The AdSS shall develop a provider network with a sufficient number of qualified and experienced Provider Case Managers who are available to provide case management services to all enrolled members and shall meet the caseload ratios as specified in Attachment A except as otherwise specified and approved by AHCCCS.

H. The AdSS shall ensure that all children receiving behavioral health services and DDD members with a Serious Mental Illness (SMI) designation are assigned to a case manager in accordance with A.A.C. R9-21-101, and that all other members are assigned a Provider Case Manager as needed, based upon a determination of the member's service acuity needs.

I. The AdSS shall ensure that providers orient new case managers to the fundamentals of providing case management services, evaluate their competency to provide case management, and provide basic and ongoing training in the specialized subjects relevant to the populations served by the provider, and as specified in ACOM Policy 407.

J. The AdSS shall ensure that the behavioral health provider provides accurate contact information for the Provider Case Manager and AdSS for assistance. The AdSS shall also require that behavioral health providers provide accurate information to the member/responsible person for what to do in cases of emergencies and/or after hours.

K. The AdSS shall ensure that providers have a system of back-up case managers in place for members who contact an office when their assigned case manager is unavailable and that members be given the opportunity to speak to the back-up case manager for assistance.

L. The AdSS shall ensure behavioral health providers respond to members/responsible person’s messages left for case managers within two business days.

M. The AdSS shall ensure that Provider 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.

N. The AdSS shall ensure that providers establish a supervisor to case manager ratio that is conducive to a sound support system 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 case manager ratio.

O. The AdSS shall ensure that Provider Case Manager supervisors have adequate time to train and review the work of newly hired case managers and to provide support and guidance to established case managers.

P. In order to prevent conflicts of interest, the AdSS shall ensure that a Provider Case Manager is not:

1. Related by blood or marriage or other significant relation to a member or to any paid caregiver for a member on their caseload.
2. Financially responsible for a member on their caseload.

3. Empowered to make financial or health-related decisions on behalf of a member on their caseload.
4. In a position to financially benefit from the provision of services to a member on their caseload.
5. A provider of paid services (e.g., Home and Community Based Services (HCBS), privately paid chores, etc.) for any member on their caseload.

Q. The AdSS shall establish and implement 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.

R. The AdSS shall submit, as specified in contract, a Case Management Plan that addresses how the AdSS will implement and monitor case management standards and caseload ratios for adult and child members. The Case Management Plan shall also include performance outcomes, lessons learned, and strategies targeted for improvement. Following the initial submission, subsequent submissions shall include

an evaluation of the AdSS's Case Management Plan from the previous year.

Signature of Chief Medical Officer: Anthony Dekker (Nov 1, 2022 12:40 PDT)
Anthony Dekker, D.O.

580 BEHAVIORAL HEALTH REFERRAL AND INTAKE PROCESS

REVISION DATE: 6/15/2022, 8/04/2021

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS), whose contract includes this requirement, and describes the behavioral health referral requirements for Title XIX eligible members, enrolled in a DDD Health Plan, to ensure members with behavioral health and substance use disorders can gain prompt access to behavioral health services.

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 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.
2. A member/responsible person may directly outreach a behavioral health provider, the Division or the AdSS 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. The AdSS,
    d. Primary care provider (PCP) (The AdSS shall ensure training and education is provided to the PCPs regarding

the behavioral health referral process.),

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 AdSS Operations Policy 449.

3. To facilitate a member's timely access to behavioral health services, the AdSS 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 designation, and those seeking an SMI designation. This 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 choice of service providers;

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:

- Assess the urgency of the member's needs.
- Track and document the disposition of referrals to ensure subsequent initiation of services. The AdSS shall comply with timeliness standards specified in AdSS Operations Policy 417.
- 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.

f. Providers shall offer a range of appointment availability and flexible scheduling options based upon the needs of the member.

4. The provider directory shall be maintained in accordance with Division Operations Policy 406 and shall indicate which providers are accepting referrals. Providers shall promptly notify the AdSS of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

B. REFERRALS FOR INDIVIDUALS ADMITTED TO A HOSPITAL

1. The AdSS provider 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 services, the AdSS provider shall ensure a referral is made to a provider agency within 24 hours.

   b. The AdSS shall ensure provider agencies attempt to conduct a face-to-face intake evaluation with the individual within 24 hours of referral and the evaluation occurs prior to discharge from the hospital.

   c. For members already receiving behavioral health services, the AdSS shall ensure coordination, transition, and discharge planning activities are completed in a timely manner as specified in Division Medical Policy 1021.

C. DIVISION OVERSIGHT OF AdSS

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

a. Annual Operational Review of related standards, including but not limited to:

i. The AdSS has policies and procedures to ensure members receive behavioral health services.

ii. 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.

iii. The AdSS ensures that training and education is provided to PCPs regarding the behavioral health referral process.

iv. 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 Policies 200-G and 200-H for a list of diagnostic and functional criteria.

v. The AdSS documentation reflects evidence that medically necessary behavioral services were determined by a qualified behavioral health professional.

2. Submit deliverable reports or other data as required.

3. Participate in oversight meetings with the Division for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

Signature of Chief Medical Officer: Anthony Dekker (Jun 14, 2022 17:44 PDT)

Anthony Dekker, D.O.

590 BEHAVIORAL HEALTH CRISIS SERVICES AND CARE COORDINATION

EFFECTIVE DATE: December 7, 2022
REFERENCES: AHCCCS Contract; AHCCCS Medical Policy Manual 590

PURPOSE

This policy describes the requirements related to the behavioral health Crisis system for Arizona Long Term Care System (ALTCS) eligible members. It applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS).

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.

POLICY

A. The AdSS shall coordinate and cover medically necessary services and care provided to members after the initial 24 hours of a Crisis episode or discharge from a Crisis stabilization setting, whichever occurs first.

B. The AdSS shall cover all emergency transportation and non-emergent transportation from Crisis receiving facilities.

C. The AdSS shall publicize Crisis Services, including the statewide Crisis phone number, prominently on their websites, in their resource directories, and on relevant member and community materials as specified in AHCCCS Contractor Operations Manual (ACOM) Policies 404, 406, and 433.

D. The AdSS shall ensure the behavioral health provider coordinates post-Crisis care and service delivery when an enrolled member engages in Crisis Services.

E. The AdSS shall ensure care coordination occurs between:

1. The member’s health plan;

2. Behavioral health provider;
3. The Division;
4. Crisis providers; and,
5. Tribal Regional Behavioral Health Authority (TRBHA) serving the member, if applicable.

F. The AdSS shall 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.

G. The AdSS shall regularly evaluate 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.

Signature of Chief Medical Officer: Anthony Dekker (Nov 29, 2022 09:23 MST)
Anthony Dekker, D.O.

670 FEDERALLY QUALIFIED HEALTHCARE CENTERS AND RURAL HEALTH CLINICS REIMBURSEMENT

EFFECTIVE DATE: October 1, 2019

PURPOSE: To establish requirements for Administrative Services Subcontractors regarding reimbursement for case management, behavioral health group therapy, Telehealth and Telemedicine services for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC).

DEFINITIONS:

Behavioral Health Technician, as specified in AAC R9-10-101, an individual who is not a Behavioral Health Professional, who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

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.

Case Management means services furnished to assist members, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, and does not include the direct delivery of underlying medical, educational, social, or other services in accordance with 42 CFR §441.18.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), for purposes of this policy, are reimbursed under the same methodology. An FQHC is a provider who is registered with AHCCCS as provider type C2 or C5. An RHC is a provider who is registered with AHCCCS as provider type 29. This Policy does not apply to any other provider or under any other circumstances.

FQHC/RHC Services, for purposes of this policy, the services of specific licensed professionals, services provided incident to those professional services, and any other ambulatory services offered by the FQHC/RHC that are otherwise included in the State Medicaid Plan.

FQHC/RHC Visit is a face-to-face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline (i.e., dental, physical, behavioral health) or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed

separately.

Services "incident to" a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (e.g., medical supplies, venipuncture, assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (e.g., x-ray, medication, laboratory test).

Prospective Payment System (PPS) Rate, for purposes of this policy, an all-inclusive per visit rate for reimbursing FQHC/RHC services.

POLICY

A. FQHC/RHC Reimbursement for Case Management (T1016)

1. Case Management is not an FQHC/RHC visit reimbursable at the all-inclusive per visit PPS rate. Case Management (T1016) is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice.

2. FQHCs/RHCs are entitled to reimbursement at the all-inclusive per visit PPS rate for encounters that meet the definition of "FQHC/RHC visit."

3. Provider Case Management is not a reimbursable service for Tribal ALTCS. This service is provided through the Tribal ALTCS Programs.

B. FQHC/RHC Reimbursement for Behavioral Health Technician Provided Services

Excluding case management, the services of a BHT may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X.

C. Behavioral Health Group Therapy/Group Services

Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter; therefore, these services are not reimbursable at the all-inclusive per visit PPS rate.

D. Telehealth and Telemedicine for FQHC/RHC Service

Telehealth and Telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AdSS Medical Policy 320-I.

For additional information regarding FQHC/RHC reimbursement, refer to AHCCCS Fee- For-Service Provider Manual, Chapter 10 addendum. For Provider Type C5, refer to AHCCCS IHS/Tribal Provider Billing Manual Chapter 20.

900 CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Actions Reported to the NPDB (National Provider Databank) or a Regulatory Board
2. Adverse Action Reporting (Including Limitations and Terminations)
3. Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Condition (OPPC)
4. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
5. Quality Management (QM) Report

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

PURPOSE

This policy applies to the Administrative Services Subcontractors' (AdSS) and establishes the requirements regarding the scope, 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. "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).

5. "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).
6. "Member" means the same as "Client" as defined in A.R.S.§36-551.
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. "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. Formerly referred to as Quality Improvement Projects (QIP).
10. "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.
11. "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

1. The AdSS's QM/PI Program shall establish and implement a QM/PI Program that includes the following elements:
   a. 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 AdSS's QM/PI program shall also include the following elements for Long-Term Services and Supports (LTSS):
    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 AdSS shall adhere to the QM/PI Program requirements as specified in Contract and AMPM Chapter 900. As part of the QM/PI Program, the AdSS shall:

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 reflects all aspects of Member care, including ancillary and behavioral health services, as specified in AMPM Policy 940. Supporting policies shall include processes 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 the requirements as specified in AMPM Policy 950;

d. Implement a process for tracking and trending 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 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, to the extent practical, health disparities based on but not limited to age, race, ethnicity, sex, primary language, and disability status;

h. Identify goals or objectives and implement interventions that are meaningful, specific, and applicable to the population(s) served;

i. Ensure and demonstrate ongoing communication and collaboration between the QM/PI Program and other functional areas of the organization;

j. Demonstrate the obtainment and incorporation of input from AHCCCS Members, stakeholders, advocates, and contracted providers in matters related to the QM/I Program activities;

k. Develop and implement a process for monitoring the quality and coordination between physical and behavioral health services. The process shall include procedures utilized to:

   i. Ensure timely updates occur between Primary Care Physicians (PCPs) and behavioral health providers regarding a Member's change in health status. The updates shall include, but are not limited to:

      1) Diagnosis of chronic conditions;

      2) Changes in physical or behavioral health condition or diagnosis;

3) Support for the petitioning process, if applicable;

4) Transition to or from an ACC-RBHA, based on Serious Mental Illness (SMI) designation, when appropriate. This could include transitions for:

a) Qualifying opt-out conditions;

b) Inter-ACC-RBHA transfers across Geographical Service Area (GSA);

c) Intra-ACC-RBHA transfer provider to provider but across county, within same GSA; and

d) All medication prescribed, or changes made in medication or dosage.

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;

n. Identify protocol or practices to monitor appropriate use of methodologies for screening or identification of high needs adult Members, and maintain policies for monitoring and documentation of ongoing implementation for AHCCCS review;

o. Identify standards for adults with an SMI diagnosis for all levels of service intensity;

p. Establish mechanisms to connect Members and families to family run organizations;

q. Provide training and monitoring for provider use of Substance Abuse Mental Health Services Administration (SAMHSA) Fidelity Tools including Assertive Community Treatment, Supported Employment, Supportive Housing, and Consumer Operated Services;

r. Provide training of clinical and general staff, including front office 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 including but not limited to Substance Abuse Block Grant (SABG) and Mental Health Block Grant (MHBG) funding, as specified in AMPM Policy 320-T1. 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 the implementation and completion of American Society of Addiction Medicine (ASAM) Criteria (most current edition at the time of service) in substance use disorder assessments, service planning, and level of care placement, and monitor fidelity of ASAM implementation in accordance with AHCCCS directed phased in approach;

u. Develop 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. Promotion and referral shall include, but not be limited to:

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 and initiate referrals when behavioral health needs are identified;

x. Implement policies and procedures that require individual and organizational providers to report to the proper authorities, as well as the AdSS, incidents of abuse, neglect, injuries (e.g., falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident. Providers shall submit Incident, Accident, and Death reports to the AdSS as specified in 9 A.A.C. 10, AMPM Policy 960, and AMPM Policy 961;

y. Implement policies and procedures that require individual and organizational providers to monitor and trend all suicides or suicides attempts;

z. Implement policies and procedures to ensure that all providers recognize signs and symptoms of suicidal ideation and at-risk behaviors for children and adults

regardless of mental health status. Policies and procedures shall 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 suicidal ideation, at-risk behaviors or when there is a significant change in either the behavioral or physical health condition of a Member;

aa. Conduct new Member Health Risk Assessment (HRA) within 90 days of the Member's effective enrollment date.

i. The AdSS shall develop and implement a process to ensure that a "best effort" attempt has been made to conduct an initial HRA of each Member's health care needs;

ii. The process shall also address activities to follow up on unsuccessful attempts to contact a Member within 90 days of the effective date of enrollment;

iii. Each attempt shall be documented; and

iv. The AdSS shall develop processes to utilize the results of HRAs to identify individuals at risk for or with special health care needs, and coordinate care (42 CFR 438.208);

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 AdSS shall have initial contact with referred Members for behavioral health services.

bb. Ensure 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 AdSS'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 mild depression, anxiety, Attention Deficit Hyperactivity Disorder (ADHD), and SUD, or Opioid Use Disorder (OUD) for Members with an SMI designation; Monitoring shall ensure that medication

management by the PCPs is given within the PCP's scope of practice;

v. 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 and/or functional status;

vi. 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 AdSS that the Member shall receive care through the behavioral health system for Evaluation or continued medication management services, the AdSS's subcontracted providers shall assist the PCP with the coordination of the referral and transfer of care. The PCP and the involved behavioral health provider shall document

the care coordination activities and transition of care in the Member's medical record;

vii. Utilizing Arizona's Controlled Substances Prescription Monitoring Program (CSPMP), in accordance with A.R.S. § 36-2606;

viii. 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

ix. 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.

cc. 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 AdSS, the

methods for coordination, and specific documentation of these processes;

b) Specify services coordinated by the AdSS's Disease Management Unit; and

c) The requirements for timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940.

dd. 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.

ee. Develop and implement procedures for Members with special health care needs, as defined in Contract, including:

i. Identifying Members with special health care needs, including those who would 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 AdSSs 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 (e.g., a standing referral or an approved number of visits); and

vi. Implement processes and measures to ensure that Members receive Special Assistance, based on criteria as specified in AMPM Policy 320-R.

ff. 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 (e.g., Children's Rehabilitative Services [CRS]);

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

performance measures, PIPs, and QM/PI Program oversight.

gg. Include requirements, either in Contract or as an extension of the Contract, for practitioners or providers to cooperate with quality improvement activities and allow the AdSS to utilize their performance measure data;

hh. Ensure the following requirements related to data integrity:

i. Information or 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. Information that is rejected shall be tracked to ensure errors are corrected and the data is resubmitted and accepted; and

iii. Corrective actions are implemented with providers or vendors when data utilized for implementing and

maintaining its QM/PI Program, including data necessary to calculate and report performance measures, received from providers or vendors is not accurate, timely, or complete.

ii. Results of the AdSS's quality improvement data review, analysis, reporting, and Evaluation are shared with AdSS staff and stakeholders with internal corrective actions implemented when self-identified concerns and performance deficiencies are identified.

i. AdSS staff and providers are kept informed of at least the following:

1) QM/PI Program requirements, activities, updates, or revisions;

2) Study and PIP results;

3) Performance measures and results;

4) Utilization data; and

5) 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. All policies and procedures shall be specific to each line of business.

C. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT PROGRAM ADMINISTRATIVE STRUCTURE AND OVERSIGHT

1. The AdSS shall administer the QM/PI Program through a clear and appropriate administrative structure that maintains the ultimate responsibility for the QM/PI Program.
2. The AdSS shall ensure the QM/PI Program work resides within the QM/PI Unit and adheres to requirements as specified in Contract and AMPM Chapter 900.

2. The AdSS shall ensure administrative structure for oversight of 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 Chief Executive Officer (CEO);
   c. The QM/PI Committee;
   d. The Peer Review Committee;
   e. QM/PI Program Staff;
   f. Delegated Entities; and
   g. The AdSS's executive management.
3. The AdSS Governing or Policy Making Body shall oversee and be accountable for the QM/PI Program, as well as 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. Changes in the QM/PI Program scope include any alterations made to the AdSS's QM/PI Program structure from one year to the next. This

may also include line of business, population, and geographic service area changes.

5. The Board of Directors, and in the absence of a Board, the executive body, shall review and approve the QM/PI Program Plan, as demonstrated via an attestation of approval by the Board of Directors or executive body.
6. The Board of Directors, and in the absence of a Board, the executive body, formally evaluates and documents the effectiveness of its QM/PI Program strategy and activities, at least annually, as demonstrated via an attestation of approval by the Board of Directors or executive body.
7. The local CMO or designated Medical Director and CEO shall be responsible for the implementation of the QM/PI Program Plan and shall have substantial involvement in the implementation, assessment, and resulting improvement of QM/PI Program activities.
8. The AdSS's CMO or designated Medical Director shall review and sign all QM/PI policies.

9. The AdSS shall have an identifiable and structured local Arizona QM/PI Committee that is responsible for QM/PI Program functions and responsibilities.
    a. At a minimum, QM/PI Committee Membership shall include:
        i. The local CMO or designated Medical Director as the chairperson of the Committee. The local CMO or designated Medical Director may designate the local Associate Medical Director as their designee only when the CMO or designated Medical Director is unable to attend the meeting. The local CEO may be identified as the co-Chair of the QM/PI Committee;
        ii. The QM/PI Manager(s);
        iii. Representation from the functional areas within the organization;
        iv. Representation of contracted or affiliated providers serving AHCCCS Members; and

v. Clinical representatives of both the AdSS 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 signed statements on file or QM/PI Committee sign-in sheets with requirements noted;

c. The QM/PI Committee shall meet at a minimum of quarterly or more frequently, as needed.

i. The frequency of committee meetings shall be sufficient to monitor all program requirements and to monitor any required actions; and

ii. The AdSS shall provide evidence of actual occurrence of these meetings through minutes and other supporting documentation.

d. The QM/PI Committee shall review the QM/PI Program objectives, policies, and procedures as specified in Contract and shall update the policies when processes or

activities are changed substantially. The QM/PI policies and procedures, and any subsequent modification to them, shall be available upon request for review by AHCCCS QM or Quality Improvement (QI) Teams;

e. The QM/PI Committee shall:

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 Contractor 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 meeting minutes shall clearly document discussions of the following when deficiencies are noted:

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.

9. The AdSS Peer Review process shall have the purpose of improving the QOC provided to Members by both individual and organizational providers.

a. The AdSS Peer Review scope shall include cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating, physical, or behavioral health care

professional or provider whether delivered in or out of state.

b. The AdSS Peer review shall be defined by specific policies and procedures which shall address the following requirements:

   i. The AdSS shall not delegate functions of Peer Review to other entities;

   ii. The Peer Review Committee shall be scheduled to meet at least quarterly, or more frequently, as needed; and

   iii. Peer review activities may be carried out as a stand-alone committee or in an executive session of the AdSS's QM Committee.

c. The Peer Review Committee shall consist of the following at minimum:

   i. AdSS's local CMO or designated Medical Director 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 AdSS Peer Review process shall ensure that providers of the same or similar specialty participate in review and recommendation of individual Peer Review cases.

f. The AdSS's Peer Review Committee shall utilize peers of the same or similar specialty through external consultation if the specialty being reviewed is not represented on the AdSS's Peer Review Committee;

g. The AdSS Peer Review Committee Members shall sign, may be an electronic signature, a confidentiality and conflict of interest statement at each Peer Review Committee meeting;

h. The AdSS Committee Members shall not participate in Peer Review activities if they have a direct or indirect interest in the Peer Review Outcome;

i. The AdSS Peer Review Committee shall evaluate referred cases based on all information made available through the QM process;

j. The AdSS Peer Review Committee is responsible for making recommendations to the AdSS's CMO or designated Medical Director.

   i. The Peer Review Committee shall determine appropriate action which may include: peer contact, education, reduced or revoked credentials, limit on new Member enrollment, sanctions, and/or other corrective actions;

   ii. The AdSS CMO or designated Medical Director shall be responsible for implementing the actions. Adverse actions taken as a result of the Peer Review Committee shall be reported to AHCCCS QM Team as specified in contract,

k. The AdSS Peer Review Committee is responsible for making appropriate recommendations to the AdSS's CMO

or designated Medical Director regarding initiation of referrals for further investigation or action to: Division of Child Safety (DCS), Adult Protective Services (APS), Arizona Department of Health Services (ADHS) Licensure Unit, appropriate regulatory agency or board; and AHCCCS.

i. Notification shall occur when the Peer Review Committee determines care was not provided according to the medical community standards.

ii. The AdSS shall submit the report to the regulatory agency as soon as possible, but no later than 24 hours after the determination; and

iii. The report may be submitted verbally or electronically, email or online, as appropriate for the regulatory agency.

l. The AdSS shall develop a process to timely report the concern to the appropriate regulatory agency, including DCS or APS, ADHS, the Attorney General's Office, law

enforcement, Office of Inspector General (OIG), and AHCCCS QM, for further research, review, or action.

i. The AdSS shall submit the report to the regulatory agency as soon as possible but no later than 24 hours of becoming aware of a concern; and

ii. The report shall be submitted verbally or electronically, as appropriate.

m. The AdSS Peer Review Committee policies and procedures shall assure that all information used in the Peer Review process is kept confidential and is not discussed outside of the Peer Review process. The AdSS's Peer Review Committee reports, meetings, minutes, documents, recommendations, and participants shall be kept confidential except for implementing recommendations made by the Peer Review Committee;

n. The AdSS shall make Peer Review documentation available upon request to AHCCCS for purposes of QM, monitoring, and oversight;

o. The AdSS shall maintain High-level Peer Review summaries as part of the original QOC file;

p. The AdSS 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 include:

   i. Cases where there is evidence of deficient quality,

   ii. 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,

   iii. Questionable clinical decisions, lack of care or substandard care,

   iv. 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,

v. Criminal or felonious actions related to practice,

vi. Issues that immediately impact the Member and that are life threatening or dangerous, and

vii. Issues that have the potential for adverse Outcome.

10. The AdSS QM/PI Program Staffing shall have qualified local personnel to carry out the functions and responsibilities specified in AMPM Chapter 900 in a timely and competent manner. QM/PI Program positions performing work functions related to the Contract shall have a direct reporting relationship to the local CMO or designated Medical Director and the CEO. The AdSS is responsible for Contract performance, whether or not subcontractors or delegated entities are used. As part of the QM/PI Program Staffing requirements, the AdSS 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 or Medical Director.

b. Develop a process to ensure that all staff is trained on the process for referring suspected QOC concerns to the QM Team that shall be provided:

i. During new 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, including, but not limited to:

i. Quality Management and Quality Improvement;

ii. Maternal child health;

iii. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and Dental;

iv. Chronic Disease management;

v. Long-Term Care;

vi. Behavioral health;

vii. Justice Involvement;

viii. Opioid and substance use;

ix. Suicide;

x. Social determinants of health;

xi. Veterans' resources and services; and

xii. Specific community initiatives and collaborations, and as required by AHCCCS.

e. AHCCCS sponsored activities are not considered community initiatives or collaborations.

11. The AdSS shall oversee Delegated Entities by:

a. Ensuring accountability for all functions and responsibilities delegated to other entities is maintained as specified in AMPM Chapter 900;

b. Ensuring the methodologies for oversight and accountability for all delegated functions be integrated into the overall QM/PI Program, meeting requirements for all delegated functions as specified in AMPM Chapter 900;

c. Including accredited agencies in the AdSS's oversight process;

d. Providing, as a prerequisite to delegation, a written analysis of its historical provision of QM/PI Program oversight function, which includes:

   i. Past goals and objectives; and

   ii. The level of effectiveness of the prior QM/PI Program oversight functions shall be documented.

e. Having policies and procedures requiring that the delegated entity report all allegations of QOC concerns and quality of service issues to the AdSS no later than 24 hours of awareness; QOC or service investigation and resolution processes shall not be delegated;

f. Evaluating 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.

g. Establishing a written contract, prior to delegation, that:

i. Specifies the delegated activities and reporting responsibilities of the entity to the AdSS; and

ii. Include the AdSS's right to terminate the contract or perform other remedies for inadequate performance.

h. The AdSS shall monitor the performance of the entity and the quality of services provided on an ongoing basis and review annually a minimum of 30 randomly selected cases per line of business for each function that is delegated. Documentation shall be kept on file for Division review. Monitoring shall include, but is not limited to:

i. Utilization;

ii. Member and provider satisfaction;

iii. QOC concerns; and

iv. Complaints.

i. The AdSS shall monitor entities that have been delegated services who are accredited through the National Committee for Quality Assurance (NCQA) or another nationally recognized entity, by reviewing a minimum of 10 randomly selected files per line of business for each function that is delegated. If any issues or concerns are noted within the files reviewed, 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. Monitoring results shall be submitted to AHCCCS in accordance with ACOM Policy 438.

j. The following documentation shall be kept on file and available for Division review:

i. Evaluation reports;

ii. Results of the AdSS's annual monitoring review of the delegated entity utilizing AHCCCS required standards for the contracted functions;

iii. Corrective Action Plans (CAP)s; 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

The AdSS 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. Delegated entities conducting monitoring activities shall have direct oversight by the AdSS's QM/PI Program QM staff. QM/PI Program monitoring and Evaluation activities shall include at minimum the following:

1. QM/PI Program scope of monitoring and Evaluation shall be comprehensive. It shall incorporate the activities used by the

AdSS and demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities shall be clearly documented in policies and procedures.

2. If collaborative opportunities exist to coordinate organizational monitoring, the lead AdSS shall coordinate and ensure that all requirements in the collaborative arrangement are met.
3. Monitoring provider compliance with policies, training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation as specified in Division and AHCCCS Minimum Subcontract Provisions and Contract.
4. Information and data gleaned from QM/PI Program monitoring and Evaluation that shows trends in QOC concerns shall be used in developing quality improvement initiatives. Selection of specific monitoring and Evaluation activities shall be appropriate to each specific service or site.
5. Development and implementation of methods for monitoring PCP activities related to:

a. Referrals for behavioral health care,

b. Coordination with the behavioral health system (e.g., ACC-RBHAs and behavioral health providers),

c. Transfer of care, when clinically indicated, based on severity of behavioral health need, and

d. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

i. Assurance of communication between prescribers, when controlled substances are used,

ii. Provider-mandated usage of the CSPMP, and

iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing Member satisfaction.

6. Development and implementation of methods for monitoring behavioral health provider activities related to:

a. Referrals for physical health care,

b. Coordination with the physical health system,

c. Use of the CSPMP. Monitoring procedures for the CSPMP process shall include:

i. Assurance of communication between prescribers, when controlled substances are used,

ii. Include provider-mandated usage of the CSPMP, and

iii. Integration strategies and activities focused on improving individual health Outcomes, enhancing care coordination, and increasing Member satisfaction.

7. Reporting of all QOC concerns including, but not limited to:

a. Incidents of abuse, neglect, exploitation, suicide attempts, opioid-related concerns, alleged human rights violations, and unexpected deaths to the Division QM Team as soon as the AdSS is aware of the incident and no later than one business day, as specified in Contract. The AdSS is expected to investigate and report case findings, including identification of organizational providers, individual

providers, paid caregivers, or the specific individual rendering the service,

b. Identified QOC concerns, reportable incidents, and/or service trends to the Division QM Team immediately upon identification. Reporting shall include trend specifications such as providers, facilities, services, and allegation types,

   i. AdSS QOC trend reports shall be incorporated into monitoring and Evaluation activities and presented to the QM/PI Committee. Policies and procedures shall be adopted to explain how the process is routinely completed.

c. The AdSS is expected to investigate all potential Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Conditions (OPPC) as QOC concerns within the AHCCCS QM Portal. For more information, refer to AMPM Policy 960.

8. Incorporation of the ADHS licensure and certification reports and other publicly reported data in their monitoring process, as applicable.
9. A process to ensure notification is made to the AdSS'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. 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.
10. The AdSS shall be responsible for ensuring 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 by:
    a. Participating in both individual and coordinated efforts to improve the QOC in placement settings or service sites; and

b. Utilizing clinical quality staff trained in QOC investigations to conduct on-site reviews if there is a health or safety concern identified either by the AdSS, Division, AHCCCS, or other party.

11. The AdSS QM staff shall conduct the monitoring of services and service sites, in accordance to Attachment A. While the AdSS 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 AdSS. Refer to Attachment A for the list of AHCCCS services, service sites, and monitoring frequency.
12. 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.

13. 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 AdSS network. A collaborative process shall be utilized in counties when more than one AdSS is contracted with and utilizes the facility as specified in Contract.
14. The AdSS, or the lead AdSS, if AdSS collaborative monitoring was completed, shall submit the AdSS monitoring summary to Division QM Team as specified in Contract. Additionally, a standardized and agreed upon tool shall be used and include at a minimum:
    a. General quality monitoring of these services includes, but is not limited to, the review and verification of:
        i. The written documentation of timeliness,
        ii. The implementation of contingency plans,
        iii. Customer satisfaction information,

iv. The effectiveness of service provisions,

v. Mandatory documents in the services or service site personnel file including:

1) Cardiopulmonary resuscitation,

2) First Aid,

3) Verification of skills or competencies to provide care,

4) 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

5) Evidence that the provider conducted the pre-hire and annually thereafter search of the APS Registry as required in Division and AHCCCS Minimum Subcontract Provisions.

b. Specific quality monitoring requirements for ALTCS Contractors are as follows:

i. 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 Responsible Person, 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. For more

general information on the DCW training and testing standards, as specified in AMPM Policy 1240-A and ACOM Policy 429, and

4) Timeliness and content of supervisory visitations as specified in AMPM Policy 1240- A.

ii. 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,

iii. The AdSS shall monitor that the LTSS services a Member receives align with those that were documented in the Member's LTSS treatment/service plan [42 CFR 438.330 (b)(5)(i)],

iv. The AdSS 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)], and

v. The AdSS may also consider incorporating the use of surveys to assess the experience of Members receiving LTSS services as a key component of the AdSS's LTSS assessment process.

Signature of Chief Medical Officer: Anthony Dekker (Oct 4, 2023 16:58 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: October 1, 2019
REFERENCES: 42 CFR 438.320, 42 CFR 438.354, 42 CFR 438.358, 42 CFR 438.310(c)(2), 42 CFR Part 457, 42 CFR Part 438, 42 CFR 438.68, 42 CFR 438.206, AMPM Chapter 900; AMPM Policy 910 Attachment A, AMPM Policy 920 Attachment A-B, AMPM Policy 980, Attachment B-D, AMPM Appendix B

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) and specifies the Quality Management and Performance Improvement (QM/PI) Program administrative requirements.

DEFINITIONS

1. "Access" means the timely use of services to achieve optimal Outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 and 42 CFR 438.206 (42 CFR 438.320).
2. "Assess or 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 AdSS service delivery systems.

3. "Corrective Action Plan" or "CAP" means a written Work Plan that identifies the root cause(s) of a deficiency, includes goals and Objectives, actions, or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and Objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and its providers, to enhance Quality Management and Process Improvement activities and the Outcomes of the activities, or to resolve a deficiency.
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 a Contractor or their contractors 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 in 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 the AdSS 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 (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 AND PERFORMANCE IMPROVEMENT PROGRAM PLAN

1. The AdSS shall develop a written QM/PI Program Plan that specifies the Objectives of the AdSS QM/PI Program and addresses the AdSS proposed approaches to meet or exceed the performance standards and requirements as specified in the AdSS contract with the Department of Economic Security (DES) under the oversight of the Division and AdSS Medical Policy Chapter 900.
2. The AdSS shall submit the QM/PI Program Planas specified in the Division contract.
3. The AdSS shall include the following in the QM/PI Program Narrative:
    a. Objectives and plans for the upcoming calendar year to meet or exceed the minimum standards and requirements as specified in AdSS contract with the Division and in AdSS Medical Policy Chapter 900.
    b. AdSS activities to identify the needs of its members with Intellectual and Developmental Disabilities (I/DD) and to coordinate care.

c. Follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

d. Description of AdSS participation in community or quality initiatives.

4. The AdSS 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. Description of how any sustained goals and Objectives shall be incorporated into the AdSS business practice and develop new goals and 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 AdSS' 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 AdSS shall include the following in its QM/PI Program Work Plan:

a. Goals and Objectives that are realistic, Measurable, and based upon established Performance Standards and requirements as specified in the current Division contract and AdSS Medical Policy Chapter 900 when appropriate.

b. Other nationally recognized benchmarks as available to establish the programs minimum performance standards or when performance standards have not been met 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 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 AdSS 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 and Objectives.

c. An Evaluation of the disparity analysis findings, progress on targeted strategies or interventions, and progress on identified goals and Objectives.

d. A detailed Evaluation of performance measure rates specific to subpopulations.

e. An analysis of the effectiveness of implemented strategies and interventions in meeting the AdSS' health equity goals and Objectives during the previous calendar year.

f. A detailed overview of the AdSS' identified health equity goals and Objectives for the upcoming calendar year to address noted disparities and promote health equity.

g. Targeted strategies or interventions planned for the upcoming calendar year to achieve its goals.

7. The AdSS shall include the following specific to members with I/DD in its Engaging Members Through Technology – Executive Summary:

a. An Evaluation of the previous calendar year's EMTT activities including, but not limited to:

i. The percent of members engaged through telehealth services and through web and mobile- based applications in comparison to total membership, and

ii. Supporting data 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 percent 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 and Objectives.

8. The AdSS shall submit the following referenced or associated Policies to the Division:
   a. New or substantially revised, relevant policies and procedures, referenced in the QM/PI Program Plan Checklist (AMPM Policy 920, QM/PI Program Plan Checklist), are submitted as separate attachments.
   b. Current policies that have not had substantive changes during the year are not required to be submitted in the Plan and will be Evaluated as part of the Division's Operational Review unless submission is seen as a value-add to the QM/PI Program Plan.
9. The AdSS shall submit the QM/PI Program Plan accompanied by a completed AMPM Policy 920, QM/PI Program Plan Checklist.

B. BEST PRACTICES AND FOLLOW-UP ON PREVIOUS YEAR'S EXTERNAL QUALITY REVIEW REPORT RECOMMENDATIONS

The AdSS shall submit recommendations as specified in contract and include:

a. 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 its members with I/DD.
b. A summary of the AdSS efforts to date in completing the most current and previous year's EQR Report recommendations, as a stand-alone document.
c. Submission of Best Practices and Follow-Up on Previous Year's EQR Report Recommendations Checklist

C. PERFORMANCE MEASURE MONITORING REPORT

1. The AdSS shall submit a report utilizing the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template and AHCCCS Performance Measure Monitoring Report & Work Plan Attachment specifying AdSS' progress in meeting, sustaining, and improving its performance for contractually

required performance measures.

2. The AdSS shall include the following in the Performance Measure Monitoring Report based on the associated reporting period:

   a. The internal rates for each performance measure.

   b. Identified barriers in implementing planned interventions and opportunities for improvement intended to support the AdSS in supporting its identified goals and Objectives.

   c. Detailed analysis of results that includes an Evaluation of AdSS trends in performance compared to the following:

      i. Performance Measure Performance Standards (PMPS) in accordance with AdSS Medical Policy Manual 970.

      ii. AdSS self-identified goals and Objectives.

      iii. Historical performance.

D. PERFORMANCE IMPROVEMENT PROJECT REPORT

1. The AdSS shall submit a Performance Improvement Project (PIP) Report that includes annual updates for both

AHCCCS-mandated and AdSS self-selected PIPs.

2. The AdSS shall comply with the instructions and requirements outlined in AMPM Policy 980, including the use of AMPM Policy 980 Attachment C, Performance Improvement Project (PIP) Report DDD Specific.

E. CORRECTIVE ACTION PLAN

1. The AdSS shall develop and implement a CAP for taking appropriate steps to improve care when issues are identified.
2. The AdSS shall submit all CAPs to the Division for review and approval prior to implementation and shall include:
    a. The concern(s) that require corrective action.
    b. Identification of any deficiency and remedial steps
    c. Documentation of proposed time frames for CAP completion.
    d. Entities responsible for making the final determinations regarding QM/PI Program concerns.
    e. Types of actions to be taken including, but not limited to:

i. Education, training, or technical assistance;

ii. Process, structure, or form changes;

iii. Follow-up Monitoring and Evaluation of improvement as well as implementing new interventions and approaches, when necessary; 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. Submission of information to the Division and other stakeholders as required. For Quality of Care (QOC) specific CAPs, information is submitted in accordance with AdSS Medical Policy 960.

3. The AdSS shall submit CAPS as required in AMPM 920, Attachment B, AHCCCS Quality Improvement Corrective Action Plan Proposal Checklist and AHCCCS Quality Improvement Corrective Action Plan Update Checklist.

4. The AdSS shall maintain documentation regarding CAPS development, implementation, performance Outcomes, identified barriers, opportunities for improvement, and best practices.

F. ADSS REPORTING REQUIREMENTS

1. The AdSS shall submit deliverables as specified in the contract between the Division and AdSS.

2. If a time extension is necessary, the AdSS shall submit a formal request in writing before the deliverable due date to the Division's Compliance Department, Quality Management or Quality Improvement team manager, as appropriate to the deliverable.

3. The QM/PI Program administrative deliverables shall be

submitted as specified in the contract between the Division and AdSS and is subject to Division approval. Any significant modifications to the QM/PI Program Plan throughout the year shall be submitted for review and approval prior to implementation.

4. The AdSS QM/PI administrative deliverables and other select deliverable submissions are provided to the Division for submission to the AHCCCS EQRO with AdSS supplied information included within the AdSS's annual EQR Report.

G. ADSS DOCUMENTATION REQUIREMENTS

The AdSS shall maintain records that document QM/PI Program activities. The records shall be made available to the Division, Quality Management or Quality Improvement teams upon request. The required documentation shall include, but is not limited to:

a. Policies and procedures

b. Studies and PIPS

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. Documentation supporting requested by the EQRO as part of the EQR process

h. Other information and data appropriate to support changes made to the scope of the QM/PI Program.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 10:58 PDT)
Anthony Dekker, D.O.

930 RESERVED

REVISION DATES: 07/29/2020, 10/1/2019
EFFECTIVE DATE: October 1, 2019

940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

REVISION DATE: 9/6/2023, 5/24/2021, 12/23/2020
EFFECTIVE DATE: October 01, 2019
REFERENCES: AMPM Policy 710, A.R.S. §13-3620, A.A.C. R9-10, 9 A.A.C. 22, Article 5, 45 CFR 160, 162, and 164, 42 CFR Part 2, 2.1 – 2.67, 42 CFR 431.300 et seq, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi), 45 CFR 431, 42 U.S.C. §290 dd-2.

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS). 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 the 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, or HCDM;

   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 the following:

   a. Medical and billing records maintained by a 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. Health information exchange 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" 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 AdSS for the provision of covered services, or ordering or referring for those services, to eligible Division Members, or any subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. GENERAL REQUIREMENTS

1. The AdSS shall require Providers to maintain comprehensive documentation related to care and services provided to Members.
2. The AdSS shall ensure, via regular monitoring activities, that documentation completed and maintained by the Providers meets the requirements specified in this policy.

B. MEDICAL RECORD REQUIREMENTS

1. The AdSS shall require 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 demographics:

i. The Member's name,

ii. Address,

iii. Telephone number,

iv. AHCCCS identification number,

v. Gender,

vi. Age,

vii. Date of birth (DOB),

viii. Marital status,

ix. Next of kin,

x. 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, and

iii. Member DOB.

d. Member name and either AHCCCS ID or Member

DOB 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,

viii. Surgeries,

ix. Emergent/urgent care received, and

x. Immunization records: required for children, recommended for adult Members if available.

2. The AdSS 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 establish a method for indicating the author; date; and time of added and revised information; and

   iv. Ensure that information is not inadvertently altered.

f. That Providers in multi-Provider offices have the treating Provider sign their treatment notes after each appointment

and procedure and occurs r as close to the actual entry of treatment notes as possible, based on either professional standards of care or requirements specified within 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 AdSS 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 AdSS 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 AdSS shall require any Provider delivering primary care services to a Member and acting as their Primary Care Provider (PCP) to maintain 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 received from a TRBHA or other 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 AdSS 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; and

iv. Financial documentation for Non-Title XIX/XXI Members receiving behavioral health services, as outlined in AMPM Policy 650 occurring 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 inAdSS 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 AdSS 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 AdSS 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 AdSS shall have written policies and procedures

addressing appropriate and confidential exchange of Member information among Providers.

5. The AdSS 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 transmit 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 AdSS shall require that the Medical Record audit process includes the Ambulatory Medical Record Review (AMRR) and the Behavioral Health Clinical Chart Audit.

2. The AdSS may, if they choose, utilize the AzAHP to conduct Medical Record review and other Provider documentation review processes.

3. The AdSS 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 the Division.

   b. Review the following physical health records:

i. EPSDT,

ii. Family planning, and

iii. Maternity components not otherwise monitored for Provider compliance by the AdSS.

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 DDD.

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 AdSS 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 AdSS 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 AdSS 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.

g. The AdSS 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.

h. The AdSS shall share the deficiencies identified during a Medical Record review with all health plans contracted with the Provider.

i. If quality of care issues are identified during the Medical Record review process, the AdSS shall notify all contractors which contract with the identified Provide, within 24 hours of identification of the quality of care issue with specifics concerning the quality of care issue.

j. If the AdSS requests approval from the Division to discontinue conducting the Medical Record reviews, the AdSS shall do the following prior to making the request:

   i. 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;

   ii. Document what processes will be used in place of the Medical Record review process to ensure

compliance with the Division and AHCCCS requirements; and

iii. 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.

4. The AdSS shall include all PCPs that serve Members less than 21 years of age and obstetricians/gynecologists in the AMRR process.

5. The AdSS shall review eight charts per practitioner and include the requirements specified in contract as a part of the AMRR.

6. The AdSS 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.

7. The AdSS shall follow the medical review process for behavioral health records as specified in contract.

8. For changes in methodology or sampling, the AdSS shall submit to the Division and AHCCCS in advance for approval as specified in the contract.

G. MULTI-SPECIALTY INTEGRATED CLINIC

1. The AdSS 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 AdSS 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 AdSS shall require that the Medical Records conform to the following standards:

   a. Each record entry be:

      i. Dated and signed with credentials noted;

      ii. Legible text, written in blue or black ink, or typewritten; and

      iii. Factual and correct.

2. If Medical Records are kept in more than one location, the AdSS shall require the agency orProvider 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 theMember'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 AdSS 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 AdSS shall treat the DRS as the property of the Provider who generates the DRS.

2. The AdSS 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 AdSS shall provide sufficient copies of records necessary for administrative purposes to the Division or AHCCCS free of charge for purposes relating to treatment, payment, or health care operations.

4. The AdSS 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 an AdSS 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 AdSS 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 AdSS shall provide access to the Division or AHCCCS to all Medical Records, whether electronic or hard copy, within 20 business days of receipt of a request.

7. The AdSS 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 AdSS shall demonstrate evidence of professional and community standards and accepted and recognized evidence-based practice guidelines as specified ine Division Medical Manual Chapter 500.

9. The AdSS shall require the Provider 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 AdSS 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 AdSS, 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 AdSS shall require that the 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, 42 CFR Part 2, 2.1 – 2.67.

3. The AdSS shall release original and copies of Medical Records only in accordance with Federal or State laws, and AHCCCS and Division policy and contracts.

4. The AdSS shall comply with HIPAA requirements and 42 CFR 431.300 et seq.

5. The AdSS shall align the Medical Records retention processes with AHCCCS and Division contract and TRBHA Intergovernmental Agreement (IGA) requirements.

6. The AdSS 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 AdSS 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 AdSS 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 AdSS 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 16:17 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' Provider 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
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-114, A.A.C. R9-10-115; 42 CFR 8.11, CFR 438, 42 CFR 455.1(a)(1), 42 CFR 455.14, 42 CFR 455.17, 42 CFR 455 Subpart B, 42 CFR 457.1201(f), 42 CFR 457.1208, 42 CFR 457.1230(a), 42 CFR 457.1233(a), IRC of 1986 7701(A)(41).

PURPOSE

This policy establishes the requirements for initial Credentialing, temporary/provisional Credentialing, and recredentialing of individual and Organizational Providers conducted by the Division of Developmental Disabilities' (Division) 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. "Network Provider" means, for the purpose of this policy, an individual or entity which has signed a Provider agreement as specified in A.R.S. § 36-2904 and that has a subcontract, or is authorized through a subcontract, to provide services pursuant to A.R.S. § 36-2901 et seq. for Members served by the AdSS health plan.
6. "Organizational Provider" means a facility providing services to Members and where Members are directed for services rather than being directed to a specific practitioner.
7. "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.
8. "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 Division Members enrolled in an AdSS' health plan, or any

subcontractor of a Provider delivering services pursuant to A.R.S 36-2901.

POLICY

A. CREDENTIALING PROVIDERS

1. The AdSS shall have a written process and a system in place for Credentialing and recredentialing Providers in its Provider Network.
2. The AdSS shall document Credentialing and recredentialing for all Providers delivering care and services to Division Members enrolled in the AdSS' health plan.
3. The AdSS shall utilize the Arizona Association of Health Plans' contracted Credential Verification Organization as part of the Credentialing and recredentialing process.
4. The AdSS 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.

5. If the AdSS delegate any Credentialing and recredentialing responsibilities to another entity, the AdSS shall retain the right to approve, suspend, or terminate any Provider selected by that entity.

6. The AdSS shall establish a Credentialing Committee to review and make decisions on Provider Credentialing.

7. The AdSS shall have written policies and procedures that:

a. Reflect the direct responsibility of the AdSS' local Chief Medical Officer or designated Medical Director, or in the absence of the Chief Medical Officer or designated Medical Director, another local designated physician to:

i. Act as the Chair of the Credentialing Committee;

ii. Implement the decisions made by the Credentialing Committee; and

iii. Oversee the Credentialing process;

b. Indicate the use of participating Arizona Medicaid Network Providers in making Credentialing decisions;

c. Describe the methodology to be used by the AdSS' staff and the local Chief Medical Officer or designated Medical Director to provide documentation that each Credentialing/ Recredentialing file was completed and reviewed prior to the presentation to the Credentialing Committee for evaluation; and

d. Notify Providers of their right to:

i. Review information obtained to evaluate the Credentialing application, attestation, or curriculum vitae;

ii. Correct erroneous information; and

iii. Receive the status of their Credentialing application upon request.

8. The AdSS shall maintain an individual electronic or hard copy Credentialing/Recredentialing file for each applying Provider and ensure each file contains:
    a. The initial Credentialing and all subsequent recredentialing applications and attestation by the Provider of the correctness and completeness of the application as demonstrated by the signature on the application;
    b. Information gained through Credentialing and recredentialing queries;
    c. Any other pertinent information used in determining whether the Provider met the AdSS' Credentialing and recredentialing standards; and
    d. Specific to recredentialing, utilization data, quality of care concerns, grievances, performance measure rates, value-based purchasing results, and level of Member satisfaction.
9. The AdSS shall enter the credentialed Providers into the AdSS' claims payment system within 30 calendar days of the Credentialing 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.

10. The AdSS shall reimburse Providers who submit claims for covered services provided to Members during the Credentialing process on or after the date of the Completed Application as defined in this Policy. If the Provider is subsequently not approved through the Credentialing Committee, the AdSS shall recoup the funding.
11. The AdSS shall have an established process to notify Providers of the Credentialing decisions within 10 calendar days of Credentialing Committee decisions.

B. TEMPORARY/PROVISIONAL CREDENTIALING

1. The AdSS shall have policies and procedures to address granting of temporary/provisional credentials when it is in the best interest of Members, as defined in this section, to have Providers available to provide care prior to completion of the entire Credentialing process.
2. The AdSS shall credential the following Providers using the temporary/provisional Credentialing process, even if the Provider

does not specifically request their application be processed as temporary/provisional:

a. Providers in a Federally Qualified Health Center (FQHC);

b. Providers in a FQHC Look-Alike organization;

c. Rural Health Clinic (RHC);

d. Hospital employed physicians (when appropriate);

e. Providers needed in medically underserved areas;

f. Providers joining an existing, contracted oral health Provider group;

g. Covering or substitute Providers providing services to Members during a contracted Provider's absence from the practice;

h. Providers eligible under the Substance Abuse and Mental Health Services Administration Certified Opioid Treatment Programs as specified in 42 CFR 8.11; and

i. Providers as directed by AHCCCS during federal or state-declared emergencies where delivery systems are or have the potential to be disrupted.

3. The AdSS local Medical Director shall review the Credentialing information obtained and determine whether to grant temporary/provisional Credentialing.
4. The AdSS shall render a decision regarding temporary/ provisional Credentialing within 14 calendar days from the date of request or identified need.
5. Upon approval of the temporary/provisional Credentialing, the AdSS shall enter the Provider information into the AdSS' claims system to allow payment to the Provider effective the date the temporary/provisional Credentialing is approved.
6. For consideration of temporary/provisional Credentialing, at a minimum, the AdSS shall ensure the Provider has a Completed Application, signed and dated, that attests to the following elements:
    a. Reasons for any inability to perform the essential functions of the position with or without accommodation;
    b. Lack of present illegal drug use;
    c. History of loss of license or felony convictions;

d. History of loss or limitation of privileges or disciplinary action;

e. Current malpractice insurance coverage;

f. Attestation by the Provider of the correctness and completeness of the application;

g. Work history for the past five years or total work history if less than five years; and

h. Current Drug Enforcement Agency or Controlled Drug System certificate if a prescriber.

7. The AdSS shall conduct Primary Source Verification of the following:

a. Licensure or certification;

b. Board certification, if applicable, or the highest level of credential attained; and

c. National Practitioner Data Bank (NPDB) query with:

i. Minimum five-year history of professional liability claims resulting in a judgment or settlement;

ii. Disciplinary status with regulatory board or agency;

iii. State sanctions or limitations of licenses; and

iv. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

8. If a covering or substitute Provider is used by a contracted Provider, and is approved through the temporary/provisional Credentialing process, the AdSS shall ensure that the claims system allows payments to the covering or substitute Provider effective the date the notification was received from the Provider of the need for a covering or substitute Provider.
9. The AdSS shall require covering or substitute Providers to meet the following requirements:
    a. Licensure: Providers and employees rendering services to Members shall be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses shall be maintained in good standing.
    b. Restriction of licensure: Providers shall notify the AdSS within two business days of the loss or restriction of a Drug Enforcement Agency permit or license, or any other action that limits or restricts the Provider's ability to practice or

provide services.

c. Professional Training: Providers and all employees rendering services to Members shall possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to Members.

d. Professional Standards: Providers and employees rendering services to Members shall provide care and services which meet or exceed the standard of care and shall comply with all standards of care established by state or federal law.

e. Continuing education: Providers and employees rendering care or services to Members shall comply with continuing education standards as required by state or federal law or regulatory agencies.

f. Regulatory compliance: Providers shall meet the minimum requirements for participating in the Medicaid program as specified by the state.

10. Following approval of temporary/ provisional Credentialing, the AdSS shall complete the entire initial Credentialing process as specified in this policy.
11. The AdSS shall not keep Providers in a temporary/provisional Credentialing status for longer than 60 calendar days.

C. INITIAL CREDENTIALING OF INDIVIDUAL PROVIDERS

1. The AdSS shall complete the individual Provider Credentialing for the following provider types:
    a. Medical Doctor;
    b. Doctor of Osteopathic Medicine;
    c. Doctor of Podiatric Medicine;
    d. Naturopathic Doctor and Naturopathic Medical Doctor;
    e. Nurse Practitioner;
    f. Physician Assistant;
    g. Certified Nurse Midwife acting as Primary Care Provider, including prenatal care and delivering Provider;
    h. Doctor of Dental Surgery and Doctor of Medical Dentistry;
    i. Affiliated Practice Dental Hygienist;
    j. Psychologist;

k. Optometrist;

l. Certified Registered Nurse Anesthetist;

m. Occupational Therapist;

n. Speech and Language Pathologist;

o. Physical Therapist; and

p. Independent behavioral health professionals who contract directly with the AdSS;

q. Board Certified Behavioral Analyst (BCBA);

r. Any non-contracted certified or licensed provider that is rendering services and sees 50 or more Members served by the AdSS per contract year; and

s. Any covering/substitute oral health providers that provide care and services to Members served by the AdSS in the absence of the contracted Provider.

2. The AdSS shall have a process for initial Credentialing of individual Providers that includes:

a. A written application to be completed 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 convictions;

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;

vii. Minimum five-year work history or total work history if less than five years; and

viii. Electronic Vendor Verification attestation form if applicable.

b. Drug Enforcement Administration or Chemical Database Service certification if a prescriber.

c. Verification from primary sources of:

i. Licensure or certification; and

ii. Board certification, if applicable, or highest level of credentials attained.

iii. For Credentialing of Independent Masters Level Behavioral Health Licensed Professionals, Primary Source Verification of:

a) Licensure by the Arizona Board of Behavioral Health Examiners (AZBBHE); and

b) A review of complaints received and disciplinary status through AZBBHE.

iv. For Credentialing of licensed BCBA, Primary Source Verification of:

a) Licensure by the Arizona Board of Psychologist Examiners; and

b) A review of complaints received and disciplinary status through the Arizona Board of Psychologist Examiners.

v. Documentation of graduation from an accredited school and completion of any required internships or residency programs, or other postgraduate training. A printout of license from the applicable Board's official website denoting that the license is active

with no restrictions is acceptable.

vi. National Practitioner Data Bank query including :

a) Minimum five-year history of professional liability claims resulting in a judgment or settlement;

b) Disciplinary status with regulatory board or agency;

c) State sanctions or limitations of licenses; and

d) Medicare/Medicaid sanctions, exclusions, and terminations for cause.

vii. Documentation that the following sites have been queried:

a) Health and Human Services Office of Inspector General List of Excluded Individuals/Entities, and

b) The System of Award Management formerly known as the Excluded Parties List System.

3. The AdSS shall ensure affiliated practice dental hygienists provide documentation of the affiliation agreement with an

AHCCCS registered dentist.

4. The AdSS may conduct an initial site visit as part of the Credentialing process.
5. For Locum Tenens, the AdSS shall verify the status of the physician with the Arizona Medicaid Board and national databases.
6. The AdSS shall ensure that Network Providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical and mental disabilities.
7. The AdSS shall ensure that network Providers deliver services in a culturally competent manner, including members with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.
8. The AdSS shall conduct timely verification of information as evidenced by approval or denial of a Provider within 60 days of receipt of a complete application.

D. RECREDENTIALING OF INDIVIDUAL PROVIDERS

The AdSS shall have recredentialing procedures that address the following requirements:

1. Recredentialing at least every three years.
2. Primary source verification current within 180 days of the recredentialing decision.
3. An update of information obtained during the initial Credentialing process as specified within this policy.
4. Verification of continuing education requirements being met.
5. A process for monitoring health care Provider specific information.

E. INITIAL CREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. As a prerequisite to contracting with an Organizational Provider, the AdSS shall ensure that the Organizational Provider has established policies and procedures that meet Division and AHCCCS requirements, including policies and procedures for Credentialing if those functions are delegated to the Organizational Provider.

2. Prior to Credentialing and contracting with an Organizational Provider, the AdSS shall:
    a. Confirm the Organizational Provider has met all the state and federal licensing and regulatory requirements. A copy of the license or letter from the regulatory agency will meet this requirement.
    b. Confirm that the Organizational Provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS). A copy of the accreditation report or letter from the accrediting body will meet this requirement.
    c. Conduct an onsite quality assessment if the Organizational Provider is not accredited.
    d. Develop a process and utilize assessment criteria for each type of unaccredited Organizational Provider that confirms that the Organizational Provider has the following:
        i. A process for ensuring that the Organizational Provider credentials its Providers for all employed and contracted Providers as specified in this policy;

ii. Liability insurance;

iii. Business license; and

iv. CMS certification or state licensure review may be substituted for the required onsite quality assessment if the review was within the past three years prior to the Credentialing date.

a) If a review was conducted within the past three years, obtain the documentation from CMS or the state licensing agency and verify that the review was conducted and that the Organizational Provider meets the AdSS' standards.

b) A letter from CMS that states the Organizational Provider was reviewed and passed inspection is sufficient documentation when the AdSS have documented that they have reviewed and approved the CMS criteria and they meet the AdSS' standards.

e. Confirm maintenance schedules for vehicles used to transport Members and the availability of age-appropriate car seats when transporting children.

f. Review and approve the Organizational Provider through the AdSS's Credentialing Committee.

3. The AdSS shall ensure Community Service Agencies are credentialed according to AHCCCS Medical Policy 965.

F. RECREDENTIALING OF ORGANIZATIONAL PROVIDERS

1. The AdSS shall recredential Organizational Providers at least every three years 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.

b. Review of the following:

   i. The most current review conducted by the Arizona Department of Health Services (ADHS) or summary of findings, documented by review date, and if applicable, the online Hospital Compare Az Care Check.

   ii. Record of onsite inspection of non-licensed Organizational Providers to ensure compliance with service specifications.

   iii. Supervision of staff and required documentation of direct supervision or clinical oversight, including a review of a valid sample of clinical charts.

   iv. Most recent audit results of the Organizational Provider.

   v. Confirmation that the service delivery address is verified as correct.

   vi. Review of staff to verify credentials and 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 quality assessment; and

vi. Review of any Adverse Actions.

d. Review and approval by the AdSS' Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

2. The AdSS shall review and monitor other types of Organizational Providers in accordance with the AdSS' contract.

3. If an Organizational Provider is not accredited or surveyed and licensed by the state, the AdSS shall conduct an onsite review.

G. NOTIFICATION REQUIREMENTS

1. The AdSS shall have written procedures for reporting to AHCCCS, Division of Health Care Management (DHCM), Quality

Management (QM), the Division's Quality Management Unit (QMU), the Provider's regulatory board or agency, ADHS Licensure Division, the Office of the Attorney General, and any other appropriate agencies.

2. The AdSS shall report any issues or quality deficiencies that result in a Provider's suspension or termination from the AdSS' network to AHCCCS/DHCM/QM and the Division QMU within one business day of the determination to take the Adverse Action.
3. If any issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS shall notify the appropriate law enforcement agency and protective services agency no later than 24 hours after identification.
4. The AdSS shall have an implemented process to report Providers to licensing and other regulatory entities for allegations of inappropriate or misuse of prescribing practices.
5. The AdSS shall report any adverse Credentialing decisions made on the basis of quality-related issues or concerns to AHCCCS/DHCM/QM and the Division QMU within one business day of determination to take the Adverse Action and include the

reason or cause of the adverse decision and when restrictions are placed on the Provider's contract.

6. The AdSS shall have an appeal process for Providers when restrictions are placed on the Provider's contract and a method to inform the Provider of the appeal process.
7. The AdSS shall have written procedures for reporting to AHCCCS/DHCM/QM and the Division QMU any final Adverse Action, taken against a Provider, supplier, vendor, or practitioner for any quality-related reason.
8. The AdSS shall not consider a final Adverse Action to be malpractice notices or settlements in which no findings or liability have been determined.
9. 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 AdSS network, Provider termination, Provider suspension, or an action that limits or restricts a Provider.

10. The AdSS shall 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 the date when the AdSS became aware of the final Adverse Action, or by the close of the AdSS' next monthly reporting cycle, whichever is later.

11. The AdSS shall send a notice of final Adverse Action to AHCCCS/DHCM/QM and the Division QMU within one business day and provide 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 heath 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.

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 Provider, supplier, or practitioner.

g. Documentation that the following sites have been queried:

   i. System of Award Management, formerly known as the Excluded Parties List System;

   ii. The Social Security Administration's Death Master File;

   iii. The National Plan and Provider Enumeration System;

   iv. List of Excluded Individuals/Entities; and

v. Any other databases directed by AHCCCS, the Division, or CMS.

12. In accordance with A.R.S. §36-2918.01 §36-2905.04, §36-2932, the AdSS shall ensure that the AHCCCS OIG is immediately notified regarding any allegation of fraud, waste, or abuse of the Medicaid Program, in accordance with AdSS Operations Policy 103 and as specified in the AdSS' contract, including allegations of fraud, waste, or abuse that were resolved internally but involved Medicaid funds.
13. The AdSS shall report to AHCCCS and the Division QMU any Credentialing denials issued by the Credential Verification Organization that are the result of licensure issues, quality of care concerns, excluded Providers, and which are due to alleged fraud, waste, or abuse.
14. The AdSS shall provide notification regarding Credentialing denials and approvals to the applicable Providers with 10 calendar days of Credentialing Committee decisions.

H. CREDENTIALING TIMELINESS AND REPORTING

1. The AdSS shall process Credentialing applications in a timely manner as shown in the below table.
2. To assess the timeliness of Credentialing, the AdSS shall divide the number of complete applications approved or denied timely during the time period, per category, by the number of complete applications that were received during the time period, per category, as specified in AMPM 950 Attachment A.
3. The AdSS shall submit the Credentialing Report as specified in the AdSS' contract using AMPM 950 Attachment A, including specifying any areas of non-compliance and corrective actions taken during the reporting quarter in the comments section of the report.
4. The AdSS shall adhere to the timeline requirements listed below by category:

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%

Signature of Chief Medical Officer: Anthony Dekker (Aug 31, 2023 16:40 PDT)
Anthony Dekker, D.O.

SUPPLEMENTAL INFORMATION

A. THERAPEUTIC FOSTER CARE PROVIDERS

1. Therapeutic Foster Care (TFC) Family Providers are licensed through the Department of Child Safety (DCS) and do not require Credentialing by the AdSS.
2. TFC Family Providers require credentialing with the Contractor.
3. For TFC Providers for children, submission of a Foster Home License, as specified in A.A.C. 21, Article 1 through 4, will be

accepted as meeting the requirements for Credentialing as an AHCCCS Provider.

B. MEDICAL AND DENTAL STUDENTS

1. AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist.
2. In limited circumstances when specific criteria are met, medical residents may provide low level evaluation and management services to members in designated settings without the presence of the teaching physician.
3. The teaching physician or teaching dentist must be an AHCCCS registered provider.

C. CONTINUING EDUCATION UNITS

TYPE	DESCRIPTION	LIMIT	CEU
1	College or university coursework	None – all CE can come from this type	1 hour of instruction = 1 CEU
2	CE issued by approved continuing education (ACE) Providers	None – all CE can come from this type	50 minutes of instruction = 1 CEU

3	Instruction Type 1 or 2	50% can come from this type*	1 hour of instruction = 1 CEU
4	CE issued by the BACB directly	25% can come from this type*	Determined by BACB
5	Take and pass the certification exam again	All CE will be fulfilled by this activity	Passing the exam equals 100% of your required CEUs, except for supervision
6	Scholarly Activities	25% can come from this type*	One publication = 8 CEUs One review = 1 CEU

*A maximum of 75 percent of the total required CE may come from categories 3, 4, 5 and 7. At least 25 percent shall come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.

960 QUALITY OF CARE CONCERNS

REVISION DATE: 8/16/23, 6/29/22

EFFECTIVE DATE: October 1, 2019

REFERENCES: Administrative Services Subcontractor (AdSS) Medical Policies 910, 961, 320-U; AdSS Operations Policies 444, 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., R9-34 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) A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281. 45 CFR 160.103, 20 U.S.C. 1232g

PURPOSE

This policy sets forth the requirements for the Division's Administrative Services Subcontractors' (AdSS) regarding the process for reviewing, reporting, evaluating, and resolving Quality of Care Concerns raised by Members, subcontracted service providers, stakeholders, or any other internal or external sources.

DEFINITIONS

1. "Adverse Action" means any type of restriction placed on a 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 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" means an incident report entered into the Arizona Health Care Cost Containment System (AHCCCS) Quality Management (QM) Portal 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 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

   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, e-mail 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.

    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 Unit /Performance Quality 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:

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 and is the following as specified in 42 CFR 482.13(e)(1)

19. "Seclusion" means the involuntary confinement of a behavioral health recipient 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 his/her 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. "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

The AdSS shall develop and implement written policies and procedures regarding the receipt, initial, and ongoing processing, and resolution of Quality of Care (QOC) or service concerns that addresses the following:

1. Documenting each issue raised, from whom it was received, and the projected time frame for resolution.

2. Determining whether one of the following processes will be used to resolve the issue:
   a. Quality Management (QM) process
   b. Grievance and appeals process
   c. Both the Grievance and QM processes concurrently
   d. Process for making initial determinations on coverage and payment issues
   e. Process for resolving disputed initial determinations.

3. Acknowledging receipt of the concern and providing an explanation of the process to be used to resolve the concern through written correspondence.

4. Informing the submitter of the process to be used to resolve the concern if the Quality Management Unit determines the concern not to be a Quality of Care Concern.

5. Assisting the Member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

6. Ensuring confidentiality of all Member information.

7. Informing the Member or provider of all applicable mechanisms for resolving the issue that are external to the AdSS processes.

8. Documenting all processes, including detailed steps used during the investigation and resolution stages, implemented to ensure complete resolution of each complaint, grievance, or appeal, including:

    a. Corrective action plan(s) or action(s) taken to resolve the concern;

    b. Documentation that training and education was completed, such as in-service attendance sheets and training objectives;

    c. New policies or procedures;

d. Follow-up with the Member that includes:

i. Assistance to ensure that the immediate health care needs are met;

ii. 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

iii. Referral to the AdSS' Corporate Compliance Unit, the Division, or AHCCCS Office of the Inspector General.

9. QOC Concerns that meet the reporting requirements specified in AdSS Policy 961, received outside of the AHCCCS QM Portal, the AdSS shall enter the QOC Concerns into the Portal as an Internal Referral (IRF) within one business day if the event is considered sentinel and two business days for all reportable incidents.

B. PROCESS OF EVALUATION AND RESOLUTION OF QOC AND SERVICE CONCERNS

1. The AdSS shall complete the QOC Concern investigation and documentation process within the AHCCCS QM Portal and include a summary of all applicable research, evaluation, intervention and resolution, details for each case.
2. The AdSS shall maintain a QOC investigation process that isa stand-alone process completed through the AdSS Quality Management Unit (QMU) and not combined with other agency meetings or processes.
3. Work units outside of the QMU:
    a. Shall not conduct QOC investigations.
    b. Shall provide subject matter expertise throughout the investigative process as requested by QMU.
4. The AdSS shall not delegate QOC investigation processes or onsite QOC visits.
5. Quality investigations may not be delegated or performed by the staff of the provider agency or facility where the identified health and safety concerns, Immediate Jeopardy, or Division-requested reviews have occurred.

6. The AdSS shall develop and implement policies and procedures that include at a minimum:

    a. Identification of QOC Concerns.

    b. Initial assessment of the severity of each QOC Concern.

    c. Prioritization of action(s) needed to resolve immediate care needs when appropriate.

    d. Review of trends related to Members, providers, including organizational providers, involved in the allegations, considering types and frequency of allegation(s), severity, and substantiation status, as well as systemic QOC Concerns, and referrals to Quality Management and Peer Review committees as appropriate.

    e. Research including:

        i. Review of the log of events.

        ii. Documentation of conversations including direct interviews of Members, staff, and witnesses to a reportable event.

iii. Medical records review.

iv. Mortality review.

f. Quantitative and qualitative analysis of the research, which may include root cause analysis.

c. The AdSS may request copies of a Member's death certificates by submitting a request to the Department of Health Services (ADHS) Vital Records and Statistics as specified in A.A.C. R9-19-314 B (13) and A.A.C. R9-19-315(E).

d. The AdSS' Quality Management staff shall conduct onsite visits when there are identified health and safety concerns, Immediate Jeopardy, or at the direction of AHCCCS or the Division.

e. The AdSS shall report onsite visits that are identified and conducted by the AdSS after 5:00 p.m. on weekdays, or that occur during weekends or on holidays to the Division QM Manager or supervisor by phone and followed up with an email to the Division 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 AdSS QM Unit:

a. May participate in the onsite visit when necessary and appropriate; but

b. Shall not take the place of Quality Management staff during reviews.

12. The AdSS shall complete and submit to the Division the Health and Safety Update – Onsite Review Form as specified in the contract with the Division or each onsite review within 24 hours of the health and safety visit.

13. The AdSS shall, based on findings of the review:

a. Identify any immediate care or recovery needs and ensure incident resolution.

b. Develop work plans and corrective action plans to ensure placement setting or service site compliance with ADHS Licensure and Division requirements regarding policy,

training, and signage requirements aimed at preventing and reporting abuse, neglect, and exploitation.

c. Conduct scheduled and unscheduled monitoring of placement setting or service sites in any of the following circumstances:

   i. In an Immediate Jeopardy status.

   ii. Multiple identified deficiencies that may affect health and safety of Members.

   iii. As determined by the AdSS QM Unit or as determined by the Division.

d. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.

e. Determine, implement, and document all appropriate interventions including an action plan to reduce or eliminate the likelihood of the concern recurring.

f. Monitor and document success of interventions.

g. Monitor placement setting or service sites upon completion

of the activities and interventions to ensure that compliance is sustained.

h. Implement new interventions and approaches when necessary.

i. Incorporate interventions into the AdSS's QM program plan if successful.

14. Ensure that investigation and resolution of Member and systemic concerns are processed timely based on the nature and severity of each case or as requested by the Division.

a. For high-profile cases, the AdSS shall communicate initial reports of immediate findings to the Division immediately but no later than 24 hours of the AdSS becoming aware of the concern and followed up by an initial finding report within seven business days.

b. For Member safety or placement concerns, the AdSS 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 AdSS shall schedule a due date for

resolution of the case for within 60 calendar days from the date of opening.

d. The AdSS shall track concerns that have aged to greater than 60 calendar days and must develop an action plan to address these cases.

e. The AdSS shall include a review of all paid claims within the last calendar year to identify the need to participate in systemic investigations when notified of provider concern to include single case agreements and providers using subcontracted providers.

15. The AdSS shall submit all requests for extensions of timelines associated with a QOC investigation to the Division for approval as soon as possible but no later than the assigned due date and must include at minimum:

a. The Member's current placement and condition.

b. The current status of the investigation.

c. The barrier to completing the investigation within the assigned time frame.

16. The AdSS shall update the case within the AHCCCS QM Portal to reflect changes during the investigation as additional details and allegations are discovered and added to the QOC.

17. The AdSS shall ensure the final Severity Level is assigned to the case at the conclusion of the investigation.

18. The AdSS 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,

    d. The Attorney General's Office,

    e. Law enforcement,

    f. AHCCCS Office of the Inspector General,

    g. The Division,

    h. Other entities as necessary.

19. The AdSS 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 a concern.

20. The AdSS shall submit to the Division all pertinent information regarding an incident of abuse, neglect, exploitation, serious incident, including suicide attempts, unexpected death, including all unexpected transplant deaths, and other serious incidents as determined by the Division or AHCCCS, via a written Incident Report to the Division no later than 24 hours after becoming aware of the incident.

    a. The AdSS shall not limit pertinent information to autopsy results;

    b. The AdSSS shall include a broad review of all issues and possible areas of concern.

    c. The AdSS shall not delay the Investigation of QOC Concern based on delays in receipt of autopsy.

    d. The AdSS shall, when available, use delayed autopsy results to confirm the resolution of the QOC Concern.

e. The AdSS shall follow procedures for reporting incidents, accidents, and deaths as specified in AdSS Medical Policy 961.

21. Upon receipt of an IAD Report from providers, the AdSS shall take action necessary to ensure the safety of the persons involved in the incident.

22. The AdSS shall review the IAD within one business day24 hours of receipt and make a determination of whether the incident includes a QOC Concern.

    a. The AdSS shall review the IAD Form to ensure it is fully and accurately completed. If an IAD is returned to the provider for corrections, the AdSS shall ensure that the provider returns the corrected version of the report within one business day of receipt.

23. The AdSS shall document all referrals made to a regulatory agency in the AHCCCS QM Portal and include, at a minimum, the following information:

    a. Name and title of the person submitting the report.

b. Name of the regulatory agency the report was submitted to.

c. Name and title of the person at the regulatory agency receiving the report.

d. Date and time reported.

e. Summary of the report.

f. Tracking number, as applicable, received from the regulatory agency as part of the reporting process.

24. The AdSS shall have a process to refer issues to the AdSS' Peer Review Committee when appropriate.

a. The AdSS shall ensure that appropriate referrals include all high-profile cases.

b. The AdSS shall not consider a referral to the Peer Review Committee as a substitute for implementing interventions aimed at individual and systemic quality improvement.

25. The AdSS shall document in the QOC file within the AHCCCS QM Portal Peer Review referrals as well as high-level summary information and must include documentation of the specific

credentials of the involved Committee members.

26. If an adverse action is taken with a provider for any reason including those related to a QOC Concern, the AdSS shall report the adverse action,including limitations and terminations, and the rationale for the adverse action to the Division's QM Unit within 24 hours of the determination to take an adverse action and to the National Practitioner Data Bank as specified in the Division contract.

27. The AdSS shall ensure continuity of care, health and safety, and Member well being in transition of care when acting on adverse actions.

    a. The AdSS shall allow adequate time for identification of new providers, transition of Members to those providers, impact to Members, and timely communication to Members to prepare for a transition.

28. While there may be instances where a move or transition must occur quickly, the AdSS shall work with the Division to ensure Member needs are met without potential gaps in care or service delivery and without treatment disruption.

29. The AdSS shall document the closure of the review or investigation within the AHCCCS QM Portal.

30. The AdSS shall document all follow-up actions or monitoring activities as well as related observations or findings in the QOC file.

31. The AdSS shall notify the Division's QM Unit as specified in contract and take appropriate action with the provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to:

    a. Check the CSPMP

    b. Coordinate care with other prescribers

    c. Refer for substance use treatment or pain management.

32. The AdSS shall present the case finding m, as appropriate, to the AdSS' Peer Review Committee for review and recommendation to the QM/PI Committee for discussion and recommendations to AdSS leadership.

33. The AdSS shall present findings to the AdSS' Credentialing

Committee in the event that the case finding may have a direct impact on the credentialing or recredentialing of a provider.

C. TRAINING, INTER-RATER RELIABILITY FOR INCIDENT AND QOC REVIEW

1. The AdSS shall provide training to QM clinical staff on QOC investigations prior to performing these investigations.
    a. All clinical staff that may perform investigations onsite shall complete training on how to conduct the investigation and avoid interference with substantiation and/or prosecution.
    b. All clinical staff that may investigate alleged incidents in skilled nursing facilities, assisted living facilities, and behavioral health residential settings shall complete training on how to conduct investigations considering the specific needs of individuals with intellectual and developmental disabilities.

b. The AdSS shall incorporate AHCCCS Medical Manual Policy 960 Attachment D guidance in the content requirements for its training for investigations involving individuals with intellectual and developmental disabilities.

c. The AdSS shall perform Inter-Rater Reliability (IRR) testing for all staff making determinations related to incidents and QOC Concerns.

d. The AdSS shall perform the testing annually with a required passing grade of 90 percent.

e. The AdSS shall use test scenarios pertinent to its covered membership and approved by its Chief Quality Officer and Medical Director.

f. The AdSS shall require staff members who do not receive a passing grade of 90% to retake the exam a second time.

g. The AdSS shall develop and implement an education plan for staff members who do not attain a passing grade of 90 percent 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 COMPLAINTS

1. The AdSS shall conduct oversight through tracking and trending of Member and provider concerns and making appropriate

referrals for independent review as described in this section.

2. The AdSS shall develop and implement a system to document, track, trend, and evaluate complaints and allegations received from Members and providers or as requested by the Division or AHCCCS, inclusive of quality care, immediate jeopardy, quality of service and immediate care need issues.

3. The AdSS shall analyze and evaluate the data from the tracking and trending system to identify and address any trends related to Members, providers, the QOC process, or services in the AdSS' service delivery system or provider network.

    a. The AdSS shall incorporate trending of Quality of Care issues in determining systemic interventions for quality improvement.

    b. The AdSS shall submit tracking and trending information to the Division to be reviewed and considered for action by the Division's Quality Management Unit and Chief Medical Officer, as Chairman of the QM/PI Committee.

4. If significant negative trends are noted in the tracking and

trending, the AdSS shall develop performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process. Tracking and trending may also identify promising practices that resulted in better outcomes for Members.

a. The AdSS shall report the results of performance improvement activities in (6) of this Section to the Division.

b. The AdSS shall refer QOC Concerns and opportunities for improvement identified through tracking and trending to the following committees, as appropriate:

i. QM/PI Committee, established in accordance with AdSS Medical Policy 910.

ii. Peer Review Committee, established in accordance with AdSS Medical Policy 910.

iii. Mortality Review Committee.

iv. Independent Oversight Committees established

pursuant to A.R.S. § 41-3801.

c. The AdSS shall make Member records availability and accessibility in compliance with federal and state confidentiality laws, including Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR 431.300 et seq.

d. The AdSS shall maintain information related to coverage and payment issues for at least five years following final resolution of the issue and must be made available to the Member, provider, Division, or AHCCCS authorized staff upon request.

e. The AdSS shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS program.

f. The AdSS' care coordination staff shall work with the Division's Support Coordination staff to facilitate and address Member complaints as a proactive measure to promote better service delivery and health outcomes.

E. PEER REVIEW COMMITTEE

1. The AdSS shall refer QOC Concerns to the AdSS' Peer Review Committee when appropriate.
    a. The AdSS shall not consider referral to the Peer Review Committee as a substitute for implementing interventions aimed at individual and systemic quality improvement.
    b. The AdSS shall document Peer Review Committee referrals and high-level summary information in the QOC file within the AHCCCS QM Portal and must include documentation of the specific credentials of the involved Committee members.
    c. The Peer Review Committee may include the following recommendations as applicable:
        i. Education/training/technical assistance
        ii. Follow-up monitoring and evaluation of improvement
        iii. Changes in processes, organizational structures, forms

iv. Informal counseling

v. Termination of affiliation, suspension, or limitation of the provider (if an adverse action is taken with a provider the AdSS reports the adverse action to the Division within one business day)

vi. Referrals to regulatory agencies

vii. Other actions as determined by AdSS

d. If an adverse action is taken with a provider for any reason including those related to a QOC Concern, the AdSS shall report the adverse action, including limitations and terminations, to the Division Quality Management Unit as well as to the National Practitioner Data Bank as specified in contract in accordance with AdSS Medical Manual Policy 950.

2. The AdSS shall notify the Division and take appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards

when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues, other prescribers, or referral for substance use treatment or pain management.

3. The AdSS shall present the findings related to (2) of this Section to, as appropriate, the AdSS' Peer Review Committee and Credentialing Committee for review and recommendations to the QM/PI Committee for discussion and recommendations to AdSS leadership.

F. REPORTING TO INDEPENDENT OVERSIGHT COMMITTEE

1. The AdSS shall provide Incident, Accident, and Death (IAD) Reports, Internal Referral (IRF) reports and Quality Of Care Concerns including, reports of possible abuse, neglect, or denial of rights involving any DDD enrolled Member to the DDD Independent Oversight Committee (IOC), established by A.R.S.§ 41-3801 and as outlined in this policy within three business days.
2. The AdSS shall incorporate IADs and IRFs that are triaged as potential QOC Concerns into the QOC record and shall submit to

the IOC as part of the QOC documentation upon completion of the QOC investigation in place of a standalone IAD/IRF within three business days of completion of the investigation.

3. The AdSS shall redact all PII from reports provided to the IOC in accordance with federal and state confidentiality laws.
4. The AdSS shall provide the IOCs Member information and records in accordance with A.R.S. §41-3804.
5. The AdSS shall provide Seclusion and Restraint Reports, IAD Reports, IRF reports and QOC reports including reports of possible abuse, neglect, or denial of rights involving any behavioral health to the IOC's as specified in the Division contract.
6. If a QOC investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS shall provide the requested documentation to the IOC via the AHCCCS Quality Management Portal.
7. The AdSS 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.

G. REQUESTS FOR PII OR PHI

1. The AdSS 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 oversight of the behavioral health system, or

   b. The IOC has written authorization from the Responsible Person to review PII or PHI.

2. If the AdSS determines that the IOC needs PII or PHI and has obtained the Responsible Person's written authorization, the AdSS shall first review the requested information and determine if any of the following types of information are present: Communicable disease related information, including confidential HIV information, 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 (2) of the Section is found,

the AdSS shall provide the information adhering to the requirements of this policy.

b. If information detailed in (2) of this Section is found, the AdSS shall contact the Responsible Person, ask if the Responsible Person is willing to sign an authorization for the release of communicable disease related information, including confidential HIV information, 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, the AdSS shall obtain written authorization as outlined below and provide the requested information to the IOC.

ii. If the Responsible Person does not agree to give authorization, the information is not included or is redacted from any documentation which is

authorized to be disclosed.

3. The AdSS 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 AdSS 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 to the extent that the PHI is directly relevant to such person's involvement with the deceased Members health care or payment related to the individual's health care,

4. The AdSS shall provide requested information that does not require authorization within 15 working days of the request.

5. The AdSS shall provide the requested information that does require authorization within five working days of receipt of the written authorization.

6. When PII or PHI is sent, the AdSS shall include a cover letter addressed 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.

7. If the AdSS denies the IOC request for PII or PHI:

   a. The AdSS shall notify the IOC within five working days that the request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division Director, or designee, review this decision.

   b. The Committee's request to review the denial must be received by the Division Assistant Director, or designee, within 60 days of the first scheduled committee meeting after the denial decision is issued,

   c. The AdSS shall refer the IOC to Division Medical Manual 960 for the process of review by the Division Assistant Director, or designee.

H. AUTHORIZATION REQUIREMENTS

1. The AdSS 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 Responsible Person of a currently or previously enrolled Member.

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 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).

I. DUTIES AND LIABILITIES OF BEHAVIORAL HEALTH PROVIDERS IN PROVIDING BEHAVIORAL HEALTH SERVICES

1. The AdSS shall develop and make available written policies and procedures that provide guidance regarding the provider's duty to warn under A.R.S. § 36-517.02 which supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law.

2. The AdSS shall incorporate the following in policies, procedures,

and provider training related to (1) of this Section:

a. With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless *both* of the following occur:

   i. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

   ii. The mental health provider fails to take reasonable precautions.

b. A.R.S. § 36-517.02 provides that any duty of a behavioral provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

   i. Communicates, when possible, the threat to all

identifiable victims,

ii. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,

iii. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or

iv. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.

c. That this statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a Member under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a Member when a Member has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a Member is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the

Member to reduce the risk of harm.

d. That all providers, regardless of their specialty or area of practice, have a duty to protect others against a Member's potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined that a Member poses a serious danger to self or others, the provider must exercise care to protect others against imminent danger of a Member harming him/herself or others. The foreseeable victim need not be specifically identified by the Member, but he/she may be someone who would be the most likely victim of the Member's dangerous conduct.

e. That the responsibility of a behavioral health provider to take reasonable precautions to prevent harm threatened by a Member may include any of the following:

i. Communicating, when possible, the threat to all identifiable victims,

ii. Notifying a law enforcement agency in the

vicinity where the Member or any potential victim resides,

iii. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U, or

iv. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

J. PROVIDER-PREVENTABLE CONDITIONS

1. The AdSS shall not provide payment for services related to provider preventable conditions.

2. If the AdSS identifies a Provider-Preventable Conditions, the AdSS shall:

   a. Conduct a QOC investigation within the AHCCCS QM Portal.

   b. Report the occurrence and results of the investigation to the Division's QM Unit quarterly, as

specified in the Contract.

c. Report the occurrence to the appropriate regulatory boards and agencies in accordance with the provisions of this policy following the outcome of the investigation.

Signature of Chief Medical Officer: Anthony Dekker (Aug 11, 2023 08:27 PDT)
Anthony Dekker, D.O.

961 INCIDENT, ACCIDENT, AND DEATH REPORTING

REVISION DATE: 8/9/2023
EFFECTIVE DATE: May 11, 2022
REFERENCES: 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; AHCCCS Medical Policies 960, 962, 1020, AdSS Operations Policy 417.

PURPOSE

The purpose of the policy is to establish the Incident, Accident, and Death reporting requirements for the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) in a consistent manner across the delivery system.

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 client receiving behavioral health services or community services.

Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency. 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 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. "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.

11. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
12. "Physical Abuse" means intentional infliction of pain or injury to a Member.
13. "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.
14. "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.
15. "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.
16. "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.
17. "Sexual Abuse" means any inappropriate interactions of a sexual

nature toward or solicited from a Member with developmental disabilities.

18. "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.

19. "Verbal/Emotional Abuse" means remarks or actions directed at a Member that are ridiculing, demeaning, threatening, derogatory, or profane.

POLICY

A. MINIMUM REQUIREMENTS FOR IAD REPORTING

1. The AdSS shall develop a process to ensure High Profile, media, and Sentinel events affecting members can be reported to the AdSS by Providers, Members, or a Member's family, at any time, 24 hours a day, seven days a week, and that these communications are provided to the AdSS Quality Management Department.

2. The AdSS shall ensure that reportable IADs and Internal Referrals are submitted within two business days of the occurrence or notification to the AdSS of the occurrence via the AHCCCS Quality Management (QM) Portal.

3. The AdSS shall ensure Sentinel IADs are submitted via the AHCCCS QM Portal within one business day of the occurrence or becoming aware of the occurrence.

4. The AdSS shall notify the Division and AHCCCS of all sentinel events via email at dddcareconcerns@azdes.gov and CQM@ahcccs.gov immediately, but within 24 hours of notification of the occurrence.

5. The AdSS shall report IADs that include any of the following:
    a. Allegations of abuse, neglect, or exploitation of a Member.
    b. Allegations of Human Rights Violations.
    c. Substance use disorders or opioid-related concerns.
    d. Death of a Member.
    e. Delays or difficulties in accessing care outside of the timeline specified in the AdSS Operations Policy 417.
    f. Healthcare acquired conditions and other provider

preventable conditions as specified in AdSS 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. Member missing from a licensed Behavioral Health

Inpatient Facility, Behavioral Health Residential Facility, Division Group Home, Assisted Living Facility, Skilled Nursing 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.

6. The AdSS shall report IADs as a Sentinel Event if they include any of the following:

a. Member death or Serious Injury associated with 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.

f. Any stage 3, stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting or any other setting where the AdSS has oversight responsibility.

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 or 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 in excess of $1,000.

7. The AdSS shall develop a process to 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 AdSS 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 IAD report does not need further documentation or review, and closure of the report.

8. The AdSS shall follow up on all IADs returned to the Provider within one business day to ensure the Provider is aware that the report has been returned and is addressing the required corrections.

9. The AdSS shall take immediate action to ensure the safety of Members where allegations of harm or potential harm exists, regardless of status assigned to the IAD, including those returned to a Provider.

10. The AdSS shall report 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.

11. The AdSS shall track and trend all IADs to identify and address systemic concerns or issues within their Provider network.

12. The AdSS shall submit reports to the Division describing the track and trend activities, as well as any systemic concerns or issues identified and how they were addressed.

13. The AdSS shall provide IAD reports to the appropriate Independent Oversight Committees as specified in AdSS Medical Policy 960.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 13:21 PDT)
Anthony Dekker, D.O.

962 REPORTING AND MONITORING OF SECLUSION & RESTRAINT

REVISION DATE: 8/9/2023
EFFECTIVE DATE: July 6, 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), AdSS Medical Policies 960 and 961

PURPOSE

This Policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS). The purpose of this policy is to establish requirements for reporting and monitoring the use of Seclusion and Restraint (SAR) involving Members with intellectual and developmental disabilities enrolled in a Division subcontracted health plan.

DEFINITIONS

1. "Behavioral Health Inpatient Facility" means, as defined in A.A.C. R9-10-101, a health care institution that provide continuous treatment to individuals experiencing behavioral health issues that cause that individual to:
    a. Have a limited or reduced ability to meet the basic physical needs;

b. Suffer harm that significantly impairs the 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

e. 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.
   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 as specified in A.A.C. R9-21-101(B).
   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. Seclusion and Restraint (SAR) shall only be used to the extent permitted by and in compliance with A.A.C. R9-10-225, A.A.C. R9-10-316 and A.A.C. R9-21-204.

2. The AdSS shall develop written policies and procedures for reporting individual reports of SAR involving Members receiving services in Behavioral Health Inpatient Facilities or Mental Health Agencies as specified in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy 962.

3. The AdSS shall develop written policies and procedures to monitor and ensure compliance of its behavioral health providers with SAR policies, procedures, and reporting requirements.

4. The AdSS shall report the use of SAR as described in this policy to the AHCCCS Division of Community Advocacy and Intergovernmental Relations, Office of Human Rights (OHR), and the appropriate Independent Oversight Committee (IOC) via collaboration with the AHCCCS Division of Health Care Management, Quality Management (QM) IOC Manager.

B. REPORTING REQUIREMENTS

1. The AdSS shall ensure that Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies providing services to Division Members, that are authorized to use SAR as specified in A.A.C. R9-21-101, A.A.C. R9-10-225, A.A.C. R9-10-316 and R9-10-1012, follow the reporting requirements specified in this policy.

2. The AdSS shall ensure that any out-of-state facility used to provide services to a Member agrees to and follows all reporting requirements as specified within this policy as a part of the contracted single case agreement.

3. The AdSS shall ensure that BHIFs and Mental Health Agencies submit individual reports of Incidents of SAR involving any Division Member enrolled in a subcontracted health plan directly to the AdSS within five days of the incident using AMPM 962 Attachment A or the agency's electronic medical record that includes all elements listed on Attachment A. If the use of SAR requires face-to-face monitoring, as specified in A.A.C.

R9-21204, a supplemental report shall be submitted to the AdSS as an attachment to the individual report.

4. The AdSS shall ensure that BHIFs and Mental Health Agencies report incidents of SAR that result in an injury to the AdSS within 24 hours of the incident.

C. SUBMITTING INDIVIDUAL REPORTS OF SAR TO THE AHCCCS QM PORTAL

1. The AdSS shall submit individual reports of SAR in the AHCCCS QM Portal as specified in contract. The AdSS shall ensure that the original AMPM 962 Attachment A or electronic medical record received from the behavioral health provider is attached to the report within the AHCCCS QM Portal.

2. The AdSS shall review each Incident of SAR and link the report to any connected Incident, Accident, or Death (IAD), Internal Referral (IRF), or Quality of Care (QOC) Concern process within the AHCCCS QM Portal at QMportal.azahcccs.gov as specified in AdSS Medical Policy 960.

D. AdSS REQUIREMENTS FOR SUBMITTING SAR REPORTS TO THE IOC

1. The AdSS shall ensure that all individual SAR reports involving behavioral health providers are uploaded for IOC review as specified in contract.

2. The AdSS shall ensure that 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. AdSS shall ensure that the disclosure of protected health information is in accordance with state and federal laws.

E. OVERSIGHT, MONITORING, TRACKING AND TRENDING

1. The AdSS shall ensure Member safety, appropriate use of SAR, reporting compliance by network providers, and the disclosure of protected health information is in accordance with state and federal laws through regular monitoring and oversight

activities.

2. The AdSS shall review all SAR reports and QOC Concerns involving the inappropriate use of SAR to identify opportunities for improvement and make recommendations to the appropriate committee as applicable.

3. The AdSS shall review and track and trend the use of SAR for all Members enrolled in the subcontracted health plan.

4. The AdSS shall report any identified trends on the use of SAR to the Division.

5. The AdSS shall submit all reports as specified in contract to the Division and participate in the Annual Operational Review.

Signature of Chief Medical Officer: Anthony Dekker (Aug 3, 2023 12:44 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 IOC determines that SAR has been used in violation of any applicable law or rule, the AHCCCS 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.

963 PEER AND RECOVERY SUPPORT SERVICE PROVISION REQUIREMENTS

REVISION DATES: 4/10/2024, 12/21/2022, 6/8/2022

REVIEW DATE: 8/15/2023

EFFECTIVE DATE: October 1, 2020

REFERENCES: A.R.S. § 32- 3251, A.R.S. Title 32, Chapter 33, A.R.S. § 36-501, A.R.S. § 32-2061, A.R.S. § 32-2091, A.A.C. R4-6-101, A.A.C. R9-10-101, AMPM 320-Q, AMPM 963; Attachment A-C, AMPM 965

PURPOSE

This policy establishes requirements for the provision of Peer Support services within the Administrative Services Subcontractors (AdSS) programs, including qualifications, supervision, continuing education, and training/credentialing of Peer and Recovery Support Specialists (PRSS). The requirements in this policy are delegated to the AdSS and the Division of Developmental Disabilities (Division) does not perform these functions. The Division oversees the AdSS and ensures implementation and compliance of all requirements in this policy, including reserving the right to assess compliance with these requirements during the Division's annual operational review of each AdSS.

DEFINITIONS

1. "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, as specified in A.A.C. R9-10-101(28).
    a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
    b. Are provided under supervision by a behavioral health professional.
2. "Behavioral Health Professional" or "BHP" means
    a. An individual licensed under A.R.S. § 32, Chapter 33, whose scope of practice allows the individual to:
        i. Independently engage in the practice of behavioral health as specified in A.R.S. § 32-3251, or
        ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as specified

in A.R.S. § 32-3251 under direct supervision as specified in A.A.C. R4-6-101.

b. A psychiatrist as specified in A.R.S. § 36-501.

c. A psychologist as specified in A.R.S. § 32-2061.

d. A physician.

e. A behavior analyst as specified 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:

i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services.

3. "Behavioral Health Technician" or "BHT" means an individual who is not a behavioral health professional who provides behavioral health services to a patient to address the patient's behavioral health issue:

a. With clinical oversight by a BHP, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed as specified in A.R.S. § 32, Chapter 33; and

b. Health-related services.

4. "Credential" for purposes of this policy, means a written document issued by a Peer Support Employment Training Program ("PSETP"), or by a state, demonstrating compliance with all qualifications and training requirements in this policy.

5. "Health Insurance Portability and Accountability Act" or "HIPPA" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

7. "Office of Individual and Family Affairs (OIFA) Alliance" means a collaborative of all OIFAs in Arizona, including AHCCCS OIFA.
8. "Peer-And-Recovery Support" means a distinct health care practice involving intentional partnerships to provide social and emotional support, based on shared experiences of living with behavioral health disorders, Substance Use Disorders, or other traumas associated with significant life disruption. 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.
9. "Peer-And-Recovery Support Specialist" or "PRSS" means an individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS programs.
10. "Peer-and-Recovery Support Specialist" or "PRSS" "Continuing Education and Ongoing Learning" means activities of professional development intended to enhance relevant knowledge and build skills within a given practice. These activities may involve, but are

not limited to, acquiring traditional Continuing Education Units (CEUs).

11. "Peer-and-Recovery Support Specialist" or "PRSS" Credential" means a written document issued to a qualified individual by operators of an AHCCCS-recognized PRSS credentialing program, a PRSS Credential which is necessary for provision of Medicaid-reimbursed Peer Support services delivered by the holder of the Credential under supervision by a Behavioral Health Technician of Behavioral Health Professional.
12. "Peer Support Employment Training Program" or "PSETP" means a training program that is in compliance with requirements in this policy through which qualified individuals are credentialed as PRSS by completing training and passing a competency exam.
13. "Self-Help/Peer Services" or "Peer Support" 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.
14. "Substance Use Disorder" or "SUD" 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.

POLICY

A. PEER SUPPORT SERVICES

1. The AdSS shall comply with Centers for Medicare and Medicaid Services (CMS) requirements for delivery of Peer Support services as specified in the State Medicaid Director Letter, SMDL #07-011, the AHCCCS/Division of Community Advocacy and Intergovernmental Relations (DCAIR), Office of Individual and Family Affairs (OIFA), that has established training requirements and credentialing standards for Peer and Recovery Support Specialist (PRSS) providing Peer Support within the AHCCCS programs.
2. The AdSS shall provide services to an individual, group, or family, that are aimed at assisting in the creation of skills to promote long-term, sustainable recovery.

B. PEER AND RECOVERY SUPPORT SPECIALIST AND TRAINER QUALIFICATIONS

1. The AdSS shall require PSETP operators to ensure individuals seeking credentialing and employment as a PRSS meet the following criteria:
    a. Qualify as a BHPP, BHT, or BHP;
    b. Consent to sharing their PRSS Credential with the Contractor and AHCCCS registered providers for verifying compliance with this Policy; and
    c. Self-identify as an individual who:
        i. Has their own lived experience of mental health conditions, or substance use, for which they have sought support; and
        ii. Has an experience of sustained recovery to share.
2. The AdSS shall require individuals facilitating training hold a PRSS Credential from an AHCCCS-recognized PSETP.
3. The AdSS PSETP operators shall:
    a. Permit only individuals holding a PRSS Credential to facilitate training;
    b. Utilize Attachment B to determine if applicants are qualified for admission;
    c. Admit only individuals completing and fulfilling all

requirements of Attachment B; and

d. Obtain consent from trainees to share their PRSS Credentials with the Contractor and AHCCCS registered providers for verifying compliance with this Policy.

4. The AdSS shall require the operator to only admit individuals completing and fulfilling all requirements of AMPM policy 963 Attachment B.

5. The AdSS shall require the PSETP operator to:

   a. Make the final determination for admission;

   b. Maintain copies of all issued PRSS Credentials; and

   c. Provide replacement Credentials to graduates upon request.

6. The AdSS and providers shall recognize credentialing from any PSETP in compliance with this Policy. If there are regional, agency or culturally specific training requirements exclusive to the AdSS, service provider or tribal community, the additional requirements shall not prevent recognition of a PRSS Credential issued in compliance with this policy.

7. The PRSS credentialing process is not a behavioral health service.

C. COMPETENCY EXAM

1. The AdSS shall require, upon completion of required training,

individuals demonstrate their ability to support the recovery of others by passing a competency exam with a minimum score of 80%.

2. Each PSETP operator may develop a unique competency exam at the discretion of the PSETP.
3. The AdSS shall require all exams include questions related to each of the curriculum core elements as specified in this Policy.
4. The AdSS shall require individuals who do not pass the exam to complete additional training at the discretion of the PSETP operator prior to taking the exam again.
5. The AdSS shall permit the provider of the exam to make a retake exam available to individuals who do not pass the competency exam.
6. The AdSS shall require agencies employing PRSS and delivering Peer Support services to ensure staff receive training focused on working with the populations served.
7. The AdSS shall ensure all AHCCCS registered providers operating a PSETP submit, upon completion of each class, Attachment C to the AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov. These reports shall contain no other identifying information apart from

what is required.

8. The AdSS shall require PSETPs retain copies of Attachment C and make copies available to the Division upon request.

D. SUBMITTING EVIDENCE OF CREDENTIALING

1. The AdSS shall require contractors to ensure provider agencies contracted to deliver Peer Support services utilize Attachment A to maintain current and ongoing documentation verifying all individuals delivering Medicaid-reimbursed Peer Support services are in compliance with this policy;
2. The AdSS shall ensure employers of PRSS have defined qualifications for BHPPs and BHTs;
3. The AdSS Contractors shall develop and make available to providers policies and procedures describing how the AdSS is monitoring and auditing/oversight activities where records specific to supervision, training, continuing education, or ongoing learning of PRSS are reviewed and maintained; and
4. The AdSS Contractors shall submit Attachment A documenting all actively employed PRSS meet the required qualifications and credentialing for the delivery of Peer Support services as specified in the contract.

E. INTER-STATE RECIPROCITY

Individuals credentialed in another state shall submit their Credentials to AHCCCS/DCAIR OIFA, via email at oifa@azahcccs.gov.

F. CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

1. The AdSS shall establish requirements for individuals employed as PRSS to obtain continuing education and ongoing learning relevant to Peer Support, including physical health and wellness.
2. The AdSS shall develop and make available to providers policies and procedures describing requirements for individuals employed as PRSS have access to and obtain a minimum of four hours of continuing education and ongoing learning relevant to Peer Support, per year, with at least one hour covering ethics and boundaries related to the practice of Peer Support.

G. SUPERVISION OF PEER AND RECOVERY SUPPORT SPECIALISTS

1. The AdSS shall require the individual providing the service has a PRSS Credential from an AHCCCS-recognized PSETP and receive supervision as specified in the Arizona Administrative Code in order to receive Medicaid reimbursement for Peer Support services.

2. The AdSS and FFS providers shall ensure:

   a. Providers have policies and procedures to establish the minimum professional, educational or experiential qualifications for BHPPs and BHTs;

   b. Provider policies and procedures establish the amount and duration of supervision for PRSS qualifying as BHPPs and BHTs;

   c. Supervision is documented and inclusive of both clinical and administrative supervision; and

   d. Supervisors of PRSS have access to training and ongoing learning relevant to the supervision of PRSSs and the delivery of Peer Support services.

H. PEER SUPPORT EMPLOYMENT TRAINING CURRICULUM STANDARDS

The AdSS shall require a PSETP to include the following core elements in the credentialing program curriculum:

a. Concepts of Hope and Recovery:

   i. Instilling the belief that recovery is real and possible;

   ii. The history of social empowerment movements and

their connection to Peer and Recovery Support, including but not limited to the following movements:

a) Self-Help;

b) Consumer/Survivor/Ex-Patient;

c) Neurodiversity;

d) Disability Rights; and

e) Civil Rights.

iii. Varied ways that behavioral health has been viewed and treated over time and in the present;

iv. Appreciating diverse paradigms and perspectives of recovery and other ways of thinking about behavioral health, including Harm Reduction, 12-Step Recovery, and Neurodiversity and other approaches;

v. Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways;

vi. Holistic approach to recovery addressing behavioral, emotional, and physical health; and

vii. Member driven/person centered service planning.

b. Advocacy and Systems Perspective:

i. State and national health systems' infrastructure including the history of Arizona's health systems;

ii. Confronting and countering discrimination, prejudice, bias, negative stereotypes, and other social injustices against those with behavioral health and Substance Use Disorders – combating internalized stigma and oppression;

iii. Organizational change - how to utilize person-first language and identity-first language to educate provider staff on recovery principles and the role and the value of Peer Support;

iv. Diversity, Equity, Inclusion and Accessibility (DEIA) for underserved and underrepresented communities;

v. Creating a sense of community in a safe and supportive environment;

vi. Forms of advocacy and effective strategies – consumer rights and navigating the health systems;

vii. The Americans with Disabilities Act (ADA); and

viii. Social Determinants of Health (SDOH).

c. Psychiatric Rehabilitation Skills and Service Delivery:

i. Strengths based approach, identifying one's own strengths, and helping others identify theirs;

ii. Building resilience;

iii. Trauma-Informed Care;

iv. Distinguishing between sympathy and empathy, and emotional intelligence;

v. Understanding learned helplessness, how it is taught and how to assist others in overcoming its effects;

vi. Motivational interviewing, communication skills and active listening;

vii. Healing relationships – building trust and creating mutual responsibility;

viii. Combating negative self-talk - noticing patterns and replacing negative statements about oneself, using mindfulness to gain self-confidence and relieve stress;

ix. Group facilitation skills;

x. Culturally & Linguistically Appropriate Services (CLAS) standards, and the role of culture in recovery; and

xi. Understanding and supporting individuals with

Intellectual and Developmental Disabilities (I/DD).

d. Professional Responsibilities of the PRSS and Self Care in the Workplace:

i. Professional boundaries and codes of ethics unique to the role of a PRSS.

ii. Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA).

iii. Responsibilities of a mandated reporter; what to report and when to report.

iv. Understanding common signs and experiences of:

a) Mental health disorders;

b) Substance Use Disorders (SUD);

c) Opioid Use Disorder (OUD);

d) Addiction;

e) Dissociation;

f) Trauma;

g) I/DD; and

h) Abuse/exploitation and neglect.

v. Familiarity with commonly used medications and

potential side effects; informed consent as specified in AMPM Policy 320-Q, General and Informed Consent.

vi. Guidance on proper service documentation, billing and using recovery language throughout documentation.

vii. Self-care skills:

a) Coping practices for helping professionals;

b) The importance of ongoing supports for overcoming stress in the workplace;

c) Using boundaries to promote personal and professional resilience; and

d) Using self-awareness to prevent compassion fatigue, secondary traumatic stress, and burnout.

e. PSETPs shall not duplicate training requirements of individuals employed by a licensed agency or Community Service Agencies (CSA).

f. A PRSS employed in CSA shall complete additional training as specified in AMPM Policy 965.

g. The AdSS shall develop and make available policies and procedures as well as additional resources for development

and improvement of PSETP curriculum, including the AdSS staff contacts for questions or assistance to PSETP operators.

I. PEER SUPPORT EMPLOYMENT TRAINING PROGRAM APPROVAL

1. The AdSS shall require AHCCCS registered providers intending to operate a PSETPs to submit a completed PSETP application to OIFAAlliance@azahcccs.gov in order to be considered for review:
   a. If the application is denied the applicant may submit a new application, no earlier than six months after initial denial.
   b. If the application is accepted, the applicant shall follow OIFA Alliance instructions for submitting their program materials for further compliance review.
2. The AdSS shall require training curriculum materials to contain:
   a. Student and trainer manuals,
   b. Handouts,
   c. Homework,
   d. Final exam,
   e. Credentialing certificate,
   f. Any other classroom materials, and
   g. Description of reasonable accommodations and alternative formats for the accessibility of program materials by all

audiences.

3. The AdSS shall require a program that makes substantial changes including change to content, classroom time to its curriculum, or if there is an addition to required elements of the program, to submit the updated content to OIFAAlliance@azahcccs.gov for review and approval.
4. The AdSS shall ensure, if there are regional or culturally specific training requirements exclusive to the AdSS or tribal community, the additional training requirements shall not prevent employment or transfer of a PRSS Credential based on the additional elements or standards.
5. The AdSS shall require all AHCCCS-recognized PSETPs to make curriculum materials available to Members of the OIFA Alliance and/or AHCCCS DFSM upon request.
6. The AdSS shall have policies, procedures, and additional resources for curriculum development of PSETP.
7. The AdSS shall designate staff to respond to questions.
8. The AdSS shall identify a point of contact within the AdSS' OIFA who is authorized to assist and advise PRSS operators in further

developing and enhancing their PSTEPs curricula.

9. The AdSS shall establish a process through which PSTEPs curricula of PRSS operators are made available to the point of contact for review upon request.
10. The AdSS OIFA point of contact shall provide feedback to PRSS operators to develop and enhance their PSTEP curricula.
11. The AdSS OIFA shall have a process in which the curriculum development of PSETP are made available to the Division for review as specified in Section F, Attachment F3, Contractor Chart of Deliverables.
12. The AdSS shall require the PSETP curriculum to be emailed to the DDD OIFA Behavioral Health Advocate Supervisor at OIFABHAdvocate@azdes.gov.

SUPPLEMENTAL INFORMATION

1. The OIFA Alliance oversees the PSETP review process including the setting of requirements, terms and conditions for recognition. Members of the OIFA Alliance will determine all PSETP applications and evaluate all submitted training materials prior to issuing or withholding approval. AHCCCS/DCAIR OIFA bases approval solely on a program’s compliance

with all requirements as specified in this policy.

2. Peer Support employment training is not a billable service for costs associated with training the agency's own employees. PSETP providers shall follow the review process as specified below.
3. The OIFA Alliance determines approval of a PSETP based on the program's compliance with the curriculum Core Elements specified in Section H of this Policy. An AHCCCS recognition of an OIFA Alliance approval is necessary for PRSS Credentials issued by the PSETP to be in compliance with CMS SMDL #07-011.
4. The PRSS credentialing process, as described in this Policy, is not a behavioral health service. Compliance with this Policy is not permission to deliver any behavioral health services PSETP operators may associate with the PRSS credentialing process.
5. Peer support services are specified as Healthcare Common Procedure Coding System (HCPCS) H0038 and H2016 in the Behavioral Health Services Matrix on the AHCCCS website. These are further defined in AMPM Policy 310-B and the AHCCCS Contract and Policy Dictionary and are subject to billing limitations in the Fee-for-Service Provider Billing Manual.
6. A PRSS credential from an AHCCCS-recognized PSETP is necessary for

provision of Medicaid-reimbursed peer support services delivered by the holder of the credential under supervision by a Behavioral Heals Technician (BHT) or Behavioral Health Professional (BHP).

7. The intent of Peer Support services is the provision of assistance to utilize the service delivery system more effectively. Peer and Recovery Support also assists with the understanding and coping with stressors of the individual's disability through support groups, coaching, role modeling, and mentoring.

8. AHCCCS/DCAIR OIFA oversees the approval of all credentialing materials including curriculum and testing tools. AHCCCS/DCAIR OIFA bases approval solely on a program's compliance with all requirements as specified in this policy.

Signature of Chief Medical Officer: Anthony Dekker (Apr 9, 2024 13:49 PDT)
Anthony Dekker, D.O.

964 CREDENTIALED FAMILY SUPPORT PARTNER REQUIREMENTS

REVISION DATES: 2/7/2024, 12/21/2022, 6/8/2022, 10/1/2020

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: October 1, 2020

REFERENCES: 42 U.S.C. 126; 47 U.S.C. 5; A.A.C. R9-10-101; A.R.S.§32-3274; AMPM Policy 964; Attachment A-B; AdSS Medical Policy 963.

PURPOSE

This policy applies to Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS). This policy establishes requirements expected of each AdSS for training and credentialing standards for individuals seeking employment as a Credentialed Family Support Provider (CFSP) in AHCCCS programs.

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, Member's Health Care Decision Maker (HCDM) 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.

2. "Americans With Disabilities Act" or "ADA" means the law passed by the Congress of the United States that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
3. "Behavioral Health Paraprofessional" or "BHPP" means as specified in A.A.C. R9-10-101.

4. "Behavioral Health Professional" or "BHP" means the same as specified in A.A.C. R9-10-101.
5. "Behavioral Health Technician" or "BHT" means an individual who is not a BHP who provides the following services to a patient to address the patient's behavioral health issue:
    a. With clinical oversight by a BHP, services that, if provided in a setting other than a health care institution, would be required to be provided by an individual licensed as specified in A.R.S. § 32-3274; and
    b. Health-related services.
6. "Child and Family Team" or "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 or 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.

7. "Comprehensive Health Plan" or "CHP" means a Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Previous to April 1, 2021, CHP was the Comprehensive Medical and Dental Program (CMDP) (A.R.S. § 8-512).
8. "Court Ordered Evaluation" or "COE" means the evaluation ordered by the court as specified in A.A.C. R9-21-101.
9. "Court Ordered Treatment" or "COT" means the treatment ordered by the court as specified in A.A.C. R9-21-101.
10. "Credentialed Family Support Provider" or "CFSP" – means an individual who is qualified under this policy and has passed an

AHCCCS/DCAIR OIFA approved CFSP Training Program to deliver Family Support Services as a Credentialed Family Support Partner.

11. "Credentialed Family Support Partner Training Program" or "CFSTP" means an AHCCCS/DCAIR OIFA approved credentialing program in compliance with competencies and requirements as specified in this policy.
12. "Credentialed Trainer" means an individual who identifies as having lived experience as specified in this Policy and provides training to individuals seeking employment as a CFSP.
13. "Family Member" means:
    a. for the adult system, an individual who has lived experience as a primary natural support for an adult with emotional, behavioral health and/or Substance Use Disorders (SUD); and
    b. for the children's system, a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health or a SUD.
14. "Family Support Service" means home care training with Family

Member(s) directed toward restoration, enhancement, or maintenance of the family functions to increase the family's ability to effectively interact and care for the individual in the home and community.

15. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record, as specified in A.A.C. R9-28-101.
16. "Integrated System of Care" or "ISOC" means integrated physical and behavioral health care within the AHCCCS health care delivery system focused on ensuring appropriate, adequate, and timely services for all persons across the lifespan, with a primary focus on improving quality of life throughout all system intersections and service interactions that individuals may encounter.
17. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
18. "Office of Human Rights" or "OHR" means established within

AHCCCS and is responsible for the hiring, training, supervision, and coordination of human rights advocates. Human rights advocates assist and advocate on behalf of Members determined to have an SMI with Service Planning, Inpatient Discharge Planning, and resolving appeals and grievances.

19. "Office of Individual and Family Affairs Alliance" means a collaborative of all Offices of Individual and Family Affairs (OIFA) in Arizona, including AHCCCS OIFA.
20. "Serious Emotional Disturbance" or "SED" means designation for individuals from birth until the age of 18 who currently meet 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.
21. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18

years of age or older.

22. "Substance Use Disorder" or "SUD" 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.

POLICY

A. PARENT/FAMILY SUPPORT

1. The AdSSs shall support the peer-to-peer relationship of Family Members as a viable component in the delivery of integrated services through provision of quality Family services in support of integrated care in the AHCCCS Children System of Care (CSOC) and Adult System of Care (ASOC).
2. The AdSS shall require:
    a. Credentialing as specified in this policy for reimbursement of Credentialed Family Support Providers (CFSP); and
    b. All Family Support Services provided by a Credentialed Family Support Partner (CFSP) are indicated as credentialed Family Support Services in documentation.

3. The AdSSs shall support the peer-to-peer support relationship available to primary caregivers of Medicaid-eligible children and natural supports of Medicaid-eligible adults who are:
    a. A parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral health, or SUD; or
    b. An individual who has lived experience as a primary natural support for an adult with emotional, behavioral health, or SUD.
4. The Division's OIFA, in coordination with AHCCCS/DCAIR OIFA shall establish and maintain ongoing training requirements and credentialing standards for providing Credentialed Family Support Services within the AHCCCS programs, Support Services are defined and not limited to:
    a. Assisting the family to adjust to the individual's needs,
    b. Developing skills to effectively interact, and
    c. Guide the individual's:
        i. Understanding of the causes and treatment of behavioral health challenges;

ii. Understanding and effective utilization of the system; or

iii. Planning for ongoing and future supports for the individual and the family.

B. CREDENTIALED FAMILY SUPPORT PARTNER AND TRAINER QUALIFICATIONS

The AdSS shall require all individuals employed as a CFSP or as a trainer in the children system or adult system to:

a. Meet the definition of a Family Member, and

b. Have lived experience navigating the adult and or child systems of care as:

i. an adult who is the primary supporter of a child, or

ii. the primary supporter of an adult.

C. CREDENTIALED FAMILY SUPPORT PARTNER TRAINING PROGRAM APPROVAL

1. The AdSS shall submit its CFSPTP curriculum, competency exam, and exam-scoring methodology, including an explanation of

accommodations or alternative formats of program materials available to individuals who have special needs, to AHCCCS/DCAIR OIFA at OIFA@azahcccs.gov., and the Division's OIFA at DDDOIFA@azdes.gov.

2. The AdSS shall obtain approval of the curriculum, competency exam, and exam-scoring methodology as specified in this policy from the Division's OIFA and AHCCCS/DCAIR OIFA shall issue feedback.
3. The AdSS shall seek assistance from the Division's identified point of contact within the OIFA who is authorized to assist and advise AdSS for CFSP operators to further develop and enhance their curricula.
    a. The Division's OIFA point of contact provides feedback through the AdSS to C~~P~~FSP operators to further develop and enhance their curricula with a focus on I/DD.
    b. The OIFA Behavioral Health Team in collaboration with other Division Function Areas reviews content of the curriculum ensuring all components and best practices are addressed.

c. In the event that the Division has comments or recommended changes, the OIFA point of contact will provide the information, tracked changes or redlined, to the DDD Health Plan Contract Unit to then disseminate to AdSS and share with CPFSP operators.

4. The AdSSs CFSPTP shall submit updated content to AHCCCS/DCAIR OIFA at OIFA@azahcccs.gov and the Division's OIFA at DDDOIFA@azdes.gov for review and approval before the changed or updated curriculum is to be utilized, if a program makes substantial changes to its curriculum or if there is an addition to required elements.

5. The AdSS shall require approval of the curriculum, competency exam, and exam-scoring methodology based on the elements required in this policy, if a CFSPTP requires regional or culturally specific training exclusive to an AdSS or specific population, the specific training cannot prevent employment or transfer of Family Support credentials based on the additional elements or standards.

6. The AdSS training shall include skills pertinent to the Family

Support of Members with intellectual or developmental disabilities.

7. The AdSS shall not combine a CFSP Training Curriculum with any other training and shall be recognized as a stand-alone program.
8. The AdSS shall ensure the curriculum is maintained and as substantial changes in the ISOC occur, the curriculum is revised.
9. The AdSS shall submit the updated content to AHCCCS/DCAIR OIFA, at OIFA@azahcccs.gov, and the Division's OIFA at DDDOIFA@azdes.gov for review and approval before the changed or updated curriculum is to be utilized.

D. COMPETENCY EXAM

1. The AdSS shall require individuals seeking employment as a CFSP to complete a competency exam as described in section E.3 of this policy, with a minimum score of 80 percent, upon completion of required training to become a CFSP.
2. The AdSS shall require all exams created by the CFSPTPs to include at a minimum, questions related to each of the curriculum core elements as specified in this policy.
3. The AdSS shall require agencies employing CFSP who are

providing Family Support Services to ensure that its employees are trained to work with the populations served.

4. The AdSS shall require upon completion of each class, all AHCCCS registered providers operating a CFSP program to utilize AMPM Policy 964, Attachment B, Credentialed Family Support Provider Graduates, to submit the names of trainees and dates of graduation to the Division, OIFA, via email at dddahcccsdeliverables@azdes.gov.
5. The AdSS shall require AMPM Policy 964, Attachment B to contain no other information apart from what is required.

E. CREDENTIALED FAMILY SUPPORT PARTNER EMPLOYMENT TRAINING CURRICULUM STANDARDS

1. The AdSS shall not duplicate training in the CFSPTP curriculum required of individuals for employment with a licensed agency or Community Service Agency (CSA), training elements in this policy are specific to the CFSP role in the AHCCCS programs and instructional for CFSP interactions.

2. The AdSS shall develop and make available policies and

procedures as well as additional resources for development of curriculum, including AdSS staff contacts for questions or assistance related to training or curriculum.

3. The AdSS shall include in their CFSPTP curriculum the following core elements:
    a. Overview of system history and knowledge of the Arizona behavioral health system that resulted in system transformation:
        i. Arizona Vision (Jason K. lawsuit);
        ii. Jacob's Law;
        iii. Arnold vs. Sarn;
        iv. Adult System of Care (ASOC)- Nine Guiding Principles;
        v. ART;
        vi. Children's System of Care (CSOC)-Twelve Guiding Principles;
        vii. CFT;
        viii. CSOC levels of care
        ix. Medicaid covered services; and

x. Rights of the caregivers and individual rights of Members.

b. Lifecycle Transitions

i. Transition aged youth, and

ii. Guardianship.

a) Types and Alternatives – (e.g., Power of Attorney, Advance Directives), and

b) Process of applying (rules and requirements).

iii. Timelines of transition to adulthood into the ASOC; and

iv. Role changes when bridging the CSOC and ASOC at transition for the individual, family, and CFT.

c. System Partner Overview

i. The Division's three categories of eligibility and eligibility process, covered services, knowledge of the Division's health plans,

ii. CHP program overview, involvement, and collaboration, understanding the CFSP and Member or family role(s) for children in the Department of

Child Safety (DCS) care, education, navigation, support, and advocacy with Members and families involved in DCS care, as described in AMPM 260.

iii. Office of Human Rights and Special Assistance (OHR);

iv. OIFA;

v. Introduction to the Americans with Disabilities Act (ADA);

vi. Introduction to Social Security Income (SSI)/Social Security Disability Insurance (SSDI):

a) Payee services, and

b) Vocational rehabilitation services and available trainings.

vii. Introduction to the criteria and processes for a SED SMI designation;

viii. Introduction to the criteria and processes for COE and COT;

ix. Crisis Services:

a) Crisis planning and prevention;

b) Crisis centers;

c) Crisis Mobile Teams; and

d) Crisis Intervention Training.

d. Advocacy and Empowerment

i. Family and Peer movements and the role of advocacy in systems transformation; and

ii. Building collaborative partnerships and relationships:

a) Engagement, identification, and utilization of strengths; and

b) Utilization and modeling of conflict resolution skills and problem-solving skills.

iii. Understanding of:

a) Individual and family culture, biases, stigma, and systems' cultures; and

b) Trauma informed care approaches.

iv. Natural or Informal supports – identifying, building, and connecting individuals and families, including families of choice, to community and natural supports;

v. Diversity, equity, inclusion, and accessibility in healthcare;

vi. Empowerment:

a) Empowerment of Family Members and other supports to identify their needs, promote self-reliance;

b) Identification of understanding of the stages of change, and unmet needs; and

c) Identification of barriers; family, system, social, emotional, physical, and using effective advocacy skills to overcome barriers.

e. Practice of Support

i. Communication techniques:

a) Individuals first, strengths-based language, using respectful communication, demonstrating care and commitment;

b) Active listening skills, demonstrating empathy, provide empathic responses, differentiation between sympathy and empathy, listening

non-judgmentally; and

c) Use of self-disclosure effectively and sharing one's own story for the benefit of the Member.

ii. Wellness, in terms of understanding:

a) The stages of grief and loss;

b) Self-care and stress management;

c) Compassion fatigue, burnout, and secondary traumatic stress;

d) Resiliency and recovery; and

e) Healthy personal and professional boundaries.

F. SUPERVISION OF CREDENTIALED FAMILY SUPPORT PARTNER

1. The AdSS shall establish the amount of hours and duration of supervision period of CFSP.
2. The AdSS shall require the criteria outlined below:
   a. Providers employing CFSP provide supervision by individuals qualified as BHT or BHP.
      i. Supervision shall be appropriate to the services being delivered and the qualifications of the CFSP as a BHT, BHP, or BHPP.

ii. Supervision shall be documented and inclusive of both clinical and administrative supervision.

b. Individuals providing supervision receive training and guidance to ensure current knowledge of best practices in providing supervision to CFSP.

3. The AdSS shall develop and make available to the providers:

a. Policies, procedures, and resources for establishing supervision requirements of service provision; and

b. Any expectations for providers related to AdSS monitoring or ~~/~~oversight activities.

G. PROCESS FOR SUBMITTING EVIDENCE OF CREDENTIALING

1. The AdSS shall ensure provider agencies:

a. Maintain documentation of required qualifications and credentialing for CFSP; and

b. Make copies of credentials available upon request by the AdSS or the Division.

2. The AdSS shall develop and make available to providers policies and procedures that describe monitoring, auditing, and oversight activities and where records specific to supervision and training

of CFSP are reviewed and maintained.

3. The AdSS shall submit information noting CFSP involvement in service delivery as specified in the AdSS contract with the Division and utilizing AMPM Policy 964 Attachment A, Credentialed Family Support Specialists Involvement in Service Delivery Report.

H. INTERSTATE RECIPROCITY

1. The AdSS shall recognize credentials issued by other states or training programs.
2. The AdSS shall require individuals credentialed in another state to submit their credential to AHCCCS/DCAIR OIFA, via email to AHCCCS OIFA.

I. CONTINUING EDUCATION AND ONGOING LEARNING REQUIREMENTS

1. The AdSS shall establish ongoing training requirements of current best practices, for individuals employed as CFSP to obtain continuing education and ongoing learning relevant to family support.
2. The AdSS shall develop and make available to providers the

policies and procedures describing requirements for individuals employed as CFSP to obtain a minimum of eight hours of continuing education and ongoing learning relevant to family support, per year.

3. The AdSS shall require at least one hour of CFSP continuing education to cover ethics and boundaries related to the practice of family support.

SUPPLEMENTAL INFORMATION

The Division's OIFA shall monitor the AdSS' OIFA to ensure that all behavioral health provider sites serving multiple Members shall have regular and ongoing opportunities for Members or Family Members to participate in decision making, quality improvement and enhancement at the provider site.

Signature of Chief Medical Officer: Anthony Dekker (Feb 1, 2024 10:00 MST)
Anthony Dekker, D.O.

965 COMMUNITY SERVICE AGENCIES

REVISION DATE: 5/25/2022, 10/1/2021

EFFECTIVE DATE: September 2, 2020

REFERENCES: A.R.S. §32-33, A.R.S. §32-3251, A.A.C. R4-6-101; A.R.S. §36-501, A.R.S. §32-2061, A.R.S. §32-2091, A.A.C. R9-10-101, A.R.S. §13-705, A.R.S. §13-3212, A.R.S. §13- 3206, A.R.S. §13-3502, A.R.S. §13-3506, A.R.S. §13-3506.01, A.R.S. §13-3512, A.R.S. §13-3555, A.R.S. §13-3558, A.R.S. §36-2903.01(B)(4), A.R.S. §41-6-10, ACOM Policy 103, AMPM Policy 940, AMPM Policy 965 Attachments A - D

PURPOSE

This policy sets forth requirements applicable to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS) for credentialing and monitoring Community Service Agencies (CSAs) and collaboration with other AHCCCS contracted health plans when CSAs participate with more than one AHCCCS contracted health plan.

SCOPE

This policy applies to the AdSS's responsibilities for credentialing and monitoring of CSAs.

DEFINITIONS

Behavioral Health Professional (BHP) must work within their scope of practice and be licensed in the state of Arizona, by the Arizona Board of Behavioral Health Examiners and includes Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Independent Substance Abuse Counselor, Licensed Associate Counselor, Licensed Master Level Social Worker, Licensed Bachelor Level Social Worker, Licensed Associate Marriage Family Therapist, Licensed Associate Substance Abuse Counselor.

A BHP may also be:

A. Psychiatrist

B. Psychologist

C. Physician (MD or DO)

D. Behavior Analyst (cannot provide treatment)

E. Registered Nurse Practitioner (if licensed as an adult psychiatric and mental health nurse)

F. Registered Nurse with:

1. A psychiatric-mental health nursing certification, or

2. One year of experience providing behavioral health services.

Behavioral Health Paraprofessional (BHPP) as specified in A.A.C. R9-10-101, is an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

A. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

B. Are provided under supervision by a behavioral health professional.

Behavioral Health Technician (BHT) as specified in A.A.C. R9-10-101, is 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 if the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, if the behavioral health services were provided in a setting other than a licensed health care institution, are provided with clinical oversight by a behavioral health professional.

Community Services Agency is a Community Service Agency is an unlicensed provider of non-medical, health related, support services. CSAs provide individualized habilitation (developmental learning), rehabilitation (relearning or readapting), employment, and advocacy services and family supports.

Lead Contractor is an AHCCCS contracted health plan that has the primary responsibility for credentialing, recredentialing and monitoring Community Service Agencies with one or more physical locations that are contracted with health plans.

POLICY

A. OVERVIEW

The AdSS shall have a standardized process for the initial and annual credentialing process of CSAs and for ongoing monitoring of CSAs for programmatic compliance. The AdSS are responsible for ensuring that qualified network community services agencies have the requisite components of the service(s), policies, procedures, and practices to implement the service. CSAs provide services that enhance or supplement behavioral health services that members receive through other licensed agencies. CSAs provide medically necessary rehabilitation and support services to members and their families, including but not limited to the following:

1. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
2. Comprehensive Community Support (Supervised Day)
3. Home Care Training Family (Family Support)
4. Ongoing Support to Maintain Employment
5. Personal Care

6. Psychoeducational Service (Pre-Job Training and Development)

7. Psychosocial Rehabilitation Living Skills Training Services

8. Self-Help/Peer Services (Peer Support)

9. Supervised Behavioral Health Day Treatment and Day Program

10. Transportation

B. INITIAL AND ANNUAL CREDENTIALING PROCESS

The AdSS shall comply with AMPM 965 Community Service Agencies and ensure the following requirements are met in the credentialing of CSAs that serve members of the Division:

1. The applicant shall complete a CSA Application (AMPM Policy 965 Attachment A, Initial Application and Credentialing Amendment Request) in accordance with the application instructions.

2. If the applicant intends to contract with one or more AHCCCS contracted health plan for one or more physical locations, a Lead Contractor will be designated as described in AMPM 965. The Lead Contractor may or may not be an AdSS. If the Lead Contractor is an AdSS, or if the CSA is contracting only with an AdSS, then the AdSS shall follow the procedures set forth in this policy.

    a. The AdSS shall send a notice to the applicant, the Division, AHCCCS/DHCM CSA Compliance Program Specialist, and applicable Contractors, notifying them that the AdSS is the Lead Contractor for credentialing. The notice shall also include documentation submission standards as specified in AMPM Policy 965 Attachment B, Documentation Submission Standards, and deadlines for the initial credentialing desk audit.

C. REVIEW AND APPROVAL PROCESS

After reviewing the application packet, the AdSS shall render a credentialing approval notice or denial decision in writing.

1. The AdSS shall send a CSA credentialing approval notice to the applicant and the Division within 30 calendar days of the AdSS receipt of a timely, compete, and accurate application packet. If the application is denied, the denial decision may include an invitation for the CSA to develop and implement a Corrective Action Plan (CAP) with an outline of information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The AdSS' decision to require a CAP is not subject to appeal.

    a. The AdSS shall send a copy of the CSA credentialing approval notice or denial decision to the Division, AHCCCS/DHCM CSA

Compliance Program Specialist and all other applicable Contractors.

b. Direct service staff members shall meet all Division, AHCCCS and CSA Program Administrator requirements as specified in AMPM Policy 965, Attachment B, such as competency requirements, before providing services.

c. The applicants shall register with AHCCCS/Provider Registration as a CSA provider type before billing for Title XIX/XXI reimbursable services. Applicants may obtain a registration packet by contacting AHCCCS/Provider Registration or via AHCCCS website.

2. Documentation submitted to AHCCCS/Provider Registration shall be consistent with information provided on the application submitted to the AdSS to avoid unnecessary delays in obtaining an AHCCCS provider identification number.

3. Applicants that are establishing more than one CSA locations shall submit a Provider Registration packet for each physical location.

D. Renewal Application Registration and Annual Onsite Monitoring Review

The AdSS shall send a notice, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, and all other applicable contractors of the onsite monitoring review at least 30 calendar days prior to the scheduled visit. The scheduled visit shall occur no less than 60 days from the annual expiration date of the CSA's AHCCCS provider registration status. The notice shall include documentation requirements as specified in AMPM Policy 965, Attachment B, and information on how to prepare for the monitoring visit, including instructions for the day of the scheduled visit.

1. The AdSS shall review all documentation in accordance with the standards as specified in AMPM Policy 965, Attachment B including, but not limited to, any updates to the fire inspection documentation and administrative procedures. Furthermore, the AdSS shall review personnel files of direct service staff members.

2. CSAs shall cooperate with the annual onsite monitoring review and shall:

a. Make available to the AdSS records that include all updated requirements.

b. Make available to the AdSS all requested member records.

c. Participate in the audit entrance and exit conferences with the AdSS employees.

3. After conducting the onsite monitoring review, the AdSS shall render a credentialing approval notice or denial decision in writing, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable AAHCCCS contracted health plans.

4. The denial decision may include an invitation for the CSA to develop and implement a CAP which outlines information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The decision by the AdSS to allow for the development and implementation of a CAP shall include considerations such as allowing the CSA to continue services is in the best interests of the members when the health, safety, and/or welfare of members will not be jeopardized.

    a. The AdSS's decision to require a CAP is not subject to appeal.

    b. The AdSS shall send the CSA credentialing approval notice or denial decision to the CSA and the Division within 30 calendar days of the AdSS onsite audit or a satisfactory completion of a CAP.

    c. The AdSS shall send the CSA approval notice or denial decision to the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable contractors.

E. Credentialing Amendment

1. CSAs shall submit an amendment, at least 30 calendar days before the change. The amendment shall be submitted to the AdSS for CSAs, utilizing AMPM Policy 965, Attachment A and Attachment B, when any of the following information or circumstances occur:

    a. Change in name or address.

    b. Change in the CSA's National Provider Identifier (NPI) and/or Tax Identification Number (TIN).

    c. Change in ownership, governing board, or Chief Executive of the program.

    d. Adding or removing a contractor with which the CSA contracts or intends to contract for the provision of services.

2. CSAs shall report changes to the AHCCCS/Provider Registration Office in addition to the submission of the credentialing amendment request via fax.

3. After conducting a review of the credentialing amendment form and associated documentation, the AdSS shall render an updated credentialing approval notice or denial decision in writing, copying the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Enrollment Unit, and all other applicable contractors.

4. The denial decision may include an invitation for the CSA to develop and implement a CAP along with an outline of information that is missing or inaccurate and shall be submitted within a specified timeframe in order for the AdSS to render a final credentialing decision. The decision by the AdSS to allow for the development and implementation of a CAP shall include considerations such as allowing the agency to continue services is in the best

interests of the members when the health, safety, and/or welfare of members will not be jeopardized.

a. The AdSS's decision to require a CAP is not subject to appeal.

b. The AdSS contractor shall send the CSA credentialing approval notice or denial decision to the CSA and the Division within 30 calendar days of the receipt of the credentialing amendment request.

c. The AdSS shall send the CSA approval notice or denial decision to the Division, AHCCCS/DHCM CSA Compliance Program Specialist, AHCCCS/Provider Registration, and all other applicable contractors.

F. Denials, Suspension, Or Revocation of a CSA AHCCCS Registration

1. If the AdSS receives notification from AHCCCS that a CSA's AHCCCS registration is denied, suspended, or revoked, it shall deny, suspend, or revoke the CSAs participation in its network.

2. The AdSS are responsible for sending the outcome of credentialing renewals, amendments, and onsite monitoring reviews that result in a denial, suspension, or revocation, to the Division, AHCCCS/Provider Registration. AHCCCS/Provider Registration is responsible for rendering the final decision about the CSAs initial or continued status as an AHCCCS registered provider.

G. CSA VOLUNTARY WITHDRAWAL OR SUSPENSION OF A CSA REGISTRATION

1. If a CSA no longer intends to deliver services as a CSA to any AdSS contractor, the CSA shall notify the AdSS that the CSA is contracted with to provide services, the Division, the AHCCCS/DHCMCSA Compliance Program Specialist, and AHCCCS/Provider Registration in writing at least 30 calendar days in advance of the last date the service will be offered.

2. If an AdSS determines that a rehabilitation and/or support service will no longer be provided by the CSA, the AdSS shall notify all AHCCCS health plans contracted with the CSA to provide services and the Division along with AHCCCS/DHCM CSA Compliance Program Specialist in writing at least 30 calendar days in advance of the contract termination date.

3. If a CSA no longer holds a contract with any AdSS contractor but intends or is in the process of contracting with another health plan the CSA shall notify AHCCCS/Provider Registration in writing at least 30 calendar days in advance of the last date the service will be offered. AHCCCS/Provider Registration, at its sole discretion, may choose to allow the CSA to remain an AHCCCS Registered Provider, but suspend the CSAs' ability to bill for services. The AdSS shall adhere to reporting and notification requirements established in contract to ensure that network changes are communicated, and transition plans are implemented for the continuation of services to members. At the point in time when the CSA is contracted with at least one AHCCCS health plan contractor, the CSA shall initiate the initial application process outlined in this policy.

4. In all circumstances noted above, the AdSS and CSAs shall coordinate the transition of members to ensure continuity of care.

H. AHCCCS CONTRACTED HEALTH PLANS COLLABORATIVE FOR CREDENTIALING AND ONSITE MONITORING REVIEWS

1. The AdSS shall coordinate CSA credentialing and onsite monitoring reviews when the CSA is contracted with more than one AHCCCS contracted health plan as described in this section.

2. The AdSS shall participate with other AHCCCS contracted health plans in a collaborative process to perform initial and annual credentialing and annual onsite monitoring of CSAs, which shall include but not be limited to the following:

   a. Designate and maintain a listing of points of contact at each contractor and providing the Division and AHCCCS/DHCMCSA Compliance Program Specialist with updated copies of the list as revisions are made.

   b. Establish criteria for determining the Lead Contractor for each CSA.

   c. Develop standard forms including communication and approval notices, audit tools, and CAPs to be utilized by the AdSS or applicable Lead Contractor. All standard forms shall be approved by AHCCCS before use, including initial drafts and proposed revisions. Develop processes and standards for member record reviews for the onsite monitoring review.

   d. Develop processes for secondary reviews by another AHCCCS contracted health plan should a CSA fail to receive an approved credentialing notice from the Lead Contractor, or upon request by a CSA or an AHCCCS contracted health plan for any reason as deemed necessary.

Signature of Chief Medical Officer: Anthony Dekker (May 17, 2022 20:38 PDT)

Anthony Dekker, D.O.

970 PERFORMANCE MEASURES

REVISION DATES: 9/6/23, 3/09/22, 10/28/20
EFFECTIVE DATE: October 1, 2019
REFERENCE: 42 CFR Part 438

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division or DDD) Administrative Services Subcontractors (AdSS) and establishes requirements to implement, Evaluate, monitor, and report on performance measures and associated improvement activities to the Division.

DEFINITIONS

1. "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, or authoritative bodies.
2. "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.

3. "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.
4. "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.
5. "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.
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. "Member" means the same as "client" as defined in A.R.S. § 36-551.
8. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or Objective, or to progress towards a positive Outcome.

9. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities and documenting results via desktop or onsite review.
10. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
11. "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.
12. "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].
13. "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.
14. "Performance Measure Performance Standards" means the minimal expected level of performance. The official performance measure rates are 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.

15. "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 Plan-Do-Study-Act 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.

14. "Statistically Significant" means a result occurs that is unlikely due to chance or random fluctuation.

15. "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

A. PERFORMANCE MEASURES

1. The AdSS shall collect, monitor, and Evaluate data relevant to Division specific performance measures for required performance metrics in the areas of:

a. Quality,

b. Timeliness,

c. Utilization,

d. Efficiency,

e. Member Satisfaction,

f. Targeted Investment, and

g. Performance Improvement.

2. The AdSS shall use ongoing collection, Monitoring, and evaluation of performance metric data to develop specific Measurable goals and Objectives aimed at enhancing the Quality Management/Performance Improvement (QM/PI) Program.

3. The AdSS shall report performance metric data to the Division for the following:

   a. Quality Management/Quality of Care (QOC);

   b. Medical Management;

   c. Maternal and Child Health;

   d. Network Adequacy; and

   e. Waiver/Program Evaluation.

4. The AdSS' QM/IP program 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) as specified in the AdSS' contract.

5. The AdSS shall measure and report on performance measures in accordance with CMS and AHCCCS requirements.

6. The AdSS shall comply with Division and AHCCCS QM/PI Program requirements to enhance performance for all required performance measures.

7. The AdSS shall compare the performance measure rates with national Benchmarks specified in the AdSS' contract effective during that measurement period.

8. The Division shall Evaluate the AdSS' compliance with performance measure requirements at least quarterly.

9. The AdSS shall include LTSS specific performance measures.

B. PERFORMANCE MEASURE REQUIREMENTS

1. The AdSS shall:

   a. Adhere to the requirements specified within the AdSS' contract related to performance measure requirements.

   b. Utilize the results of the Official Rates in evaluating the QM/PI Program.

   c. Show Statistically Significant improvement from year to year, which is sustained over time, to meet the Performance Measure Performance Standards (PMPS).

      i. Sustained improvement is demonstrated when it

establishes how the Statistically Significant improvement can be reasonably attributable to interventions undertaken by the AdSS, and

ii. Maintains or increases the improvements in performance for at least one year after the Performance Improvement is first achieved.

d. Measure and report performance measures, and meet any associated standards identified by the Division, AHCCCS or CMS.

e. Achieve the PMPS outlined in the AdSS' contract for each measure using the Official Rates.

f. Demonstrate sustained and improved efforts throughout the performance cycle when the PMPS have been met.

2. The AdSS shall develop an evidence-based Corrective Action Plan (CAP) for each performance measure not meeting the PMPS to improve performance to at least the minimum standards required by the Division and align with the requirements of AHCCCS Medical Policy 920, Attachment B.

3. The AdSS shall ensure that each CAP includes a list of activities or strategies to allocate increased administrative resources to improve rates for a specific measure or service area.
4. The AdSS shall submit the CAP to the Division for review and approval prior to implementation.
5. The AdSS shall show Statistically Significant and sustained improvement towards meeting the PMPS.
6. If requested by the Division, the AdSS shall develop CAPs for measures that are below the PMPS or that show a Statistically Significant decrease in rates even if it meets or exceeds the PMPS.
7. The AdSS shall report any discrepancies identified in encounters received by the Division, and the status of such discrepancies, to the Division's Quality Improvement Manager.

C. PERFORMANCE MEASURE ANALYSIS

1. The AdSS shall conduct data analysis related to the performance measure rates to improve the quality of the care provided to Members, identify opportunities for improvement, and implement targeted interventions.

2. The AdSS shall Evaluate performance rates to improve the quality of care provided to members, identify opportunities for improvement, and implement targeted interventions.

3. The AdSS shall evaluate performance for aggregate and subpopulations, inclusive of any focus areas identified by the Division or AHCCCS, including the analysis of performance to identify health disparities and related opportunities for improvement.

4. The AdSS shall utilize proven quality improvement tools when conducting root-cause analysis and problem-solving activities.

5. The AdSS shall identify and implement targeted interventions to address any noted disparities identified as part of the AdSS' data analysis efforts.

6. The AdSS 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. When AdSS are directed to collect data to measure performance, and if requested by the Division, the AdSS shall submit specific documentation to verify that indicator criteria were met in accordance with Division requirements.

2. The AdSS shall assign qualified personnel to collect data.

3. The AdSS shall ensure Inter-Rater Reliability if more than one person is collecting and entering data.

4. The AdSS shall ensure that data collected from multiple individuals is consistent and comparable through an implemented Inter-Rater Reliability process, as specified in AdSS Medical Policy 960, and documented as follows:

    a. A detailed description of the Methodology for conducting Inter-Rater Reliability and required training;

    b. Oversight and validation of data collection;

    c. Minimum testing score required to continue participation in the data collection and reporting process;

d. A mechanism for evaluating individual accuracy scores; and

e. Actions taken if an individual does not meet the established accuracy score.

5. The AdSS shall monitor and track the Inter-Rater Reliability accuracy scores and associated follow-up activities.

6. Upon request from the Division, the AdSS shall provide evidence of implementation of the Inter-Rater Reliability process and associated Monitoring.

E. PERFORMANCE METRIC AND MEASURE REPORTING

1. The AdSS shall report the QM/PI Program performance to the Division using the AHCCCS Performance Measure Monitoring Report & Work Plan Evaluation Template.

2. The AdSS shall analyze and report the performance separately by DDD line of business.

3. The AdSS shall calculate and report combined rates/percentages for the DDD population; however, the AdSS shall have the ability to calculate and report numerators, denominators, and

rate/percentage for Medicaid, which is provided in accordance with AHCCCS or Division request or instructions.

3. The AdSS shall monitor KidsCare performance metrics and measures to ensure compliance with contractual standards.

4. The AdSS shall report performance measure performance to the Division in accordance with the AdSS' contract.

Signature of the Chief Medical Officer: Anthony Dekker (Aug 30, 2023 16:28 PDT)
Anthony Dekker, D.O.

980 PERFORMANCE IMPROVEMENT PROJECTS

REVISION DATE: 6/7/2023, 9/15/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.330, Section F3, Contractor Chart of Deliverables

PURPOSE

This policy applies to the Division of Developmental Disabilities' (Division) Administrative Services Subcontractors (AdSS) and delineates the purpose, design, implementation, and reporting of Division or AHCCCS-mandated and AdSS self-selected Performance Improvement Projects (PIPs).

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. "Methodology" means the planned documented process, steps, activities, or actions taken to achieve a goal or objective, or to progress towards a positive outcome.
5. "Monitoring" means the process of auditing, observing, evaluating, analyzing, and conducting follow-up activities, and documenting results via desktop or on-site review.
6. "Objective" means a measurable step, generally one of a series of progressive steps, to achieve a goal.
7. "Outcomes" means changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services [42 CFR 438.320].
8. "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.

9. "Plan Do Study Act (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, trying it, observing the results, and acting on what is learned. 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.
10. "Plan Do Study Act (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.
11. "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.

12. "Statistically Significant" means a judgment of whether a result occurs because of change. When a result is statistically significant, it means that it is unlikely that the result occurs because of chance or random fluctuation. There is a cutoff for determining statistical significance. This cutoff is the significance level. If the probability of a result (the significance value) is less than the cutoff (the significance level), the result is judged to be statistically significant.

13. "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. PERFORMANCE IMPROVEMENT PROJECT (PIP) REQUIREMENTS

1. The AdSS shall participate in PIPs selected by the Division and AHCCCS.

2. The AdSS shall select and design, with Division approval, additional PIPs specific to needs identified through internal monitoring of trends and data.

3. The AdSS shall consider all populations and services covered when developing quality assessments and PIPs.

4. The AdSS shall participate in performance measures and PIPs that are mandated by the Centers for Medicare and Medicaid Services (CMS).

B. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) DESIGN

1. The AdSS shall conduct PIPs, including any PIPs required by CMS, that focus on either clinical or non-clinical areas.

    a. Clinical focus topics may include:

i. Primary, secondary, and/or tertiary prevention of acute conditions;
ii. Primary, secondary, and/or tertiary prevention of chronic conditions;
iii. Primary, secondary, and/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. Non-clinical focus topics may include:
i. Availability, accessibility, and adequacy of Contractor's service delivery system;
ii. Cultural competency of services;
iii. Interpersonal aspects of care (e.g., quality of provider/member encounters); and
iv. Appeals, grievances, and other complaints.

2. The AdSS shall identify and implement clinical and non-clinical focused PIPs that are meaningful to the population(s) served and based on self-identified opportunities for improvement. This will be supported by:

a. Root cause analyses,

b. External and internal data,

c. Surveillance of trends, or

d. Other information available to the AdSS.

3. The AdSS shall adhere to the protocol in 42 CFR 438.330 when developing PIPs.

4. The AdSS shall also 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.

5. The AdSS shall use the PDSA Method to test changes (interventions) quickly and refine them, as necessary.

6. The AdSS shall utilize several PDSA Cycles within the PIP lifespan.

7. The AdSS shall implement the PDSA Cycles in as short a time frame as practical, based on the PIP topic.

8. The AdSS shall include the following steps in the PDSA Cycle:

a. Plan the change(s) or intervention(s), including a plan

for collecting data. State the objective(s) of the intervention(s).

b. Try out the intervention(s) and document any problems or unexpected results.

c. Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

d. Refine the change(s) or intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).

e. Continue the cycle as new data becomes available until improvement is achieved.

9. The AdSS shall include all PDSA Cycles conducted as part of the PIP within the AdSS' PIP Report submissions.

C. PERFORMANCE IMPROVEMENT PROJECT (PIP) TIMEFRAMES

1. AHCCCS-Mandated PIPs

a. The AdSS shall initiate mandated PIPs on the date established by the Division or AHCCCS.

b. The AdSS shall collect and analyze data at the beginning of the PIP.

c. During the Intervention year, the AdSS shall implement innovative and/or evidence-based interventions to improve performance.

d. The AdSS shall base this on an evaluation of barriers and root cause analysis.

e. The AdSS' interventions shall consider any unique factors such as:

    i. The AdSS' membership,

    ii. The provider network, and

    iii. The geographic area(s) served.

f. The AdSS shall utilize annual measurements to evaluate their performance; however, AHCCCS may require interim measurements, depending on the resources required to collect and analyze data.

g. In cases where AHCCCS elects to implement Rapid Cycle PIPs, the AdSS shall report at the intervals indicated within the associated PIP methodologies.

h. The AdSS' participation in the PIP shall continue until they demonstrate significant and sustained improvement, as outlined in Section E, or as directed by AHCCCS.

2. AdSS Self-Selected PIPs

a. Self-selected PIP timelines may vary with the AdSS encouraged to implement Rapid Cycle PIPs where applicable and appropriate, and

b. The AdSS' participation in the PIP shall continue until the AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS 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 AdSS shall ensure that data collected from multiple parties/individuals for PIP indicators is consistent and comparable through an implemented inter-rater reliability process.

3. The AdSS' documented inter-rater reliability process shall include:

   a. A detailed description of the AdSS' 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 AdSS shall monitor and track the inter-rater reliability accuracy scores and associated follow up activities.

5. The AdSS shall provide evidence of implementation of the inter-rater reliability process as well as the associated monitoring upon AHCCCS request.

F. MEASUREMENT OF SIGNIFICANT DEMONSTRABLE IMPROVEMENT

1. The AdSS shall implement interventions to achieve and sustain statistically significant improvement, followed by sustained improvement for one consecutive year, for each PIP indicator.

2. The AdSS shall initiate interventions that result in significant improvement, sustained over time, in its performance for the PIP indicators being measured.

3. The AdSS shall show evidence of improvement in repeated measurements of the PIP indicators specified for each active PIP.

4. The AdSS 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 AdSS shall demonstrate sustained improvement when it:
    a. Establishes how the significant improvement can be reasonably attributable to interventions implemented by the Contractor (i.e., improvement occurred due to the project and its interventions, not another unrelated reason); and
    b. Maintains, or increases, the improvements in performance for at least one year after the significant improvement in performance is first achieved.

G. PERFORMANCE IMPROVEMENT PROJECTS (PIPS) REPORTING REQUIREMENTS

1. The AdSS 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 AdSS shall utilize, as outlined in this

section, when preparing and submitting the required deliverables.

2. The AdSS shall include baseline and annual remeasurements, inclusive of rates and results used as the basis for analysis, both quantitative and qualitative, and the selection/modification of interventions, within the AdSS's PIP report submissions.
3. The AdSS shall submit reports that contain population/line of business-specific data, reflective of the AdSS' performance during the current and previous reporting periods in alignment with the associated PIP timeline.
4. The AdSS 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. AHCCCS-mandated PIPs
    a. The AdSS shall submit PIP reports for all AHCCCS-mandated PIPs, as specified in Contract.

b. The AdSS shall utilize the AHCCCS PIP Report Template and Attachment that is applicable to the population/line of business being reported.

c. The AdSS shall report rates and results, reflective of combined Title XIX and Title XXI populations, as applicable to the population/line of business.

d. The AdSS shall indicate if the interventions are applicable to Title XIX, Title XXI, or both populations.

e. The AdSS shall submit a final PIP report, as specified in Contract, following the year in which significant and sustained improvement is demonstrated.

f. The AdSS shall 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 Contract and the associated AHCCCS PIP Methodology.

g. The AdSS shall 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 AdSS 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. The AdSS shall keep AHCCCS-mandated PIPs open until formal notification of approval for PIP closure from AHCCCS is received.

i. The AdSS shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

6. AdSS self-selected PIPs

a. The AdSS shall submit a Contractor Self-Selected PIP Initiation Notification, as specified in Contract.

b. The AdSS shall submit PIP reports for self-selected PIPs, active during the previous calendar year, as specified in Contract.

c. The AdSS shall utilize the AHCCCS PIP Report Template and Attachment, specific to population/line of business.

d. The AdSS shall indicate if measurements/rates and results are reflective of combined Title XIX and Title XXI populations, as applicable to population/line of business.

e. The AdSS shall indicate if the interventions are applicable to the Title XIX, Title XXI, or both populations.

f. The AdSS shall submit a final self-selected PIP report, as specified in Contract, following the year in which significant and sustained improvement is demonstrated.

g. The AdSS shall 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 Contract.

h. The AdSS shall evaluate significant and sustained improvement based on the AdSS' internally collected and validated data for self-selected PIPs that are not based on standardized performance measures and calendar year performance.

i. The AdSS shall 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 AdSS 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 AdSS shall keep AdSS self-selected PIPs open until the AdSS has met criteria related to significant and sustained improvement.

k. The AdSS shall submit a PIP Closure Request for each PIP they are requesting to close for AHCCCS' review and approval.

l. The AdSS shall indicate the rationale for closing a PIP in cases where the AdSS has not met criteria related to significant and sustained improvement to support PIP closure.

m. The AdSS shall close the PIP when formal notification of approval for PIP closure has been received from AHCCCS.

n. The AdSS shall resubmit their final PIP report if the AHCCCS PIP Checklist requirements are not met.

Signature of Chief Medical Officer: Anthony Dekker (Jun 2, 2023 15:35 PDT)
Anthony Dekker, D.O.

1000 CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. HIV Specialty Provider List
2. Non-Transplant and Catastrophic Reinsurance
3. Outpatient Commitment COT Monitoring
4. Pregnant Women and Post-Partum
5. Prescription Drug Utilization Report
6. Transplant Log

1001 SECOND LEVEL REVIEW

EFFECTIVE DATE: May 3, 2023
REFERENCES:

PURPOSE

The purpose of this policy is to outline the requirements related to the Second Level Review process for Arizona Long Term Care System (ALTCS) eligible members. It applies to the Division of Developmental Disabilities Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Behavioral Health Residential Facility" or "BHRF" means 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.
2. "Health Care Professional" means a physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant,

speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

3. "Practitioner" refers to a Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist.
4. "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. AUTHORIZATION OF SERVICES

1. The AdSS shall have written policies and procedures for processing requests for initial and continuing authorizations of services.
2. The AdSS shall ensure timely notification of requests for services that are provided by the Division.
3. The AdSS shall ensure that any decision to deny a service authorization request or to authorize a service amount shall be made by a Health Care Professional who has appropriate clinical expertise in treating the member's condition or disease.
4. The AdSS shall submit authorizations requests for the following services to the Division for Second Level Review prior to issuing a decision:
    a. Behavioral Health Residential Facility (denials only);
    b. Enclosed or partially enclosed beds;
    c. Hysterectomy;
    d. Sterilization;
    e. Termination of pregnancy; or
    f. Transplants (denials only).

5. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant related medications prior to denying services.
6. The AdSS shall submit a request to the Division for prior authorization with clinical documentation that supports medical necessity for the required service and includes the following:
    a. Medical records related to the request;
    b. Prescription signed by a Practitioner; and
    c. If the request is for an enclosed bed, the Healthcare Common Procedure Coding System (HCPCS) code of the bed being requested and a picture of the bed if using miscellaneous HCPCS E1399.
7. The AdSS shall submit the requests to the Division in a timely manner to allow the Division, at minimum, seven business days, for review and response for standard service authorization requests, and two business days for expedited service authorization requests. Expedited requests must be clearly labeled as expedited.

7. The AdSS may request a peer-to-peer review with the Division Medical Director if there is a disagreement regarding a service authorization.

Signature of Chief Medical Officer: Anthony Dekker (Apr 28, 2023 11:33 PDT)
Anthony Dekker, D.O.

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

REVISION DATE: 8/4/2021, 10/28/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907, A.R.S. § 36-2907(B), 9 A. A.C. 34, A.A.C. R9-22-201 et seq., 42 CFR 438.210(b)(3), 42 CFR 438.406(a)(2)(i), Section F3, Contractor Chart of Deliverables, ACOM Policy 414, ACOM 438, AMPM Policy 1020

PURPOSE

The Division of Developmental Disabilities (Division) contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility of implementation of the Medical Management administrative requirements. The Division oversees the AdSS and ensures implementation and compliance of all requirements in this policy.

DEFINITIONS

Plan, Do, Study Act Method (PDSA) - 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 AdSS shall develop a written Medical Management Plan that describes the methodology used to meet or exceed the standards and requirements of its contract with the Division, and AdSS Medical Policy Manual Chapter 1000.

B. The AdSS shall submit the Medical Management Plan, and any subsequent modifications, to the Division for review and approval prior to implementation. Refer to AMPM Policy 1020.

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 AdSS' administrative structure for oversight of its Medical Management program as required by this policy, including the role and responsibilities of all of the following:

    a. The governing or policy-making body

    b. The Medical Management Committee

    c. The AdSS 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 AdSS Chief Medical Officer 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 and meet qualification required by this policy.

5. The AdSS' specific Medical Management goals and measurable objectives as required by AMPM Policy 1020.

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 AdSS' method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AMPM Policy 1020.

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 this policy.

9. Documentation of input into the medical coverage policies from the AdSS or affiliated 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 AdSS are 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 AMPM Policy 1020. 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 the Division after being reviewed and approved by the AdSS' 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 Section F3, Contractor Chart of Deliverables, for reporting requirements and timelines.

Medical Management Administrative Oversight

A. The AdSS Medical Management program shall be administered through a clear and appropriate administrative structure. The governing or policy-making body shall oversee and be accountable for the Medical Management program. AdSS shall ensure ongoing communication and collaboration between the Medical Management program and the other functional areas of the AdSS' organization (e.g., quality management, member and provider services).

B. The AdSS 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 or designated 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 shall have 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 shall be sufficient to demonstrate that the Medical Management Committee monitors all findings and required actions. At a minimum, the Medical Management Committee shall meet quarterly.

G. Medical Management Committee meeting minutes shall 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 the following:

1. The Medical Management responsibilities are clearly documented for each Medical Management function/activity.

2. The AdSS and their 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 AdSS and their 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 Division.

H. The Medical Management program shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in AdSS Medical Policy Manual Chapter 1000.

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 AdSS' 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 AdSS shall maintain records that document Medical Management activities, and it shall make the information available to the Division 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 AdSS shall have written policies and procedures pertaining to all of the following:

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 AdSS 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.

2. 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.

3. Per 42 CFR 438.406(a)(2)(i) qualified health care professionals, with appropriate clinical expertise in treating the member's 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.

4. 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

5. Decision-making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

6. 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%.

7. Prompt notifications to the requesting provider and the member/guardian/designated 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 Division's AdSS Operations Manual, ACOM Policy 414, and 9 A.A.C. 34.

O. The AdSS 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 AdSS shall oversee and maintain accountability for all functions or responsibilities described in AdSS Medical Policy Manual Chapter 1000 that are delegated to other entities. Documentation shall be kept on file for Division review, and the documentation shall demonstrate and confirm the following requirements have been met for all delegated functions:

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 AdSS shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement shall be submitted the contractor review checklist adopted by the Division and located in the AHCCCS Contractor Operations Manual. Refer to 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 AdSS 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, 10/1/2021, 8/4/2021
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. §38-211; A.A.C. R9-201, 42 CFR 435.1010, 438.3, 438.114(a), 438.210, 438.236, 438.240(b)(3), 447.26, 456.125; Section F3, 42 CFR Part 457, and 42 CFR Part 438, Contractor Chart of Deliverables; AMPM Policy 310, AMPM Attachment 1020-A, AMPM Attachment 1020-B

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines utilization management functions provided by the AdSS to ensure effective treatment services and coordination of care are furnished that achieve optimal outcomes for members. The policy also addresses how the AdSS identifies opportunities for improvement in utilization management.

DEFINITIONS

1. "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.

2. "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).

3. "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 [42 CFR 438.114(a)]; or

d. Serious physical harm to another individual (for behavioral health conditions)

4. "Health Care Acquired Condition (HCAC)" means a condition that 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.)

5. "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.

6. "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; or
   e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.
7. "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.

8. "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, or
   c. Wrong site surgery.

9. "Peer-Reviewed Study" means prior to publication, 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.

10. "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 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.

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. A.R.S. § 36-551.

12. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

13. "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 recovery and support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

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. "Subcontracted health plan" means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

16. "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.

17. "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 AdSS shall develop and implement policies and processes to collect, validate, analyze, monitor, and report the Division's enrollment utilization data.

2. On an ongoing basis, the AdSS' Medical Management (MM) Committee shall review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified specific to the Division enrolled members. Evaluation shall include a review of the impact to both service quality and outcome.

3. The MM Committee shall determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address overutilization and underutilization of services shall be integrated throughout the organization. All such strategies shall have measurable

outcomes that are reported in AdSS MM Committee minutes and shared at quarterly Division and AdSS meetings.

B. CONCURRENT REVIEW

1. The AdSS shall have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings.

2. The AdSS shall have procedures for review of medical necessity before a planned institutional admission (pre-certification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

3. The AdSS shall have policies and procedures for the concurrent review process that:
    a. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information shall include, but is not limited to symptoms, diagnostic test results, diagnoses, and required services.
    b. Specify timeframes and frequency for conducting concurrent review and decisions:

i. Authorization for institutional stays that shall have a specified date by which the need for continued stay shall be reviewed based on the expected course of the stay and medical necessity.

ii. Admission reviews shall be conducted within one business day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) (42 CFR 456.125).

c. Provide a process for review that includes, but is not limited to:

i. Necessity of admission and appropriateness of the service setting;

ii. Quality of care;

iii. Length of stay;

iv. Whether services meet the member needs;

v. Denials or reduction in the level of service;

vi. Discharge needs;

vii. Utilization pattern analysis;

viii. Establish a method for the AdSS' participation in the proactive discharge planning of all members in hospital, and institutional settings. The proactive discharge planning process shall demonstrate communication with the Division's support coordinator assigned to the member.

4. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
5. 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. When providing concurrent review, the AdSS shall compare the member's medical information against medical necessity criteria that describe the condition or service.
6. Initial institutional stays shall be based on the AdSS' adopted criteria, the member's specific condition, and the projected

discharge date. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay shall be assigned a next review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member's record.

7. Coordination shall include proactive discharge planning, starting within one day of admission, between all potential payment and care sources and shall continue after completion of the institutional stay.
8. AdSS shall submit the "Contractor Quarterly Showing Report for Inpatient Hospital Services" as specified in Contract.
9. Providers who request authorization for a service shall be notified of the option to request a peer-to-peer discussion with the appropriate AdSS health plan when additional information is requested or when the admission or continued stay is denied. Requests for peer-to-peer review and disposition of the request shall be clearly documented.

C. DISCHARGE PLANNING

1. The AdSS shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services with the Division's Support Coordination.

2. The AdSS shall furnish acute care services to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays while the Division shall furnish any HCBS/LTC services for the member.

3. The intent of the discharge planning policy and procedure is to increase the management of inpatient admissions, improve the coordination of post discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions.

4. The AdSS shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio psychosocial and medical needs of the

member in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

5. The AdSS shall conduct a proactive assessment of discharge needs before admission when feasible.

6. The AdSS 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 continued post discharge to ensure a timely, effective, safe, and appropriate discharge.

7. The AdSS staff participating in the discharge planning process 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,
    c. Is provided with resources, referrals, and possible interventions to meet the member’s assessed and

anticipated needs after discharge.

8. The AdSS shall allow:
    a. 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.
    b. Care management, intensive outpatient services, support coordination, and/or peer service are available to the member while waiting for the appropriate covered behavioral health service.
9. The support coordinator shall seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.
10. Discharge planning, coordination, and management of care shall include:
    a. Follow-up appointment with the PCP and/or specialist within 7 days;

b. Safe and clinically appropriate 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, TRBHA and other contractors 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 (within limits for outpatient physical/occupational therapy visits for members 21 years of age and older);

k. Referral to appropriate community resources;

l. Referral to AdSS' Disease Management or Care

Management (if needed);

m. A post discharge follow-up call to the member/responsible person within three business days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed clinical, behavioral, physical health, and social needs;

n. Proactive discharge planning when the AdSS is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The AdSS shall have an 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. PA is required in certain circumstances.

2. The AdSS shall develop and implement a system that includes at least two modes of delivery for providers to submit PA requests

such as telephone, fax, or electronically through a portal on the AdSS' website.

3. The AdSS shall ensure providers who request authorization for a service are notified that they have the option to request a peer-to-peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS shall coordinate the discussion with the requesting provider when appropriate.
4. The AdSS shall develop and implement policies and procedures, coverage criteria, and processes for approval of covered services, which include required time frames for authorization determination.
5. The AdSS shall have policies and procedures for approval of specified services that:
    a. Identify and communicate to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization shall also

be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS websites, and/or provider manuals. Changes in the coverage criteria shall be communicated to members, TRBHAs, and providers at least 30 days before implementation of the change;

b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria shall be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria shall be available to members upon request;

c. Authorize services in a sufficient amount, duration, and scope to achieve the purpose for which the services are furnished;

d. Ensure consistent application of review criteria by incorporating inter-rater reliability assessments;

e. Specify timeframes for responding to requests for initial

and continuous determinations for standard and expedited authorization requests as defined in, AdSS Operations Manual Policy 414, and 42 CFR 438.210;

f. Provide decisions and notice as expeditiously as the member's health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i);

g. Provide for consultation with the requesting provider when appropriate; and

h. Review all PA requirements for services, items, or medications annually. The review shall be reported through the MM Committee and shall include the rationale for changes made to PA requirements. A summary of the PA requirement changes and the rationale for those changes shall be documented in the MM Committee meeting minutes.

6. The AdSS shall develop and implement policies for processing

and making determinations for PA requests for medications.

7. The AdSS shall ensure the following:

   a. A decision to a submitted PA request for a medication is provided by telephone, fax, electronically, or other telecommunication device within 24 hours of receipt of the submitted request for PA;

   b. A request for additional information is sent to the prescriber by telephone, fax, electronically, or other telecommunication device within 24 hours of the submitted request when the PA request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request;

   c. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)].

8. The AdSS criteria for decisions on coverage and medical

necessity for both physical and behavioral services shall be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

9. The AdSS may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness, or condition of the member.

10. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.

11. The AdSS shall have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS' obligation to render a determination regarding coverage within the timeframes established in this policy.

E. INTER-RATER RELIABILITY

1. The AdSS shall have in place a process to ensure consistent application of review criteria in making medical necessity decisions that include prior authorization, concurrent review, and retrospective review. Inter-rater reliability (IRR) testing of all staff involved in these processes shall be done at orientation and at least annually thereafter. A corrective action plan shall be included for staff that do not meet the minimum compliance goal of 90%.

2. At least annually, the IRR testing results shall be presented to the MM Committee for review and approval.

3. At least annually and upon request, IRR testing results shall be provided to the Division.

F. RETROSPECTIVE REVIEW

1. The AdSS shall conduct a retrospective review, which is guided by policies and procedures that:

a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,

b. List services requiring retrospective review, and

c. Specify time frame(s) for completion of the review.

2. Criteria for decisions on medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

3. The AdSS shall have a process for consistent application of review criteria.

4. Guidelines for Provider-Preventable Conditions:

a. Title 42 CFR Section 447.26 prohibits payment for services related to Provider Preventable Conditions. Provider Preventable Condition means a condition that meets the definition ofHealth Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC);

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 shall 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 Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The AdSS shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:

   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;

   b. Consider the needs of people with intellectual/developmental disabilities (I/DD) who are

enrolled with the AdSS;

c. Are either:

i. Adopted in consultation with contracting health care professionals and National Practice Standards, or

ii. 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. Published peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

d. Are disseminated by the AdSS to all affected providers and, upon the request, to members/responsible person and potential members; and

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 CFR 438.236).

2. The AdSS 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.
3. The AdSS shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The AdSS shall develop and implement written policies and 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.
2. The AdSS shall have policies and procedures that include the

process and timeframe for making a clinical determination when a time sensitive request is made.

3. The AdSS shall make a decision in response to an expedited request as expeditiously as the member's condition warrants and not later than 72 hours from receipt of request.

4. 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.

5. The AdSS shall evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature shall also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

6. The AdSS shall establish:

   a. Coverage rules, practice guidelines, payment policies,

policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met;

b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received;

c. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.

I. MONITORING AND OVERSIGHT

1. The AdSS shall meet with the Division Health Care Services (HCS) quarterly to review the Medical Management Committee minutes, reports with data analysis and action plans, over and under utilization, outliers, and opportunities for performance improvement.

2. Annually the Division shall perform an Operational Review of the AdSS utilization process.

J. SUPPLEMENTAL INFORMATION

1. The AdSS are responsible for the administration of utilization management activities for all contracted services they provide to members served by the Division.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:48 MST)
Anthony Dekker, D.O.

1021 CARE MANAGEMENT

REVISION DATE: 8/30/2023
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 Administrative Services Subcontractors (AdSS) for provision of Care Management services and collaboration with the Division of Developmental Disabilities (Division) to improve health outcomes for Members eligible for ALTCS who may or may not have a chronic disease but have physical or behavioral health needs or risks that require immediate AdSS intervention.

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 plan of care 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 by the AdSS 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. "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.

6. "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.

7. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "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.

10. "Planning Team" means a group of people including the Member; 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.

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.

12. "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.

13. "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 (PCP).

14. "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.

15. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The AdSS shall have in place a Care Management process with the primary purpose of coordinating care and assisting in accessing resources for Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The AdSS shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, provider or the Division.

3. The AdSS shall provide Care Management that is designed to be short-term and time-limited in nature.

4. The AdSS 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.

5. The AdSS shall provide care coordination to ensure Members receive the necessary services to prevent or reduce an adverse health outcome.

6. The AdSS shall ensure that clinical resources and assessment tools utilized are evidenced-based.

7. 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.

8. The AdSS 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.

9. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and coordinating care.

10. The AdSS Care Management system shall automatically document the staff member's name and ID and the date and time the action or contact with the Member occurred.

11. The AdSS Care Management system shall also provide automatic prompts and reminders to follow-up with the Member as specified in the Member's care plan.

12. The AdSS shall provide Care Management at the contractor level as an administrative function. The AdSS shall receive prior approval from the Division if the AdSS intends to delegate a portion of Care Management functions.

13. The AdSS shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the Tribal Regional Behavioral Health

Authority (TRBHA) case manager.

14. Care Managers shall work closely with the case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

15. The AdSS shall develop Member selection criteria for the Care Management model to determine the service intensity or targeted interventions a Member may require to help achieve improved health outcomes and reduce risk and cost.

16. The AdSS 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.

17. The AdSS shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. CARE MANAGER RESPONSIBILITIES

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;

      iv. Social Determinants of Health (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 Care Management.

2. Care Managers shall work with the Support Coordinator, the provider case manager, AdSS tribal liaison, the Primary Care Physician (PCP) or specialist(s) 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 plan of care.

C. AdSS RESPONSIBILITIES

1. The AdSS shall establish policies and procedures that reflect integration of services to ensure 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 Division 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 AdSS, 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 AdSS is providing pertinent diagnoses and changes in condition to the PCP:

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 Member as part of AdSS 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 AdSS 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 for Members

already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the AdSS' provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensure access to appropriate services such as Medication Assisted Treatment (MAT) and peer support services;

2. The AdSS shall develop policies and implement procedures for Members with SHCN, as specified in the contract with the Division 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 AdSS shall implement measures to ensure that the Responsible Person 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 AdSS 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. The Care Manager shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS providers, and facilities throughout the continuum of services.

6. The Care Manager 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 AdSS.

7. The AdSS 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 AdSS 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 AdSS shall demonstrate proactive care coordination efforts for all Members awaiting admission to, or discharge from ASH.

10. The AdSS 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 AdSS shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The AdSS shall submit 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 the

Division.

13. The AdSS 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.

14. The AdSS shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

15. The AdSS 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.

16. The AdSS shall ensure Care Management interventions to educate Responsible Persons 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. Social Determinants of Health (SDOH) resources.

17. The AdSS shall submit AMPM Attachment 1021-A as specified in the contract with the Division, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

18. The AdSS shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

19. The AdSS 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.

20. The AdSS Chief Medical Officer shall be involved when Members experience a delay in discharge from institutional settings or the ED.
21. The AdSS shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with the Division.
22. The AdSS shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the MM Program workplan.
23. The AdSS shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.
24. The AdSS 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 the Division, utilizing AMPM Policy 1010 Attachment A and Attachment B.

25. The AdSS tribal liaison shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to enrolled American Indian and Alaskan Native Members.
26. The AdSS tribal liaison shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.
27. The AdSS shall meet with the Division HCS 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.
28. The AdSS shall coordinate with the Division's Behavioral Health Complex Care Specialist and Support Coordinator 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. HIGH NEEDS/HIGH COST (HNHC) PROGRAM

1. The AdSS shall identify, implement, and monitor interventions for providing appropriate and timely care to Members with high needs or high costs who have physical or behavioral health needs.
2. The AdSS shall collaborate with the Division HCS to coordinate care for Members enrolled in the High Needs/High Costs (HNHC) program who have physical or behavioral health needs.
3. The AdSS shall participate in care coordination or interdisciplinary team meetings at least monthly, or more often, as needed, to affect change and if needed to discuss barriers and outcomes.
4. The AdSS shall implement the following:
    a. Planning interventions for addressing appropriate and timely care for the identified Members.
    b. Specifying methodologies, inclusion criteria, interventions, and Member outcomes based on data analysis; and
    c. Utilizing additional criteria if the AdSS determines it necessary.

5. The AdSS shall submit an overview of the HNHC program, which shall include the requirements in section (D), in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A.
6. The AdSS shall submit 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.
7. The AdSS shall submit the High-Cost Behavioral Health Report on AMPM Attachment 1021-E as specified in the contract with the Division.
8. The AdSS Care Management program for HNHC Members shall incorporate a stratification approach to differentiate levels of Care Management provided based on factors such as:
    a. The severity of the conditions;
    b. Complexity of treatment coordination needs;
    c. Presence of co-occurring substance use or mental health conditions;
    d. Health or safety risks;

e. Inpatient or ED utilization;

f. Poly-Pharmacy;

g. Functional deficits; and

h. Involvement with other Member-serving systems.

9. The AdSS shall provide in their proposed stratification methodology the appropriate levels of Care Management necessary to ensure health, welfare and safety for Members and should consider such factors as:

   a. Caseload mix;

   b. Member acuity and coordination needs; and

   c. Care Manager qualifications, experience and responsibilities.

10. The AdSS shall ensure the Care Management program for High Need/High Cost Members has prior approval of the Division. Material changes to a Division-approved Care Management program must be approved in advance by the Division.

11. The AdSS shall develop and implement policies and procedures related to the AdSS Care Management program for HNHC

Members to ensure the active coordination of integrated physical and behavioral health services with Long Term Support Services (LTSS), in collaboration with the Support Coordinator for HNHC Members.

Signature of Chief Medical Officer: Anthony Dekker (Aug 22, 2023 10:01 PDT)
Anthony Dekker, D.O.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: January 18, 2023

REFERENCES: 42 CFR § 438.62(b); A.R.S.§ 36-551; AMPM 1022; AMPM 541

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop a process for justice system reach-in care coordination activities, to support facilitating transition of members who have chronic and/or complex care needs out of jails and prisons, into communities.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means a person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.
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 Case Management, Care Management does not include the day-to-day duties of service delivery.

3. "Justice System Liaison" for the purpose of this policy 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. This includes, but is not limited to, sequential intercept modeling, crisis system utilization, and

specialty court programs.

POLICY

A. JUSTICE REACH-IN

1. Administrative Services Subcontractors shall notify the Division's Justice System Liaison, upon becoming aware that a Division member has become an inmate of a public institution.

2. The AdSS shall assist the Justice System Liaison in reach-in care coordination efforts, for members who have been incarcerated for 20 days or longer and have an anticipated release date.

3. The AdSS shall establish care management protocols for members involved in reach-in care coordination, which include but are not limited to members who have substance abuse disorder and/or meet medical necessity criteria to receive Medication Assisted Treatment (MAT), as consistent with AMPM 1022.

4. The AdSS shall notify the Division upon becoming aware that the incarcerated member's enrollment has not been suspended

to allow the Division to adjust eligibility dates, based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division.

5. The AdSS shall also utilize the renewal date information to identify incarcerated members who may have missed their eligibility redetermination dates while incarcerated causing a discontinuance of benefits, and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

6. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) to provide care management to members

7. The AdSS shall begin reach-In care activities upon knowledge of a member's anticipated release date and shall include education regarding care, services, resources, appointment information, subcontracted provider and care management contact information.

8. The AdSS shall monitor progress and submit a monitoring

progress report throughout the year as specified in the current Contract.

Signature of Chief Medical Officer: Anthony Dekker (Feb 14, 2023 15:09 MST)

Anthony Dekker, D.O.

1023 DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. §36-551, AMPM 1023, Division Medical Manual Policy 1023

PURPOSE

This policy outlines the Administrative Services Subcontractors (AdSS) responsibilities for supporting the identification, early intervention and management of chronic diseases and conditions, and improving wellness and quality of life for Division of Developmental Disabilities (Division) members enrolled or eligible for the Division Disease/Chronic Care Management Program.

DEFINITIONS

1. "Disease/Chronic Condition Intervention Plan" means a protocol targeted at managing a disease/chronic condition and improving health outcomes.
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 client or an applicant for whom no guardian has been appointed A.R.S. §36-551.

3. "Person Centered Service Plan" is 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 (DCCMP) focuses on members with high need/high risk and/or chronic conditions to improve health outcomes. Member participation is voluntary. The AdSS shall work with support coordination and Health Care Services (HCS) to promote sustainable healthy outcomes, living well with chronic conditions, healthy lifestyles, coping and support strategies, and engagement in treatment for members.

The AdSS shall identify opportunities for improvement and

applications/enhancements to support network development, sustainability, and improved outcomes.

A. MEMBER IDENTIFICATION/REFERRAL

The AdSS shall identify members who may be eligible for the program including members who:

1. Have been diagnosed with a chronic medical condition and complex care needs, requiring care from a multidisciplinary team;

2. Are identified as at risk or experiencing poor health outcomes by a health assessment, diagnostics or other relevant medical testing;

3. Have 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. Have been diagnosed with post- Covid-19 condition(s); or

5. Have exhibited high or low utilization of services for high need conditions.

6. The AdSS shall use screenings and assessments to identify eligible members. These screenings and assessment may include, but not limited to, the following:

    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

7. The AdSS shall refer members who may be eligible and may benefit from the program to Support Coordination, and the HCS for enrollment.

B. ROLES AND RESPONSIBILITIES

The AdSS shall work collaboratively with the Division DCCMP, the member/ responsible person and Support Coordination to provide access, support and/or technical assistance to develop and implement an individualized Disease/Chronic Condition Intervention Plan. Activities may include but are not limited to:

1. Exchange of clinical, medical and administrative information to facilitate well-coordinated, interdisciplinary care and avoid unnecessary duplication.

2. Conducting a comprehensive health assessment to identify high risk behaviors or health concerns/issues.

3. Identification and access to:

    a. Evidence-based practices and individualized interventions/strategies.

    b. Health education, resources and support tailored to the member's needs including maternity care programs, services for pregnant members and family planning.

    c. Healthy living and wellness programs addressing health risk-reduction and healthy lifestyle choices.

d. Industry-leading tools, technology, and strategies that improve clinical and administrative outcomes and reduce unnecessary costs.

e. Self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/chronic conditions.

4. Regular engagement, ongoing support and technical assistance with the DCCM program/care team to support sustainability and continuity of care.

5. Collaboration, training, technical assistance and oversight with appropriate providers who are part of the care team to implement the member's program and desired outcomes.

6. Supporting continuity of care as part of plan implementation and discharge coordination/integration with the Support Coordination process and the person-centered service plan.

7. Ongoing monitoring to promote early identification of needed additional support and/or intervention to preserve and sustain outcomes.

8. Identification and implementation of provider network enhancements that support better health outcomes including, but not limited to, the following:

   a. Implementation of optimal clinical care pathways and interventions.

   b. Identification of increased opportunities to expand virtual care.

   c. Inclusion of self-help resources/programs including digital, web based and/or community resources designed to improve health and wellness for specific disease/chronic conditions.

   d. Education for providers regarding specific evidenced-based practices and successful interventions attributable to specific diseases and/or chronic conditions.

C. OVERSIGHT AND MONITORING

1. The AdSS shall meet with the HCS DCCMP Manager/Administrator at least quarterly to review performance metrics, successful interventions and

opportunities for improvement.

2. The AdSS shall monitor its provider network's compliance with the member DCCMP interventions and shall take appropriate corrective action for any noncompliance.

Signature of Chief Medical Officer: Anthony Dekker (Jul 11, 2022 14:00 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 and 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 AdSS's responsibility for developing and implementing a Drug Utilization Review (DUR) process that includes retrospective, concurrent and prospective drug utilization edits.

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, 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.

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 AdSS 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 AdSS 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 AdSS shall report the following to the Division:
    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 AdSS shall perform DUR to ensure that Members are receiving medications appropriately with limited adverse drug reactions.

3. The AdSS shall perform DUR that consists of retrospective, concurrent and prospective DUR.

4. The AdSS shall use Arizona Health Care Cost Containment System (AHCCCS) Prior Authorization (PA) clinical guidelines.

5. The AdSS shall base opioid monitoring per Federal regulations.

B. CONCURRENT UTILIZATION REVIEW

1. The AdSS shall implement a concurrent DUR process that occurs between the pharmacies and Pharmacy Benefits Manager's (PBM) electronic DUR system at the Point of Sale (POS).

2. The AdSS shall provide 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 AdSS shall implement a retrospective DUR process to detect aberrant prescribing practice patterns, pharmacy dispensing patterns and medication administration patterns to prevent inappropriate use, misuse, or Waste.

2. The AdSS shall perform retrospective utilization reviews 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 AdSS shall implement a prospective DUR process that promotes positive health outcomes using PA to ensure clinically effective medications are prescribed in the most cost-efficient manner.

2. The AdSS shall require the PBM to enable prospective DUR edits during the adjudication of a claim 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 AdSS shall utilize the AHCCCS PA guidelines for any medications that require PA, have quantity limits or step therapy requirements or are non-preferred medications.

F. PROVIDER EDUCATIONAL INTERVENTIONS

The AdSS shall have 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 AdSS shall report Members assigned to an Exclusive Pharmacy or Exclusive Provider, or both on form AMPM 1024 Attachment A.

2. The AdSS shall provide AMPM 1024 Attachment A to the Division as a quarterly deliverable when aberrant pharmacy or aberrant provider utilization is identified.

H. OPIOID UTILIZATION

1. The AdSS shall perform DUR activities as part of Federal Opioid Legislation, and report to the Division 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 AdSS shall exclude Members with a diagnosis of cancer, in hospice or palliative care from opioid safety edits and utilization

management limitations associated with opioids.

Signature of Chief Medical Officer: Anthony Dekker (Mar 21, 2024 09:29 PDT)

Anthony Dekker, D.O.

1040 OUTREACH, ENGAGEMENT, AND RE-ENGAGEMENT FOR BEHAVIORAL HEALTH

EFFECTIVE DATE: October 28, 2020
REFERENCES: AMPM Policy 320-R, AMPM Policy 320-U

Overview

This policy establishes requirements of the Division of Developmental Disabilities (Division) for the outreach, engagement, and reengagement activities for members seeking and receiving behavioral health services by each Administrative Services Subcontractor (AdSS).Each AdSS must develop and make 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 AdSS 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 AdSS will provide and participate 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 AdSS 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. Development of outreach programs to members experiencing homelessness;

F. Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;

G. Publication and distribution of informational materials;

H. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs;

I. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers;

J. 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;

K. Provision of information to behavioral health advocacy organizations; and

L. 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 AdSS 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 AdSS must 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. 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 re-engage 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 AdSS must ensure activities are documented in the member's case file and follow-up activities are conducted to maintain engagement within the following timeframes.

The Division has District Nurses available to assist 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.

1050 RESERVED

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 01, 2019

1060 RESERVED

REVISION DATE: 10/28/2020
EFFECTIVE DATE: October 1, 2019

1210 INSTITUTIONAL SERVICES AND SETTINGS

EFFECTIVE DATE: October 1, 2019

This policy applies to AdSS and its contractors. 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 include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), Inpatient Behavioral Health Residential Treatment Facilities and Nursing Facility (NF) Services.

AdSS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. For purposes of this Service Specification, the term "Contractor" refers to the facility.

Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

Nursing Facility

See Chapter 310-R of this manual regarding acute NF Services for members who are ALTCS eligible and members in the ALTCS transitional program.

Service Description and Goals

This service provides habilitative 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

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.

Contractor Requirements

The Contractor must:

A. Be licensed and certified by the appropriate Arizona state agencies.

B. 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. 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.

E. Provide all services in a culturally relevant and linguistically appropriate manner for the population to be served.

F. Provide services to members who meet the eligibility requirements for such services as determined by the AdSS and who have been evaluated and placed by the AdSS in coordination with the Division.

G. Provide a healthy, safe, and clean environment that meets the medical, physical, and emotional needs of the member.

H. Provide services, equipment, and supplies as specified in A.A.C. R9-28-204(B), as may be amended.

I. Responsible for coordinating the delivery of the auxiliary services specified in A.A.C. R9-28-204(C), as may be amended.

J. Maintain a complete file for each member that includes physician's orders, care plans, treatment records, medication records, evaluations and assessments, progress reports and any other needed documentation. The member's file must be made available to the AdSS immediately, or as specified by the Division.

K. Ensure that a PASRR Level I assessment is completed on members prior to admission and whenever a significant change in the physical or mental status of the member occurs.

1. Failure to have the proper PASRR screening on file, prior to placement of a member in a Skilled Nursing Facility may result in federal financial participation (FFP) withheld from AHCCCS. If withholding of FFP occurs, the Division will recoup the withheld amount from the AdSS's subsequent capitation payment. The AdSS may, at its option, recoup the withholding from the Contractor that admitted the member without the proper PASRR.

2. Ensure that the completed PASRR Level I is maintained in the member's file, and appropriate referrals made, as needed.

3. If there are indications that a member may have a cognitive/intellectual disability or a related diagnosis, forward the completed PASRR Level I and all supporting documentation, including Minimum Data Set (MDS), health and progress notes, assessments, or other supporting documentation to the AdSS, who is responsible to forward the submitted documents to the Division's Health Care Services Representative (i.e., the PASRR Coordinator). The Division is responsible for completing PASRR Level II reviews.

L. PASRR Level II reviews must occur for each member whose expected stay in the Skilled Nursing Facility will exceed 90 days.

1. If the results of a PASRR Level II review indicate there is a change in the member's condition, ensure:

    a. Recommendations are followed,

    b. Appropriate referrals are made, as needed, and

    c. The Division's Health Care Services representative (e.g., the PASRR Coordinator) is contacted for prior approval before billing a different level of care.

    d. Ensure that any subsequent documentation (e.g., PASRR Level II) is maintained in the member's file.

M. Complete a quarterly review of the member to assess key indicators or resident status and revise the plan of care as necessary.

N. Conduct a reassessment within one year or whenever there is a significant change in the member's status.

O. Provide medical, physical, and emotional care and supervision as follows:

1. Provide nursing care treatment as indicated in the prescribed care plan. The care plan must be specific to the member and be available immediately or as specified by the AdSS.

2. Provide dietary management, including the preparation and administration of special diets and adaptive mealtime equipment.

3. Provide access to dental care and treatment, in accordance with Chapter 300 of the Division's Medical Policy Manual.

4. Provide access to podiatric care and treatment, in accordance with Chapter 300 of the Division's Medical Policy Manual.

5. Provide activities (e.g., therapeutic, vocational), recreational services, and spiritual services in accordance with the member's preference.

6. Provide coordination of services to the member from various agencies, as appropriate. Maintain records of interactions with other agencies or service providers relative to the member.

7. Participate in the development and review of the member's planning document (e.g., Individual Support Plan, Individualized Family Services Plan).

8. Participate in discharge planning following the process specified in the Division's Policy Manuals, as may be amended.

9. Provide an outcome measurement system whereby the member/member's representative can provide feedback regarding satisfaction with the performance of the Contractor. The outcome measurement system must be made available to the AdSS upon request.

P. Provide Progress Reports on the member's planning document (e.g., ISP) objectives every thirty (30) days to the designated Support Coordinator

Contractor Qualifications

A. Skilled Nursing Facility(s) must be licensed by the Arizona Department of Health Services (ADHS) and Medicare/Medicaid certified in accordance with 42 C.F.R. § 483, as may be amended.

B. Skilled Nursing Facility(s) must be is licensed, certified, and monitored in accordance with A.R.S. Title 6, Chapter 4, as may be amended.

C. Skilled Nursing Facility(s) must be registered with AHCCCS to provide this service for that portion of the facility subject to Title XIX (Medicaid) reimbursement.

D. Comply with all applicable federal and state laws relating to professional conditions, standards and requirements for nursing facilities, and all health, safety and physical plant requirements established by federal and state laws.

E. Have procedures that ensure temporary nursing care registry personnel, including Nurses' Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R. § 483.75(e)3 and (g)2 and fingerprinted as required by A.R.S. § 36-411, as may be amended.

F. Maintain on-site files that document appropriate licenses and inspections. Files must be made available to the AdSS immediately upon request or as specified by the AdSS.

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 and a less restrictive level of care is not aviable in a home and community case service setting as determined by the member's planning team.

B. The AdSS must contact the Division by Day 45 of a member's acute NF placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in this chapter, the AdSS must obtain approval from the Division. The Division will use an acuity tool will determine the level of institutional placement prior to placement. If the Primary Care Provider (PCP) or the Division 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.

C. 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.

Reassessment for Continued Placement

A. Members residing in an NF must be reassessed by the AdSS 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 by the AdSS when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met and alternative placement has been identified. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to allow the support coordinator 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 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.

NF Contract Termination

If the AdSS places an NF on termination status:

A. No new members will be admitted to the NF.

B. 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 include the Division's support coordinator and must identify contracted residential alternatives that are available to the member.

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.

1240-D EMERGENCY ALERT SYSTEM

REVISION DATE: 02/22/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM 1240-D; Division Medical Policy 1240-D

PURPOSE

This policy establishes the requirements for Administrative Services Subcontractors (AdSS) in the management of Emergency Alert Systems for Members enrolled in AdSS health plans.

DEFINITIONS

1. "Emergency Alert System" or "EAS" means a service that provides monitoring devices or systems for members who are unable to access assistance in an emergency 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 the same as "client" as defined in A.R.S. § 36-551.

POLICY

A. The AdSS shall offer and make available EAS to 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 or available emergency assistance on a 24-hour basis;
3. The assessment of the Member's medical or functional level documents an acute or chronic medical condition;
4. The primary care provider has prescribed the EAS;
5. The Member has the ability to use and operate the system; and
6. If the Member lives in an alternative HCBS setting, the need is justified by the Member's support coordinator.

Signature of Chief Medical Officer: Anthony Dekker (Feb 15, 2023 12:14 MST)
Anthony Dekker, D.O.

1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS AMPM 310-X, Attachment A

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division covers occupational, physical, respiratory and speech therapy services that are ordered by a Primary Care Provider (PCP), approved by the Division or AdSS, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this policy. The AdSS is responsible for providing rehabilitative therapy and habilitative physical therapy services for members Age 21 and older.

Members residing in their own home, and HCB approved alternative residential setting or an institutional setting may receive physical, occupational and speech therapies through a licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational, or speech therapist in independent practice, as applicable.

Services require a PCP or attending physician's order and must be included in the member's record. The record must be reviewed at least every 62 days (bi-monthly) by the member's PCP or attending physician.

Therapy services must be prescribed by the member's PCP or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member's physician for reasonable and necessary treatment of a member's illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposed of the Policy, reasonable and necessary means:

A. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member's condition.

B. Based on the amount, frequency, and duration of the services must be reasonable.

Developmental/Restorative Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member's illness or injury. If the member's expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.

Maintenance Program

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member's condition has been assessed, and the member's caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Division Medical Manual Chapter 300 for additional information regarding therapy services.

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 these 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 use direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical and Speech Therapy

Therapy Descriptions (Occupational, Physical and Speech)

A. Physical Therapy

The Division covers inpatient and outpatient Physical Therapy (PT) services to members eligible for the Division and ALTCS. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members. Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

B. Occupational Therapy

The Division covers inpatient and outpatient occupational therapy for members eligible for the Division and ALTCS to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process.

C. Speech Therapy

The Division covers inpatient and outpatient speech therapy services including evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with 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

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.

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

E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy must 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

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:

A. Limits as specified in AHCCCS AMPM 310-X, Attachment A – AHCCCS Adult Member (Persons Age 21 and Older) Therapy Benefit Table

B. Therapy for educational purposes.

Respiratory Therapy

The Division covers respiratory care services prescribed by a PCP or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

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.

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 must 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, 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 AdSS 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

9. Giving instruction on the use and care of special equipment to the member 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 must 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) must 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 must review the plan of care at least every 60 days.

C. The provider must submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in any of 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.

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 must collaborate with other service providers and agencies involved with the member.