1021 CARE MANAGEMENT

REVISION DATE: MM/DD/YYYY
EFFECTIVE DATE: July 20, 2022
REFERENCES: A.R.S. § 13-3994; A.R.S. § 31-501; A.R.S. §§ 36-551; A.R.S. § 38-211; 42 CFR 438.100(a)(1); 42 CFR 438.100(b)(2)(vi); 42 CFR 438.208(b)(2)(ii) and (iii); 42 CFR 438.208(b)(2)(iv); 42 CFR 457.1220; 42 CFR 457.1230(c); 45 CFR Part 160 and 164; AMPM 310-HH; AMPM 520; AMPM 570; AMPM 580; AMPM 940; AMPM 1010; AMPM 1021; AMPM 1620; ACOM 438.

PURPOSE

This policy sets forth roles and responsibilities of the Division of Developmental Disabilities (Division)for provision of Care Management services and collaboration with Support Coordination to improve health outcomes for Tribal Health Program (THP) Members who have physical or behavioral health needs or risks that require immediate Division intervention. This policy provides information on the Division's monitoring and oversight of the Administrative Services Subcontractors (AdSS) Care Management and High Needs/High Cost (HNHC) programs. The policy also provides details of the Divisions responsibilities for the High Needs/High Cost program.

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DEFINITIONS

1. "Advance Care Planning" means a part of the End-of-Life Care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:
   a. Educate the member about their illness and the health care options that are available to them.
   b. Share the member's wishes with family, friends, and his or her physicians.
   c. Develop a written care plan ~~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 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

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Coordination, Care Management does not include the day-to-day duties of service delivery.

4. "Care Manager" means someone who provides Care Management services.

5. "Division Tribal Team" means for the purpose of this policy, the Tribal Liaison (Tribal Social Service referrals), Tribal Health Coordinator (general healthcare navigation inquires) and the Tribal RN Liaison (referrals to IHS 638 facilities programs), depending on the service need.

6. "End-of-Life Care" means a concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex, or terminal illness.

7. "Informal Supports" means non-billable services provided to a member by a family member, friend, or volunteer to assist or perform functions such as:

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a. Housekeeping,

b. Personal care,

c. Food preparation,

d. Shopping,

e. Pet care, or

f. Non-medical comfort measures.

8. "Medication Assisted Treatment" or "MAT" means the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

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

10. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the Services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

11. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of

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Arizona Department of Economic Security staff, as necessary; and any person selected by the Member; Responsible Person; or the Department.

12. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

13. "Social Determinants of Health" or "SDOH" means the social, environmental, and economic factors that can influence health status and have an impact on health outcomes.

14. "Special Health Care Needs (SHCN)" means serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally, that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

15. "Support Coordination" means a collaborative process which

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assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

16. "Support Coordinator" means the same as "case manager" under A.R.S. § 36-551.

POLICY

A. COMPONENTS OF CARE MANAGEMENT

1. The Division shall have in place a Care Management process with the primary purpose of coordinating care and assisting in accessing resources for ALTCS eligible Members with multiple or complex conditions and who require intensive physical, or behavioral health support services.

2. The Division shall ensure the AdSS provides Care Management for members enrolled with the AdSS.

3. The Division shall provide Care Management for members enrolled with the Tribal Health Program.

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4. The Division shall have multiple methods for referring a Member to Care Management, including referrals from the Member or Responsible Person, internal sources, or provider.

5. The Division shall provide Care Management that is designed to be short-term and time-limited in nature.

6. The Division shall require the following Care Management services:
    a. Assistance in making and keeping needed physical or behavioral health appointments;
    b. Following up and explaining hospital discharge instructions;
    c. Health coaching and referrals related to the Member's immediate needs;
    d. Primary Care Provider (PCP) reconnection; and
    e. Offering other resources or materials related to wellness, lifestyle, and prevention.

7. The Division shall provide care coordination to ensure Members receive the necessary services to prevent or reduce an adverse

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health outcome.

8. The Division shall ensure that clinical resources and assessment tools utilized are evidenced-based.

9. Care Managers shall establish a process to ensure coordination of Member physical and behavioral health care needs across the continuum, based on early identification of health risk factors or Special Health Care Needs (SHCN) consistent with the Planning Document.

10. The Division shall ensure the coordination ensures provision of physical and behavioral services in any setting that meets the Member's needs in the most cost-effective manner available.

11. Care Managers shall be expected to have direct contact with Members for the purpose of providing information and coordinating care.

12. The Division shall implement a Care Management system that ~~The Division's Care Management system shall~~ automatically documents the staff member's name and ID and the date and

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time the action or contact with the member occurred.

13. The Division shall implement a Care Management system ~~The Division's Care Management system shall also~~ that provides automatic prompts and reminders to follow-up with the member as specified in the member's care plan.

14. The Division shall provide Care Management as an administrative function.

15. The Division shall obtain approval by the Arizona Health Care Cost Containment System (AHCCCS) prior to delegating a portion of the Care Management functions to another entity.

16. The Division shall ensure the Care Managers are not performing the day-to-day duties of the Division Support Coordinator, the provider case manager, or the TRBHA case manager.

17. Care Managers shall work closely with case managers referred to in this section, to ensure the most appropriate service plan and services for Members.

18. The Division shall identify and refer members that meet criteria

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for Care Management services, including:

a. Frequent use of the Emergency Department instead of seeing providers for ongoing issues (4 or more occurrences within the past 6 months);

b. Multiple physical or behavioral health hospitalizations (3 or more inpatient or readmissions within the past 6 months);

c. Discharged from an inpatient or skilled facility and requires coordination of post-acute services;

d. Missed 3 or more physical or behavioral health appointments within the past 3 months;

e. Having difficulty obtaining medical benefits or referrals ordered by providers;

f. Diagnosed with heart failure, diabetes, asthma, chronic obstructive pulmonary disease, or depression and requires assistance with management of the condition;

g. In the process of receiving a transplant or up to one year post-transplant;

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h. Diagnosed with Human Immunodeficiency Virus (HIV);

i. Pregnant;

j. Diagnosed with a behavioral health disorder, the condition is not stable and requires assistance with management of the condition;

k. Needs exclusive provider restriction for overutilization of drugs with abuse potential;

l. Needs referral to or is currently receiving Medication Assisted Treatment (MAT) for opioid use;

m. Has Social Determinants Of Health (SDOH) needs that are impacting member's ability to obtain the appropriate care (e.g., basic needs not being met, safety issues in home environment, etc.);

n. Survivor of sex trafficking;

o. Recently been incarcerated or is transitioning out of jail or prison within the next 30 days;

p. Needs out of state services;

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q. Requires assistance with Tribal Nations or providers;

r. Is a child with one or more of the following:

i. Newborn with neonatal abstinence syndrome or maternal drug exposure,

ii. Child and Adolescent Level of Care Utilization System (CALOCUS) level 4 or higher,

iii. Serious emotional disturbance,

iv. Recently removed from their home and placed in foster care.

s. Have multiple complaints regarding services or the Arizona Health Care Cost Containment System (AHCCCS) Program. This includes members who do not otherwise meet the Division criteria for Care Management as well as members who contact governmental entities for assistance, including AHCCCS.

19. The Division shall integrate data from medical and behavioral health claims or encounters, pharmacy claims, laboratory

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results, Health Risk Assessments (HRA)s, Electronic Medical Records (EMRs), health services programs within the organization, or other advanced data sources to develop the selection criteria.

20. The Division shall stratify Members for Care Management for targeted interventions, on at least an annual basis.

B. DIVISION CARE MANAGEMENT RESPONSIBILITIES FOR THP MEMBERS

1. Care Managers shall comprehensively assess the Member and develop and implement a care plan that has the following:
   a. Initial assessment of Members:
      i. Health status;
      ii. Physical and behavioral health history, including medications and cognitive function;
      iii. Activities of daily living; and
      iv. SDOH.
   b. Life planning activities, including wills, living wills, advance directives, health care powers of attorney, End-of-Life Care

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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

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of the Care Management plan.

2. Care Managers shall work with the Support Coordinator, the provider case manager, Division Tribal Team, the Primary Care Physician (PCP) or specialists to coordinate and address Member needs within 30 days after the member has been determined eligible to receive Care Management.

3. Care Managers shall continuously document interventions and changes in the care plan ~~plan of care~~.

C. DIVISION RESPONSIBILITIES

1. The Division shall ensure integration of services and continuity of care by:

   a. Ensuring that in the process of coordinating care, each Member's privacy is protected in accordance with the privacy requirements including those specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi);

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b. Allowing Member choice in selecting a PCP, TRBHA or a behavioral health provider who is formally designated as having primary responsibility for coordinating the member's overall health care.

c. Ensuring access to care that is appropriate to their individual needs as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

d. Ensuring each Member receiving care coordination has an individual or entity that is formally designated as primarily responsible for coordinating services for the Member, such as the Support Coordinator, the provider case manager, or TRBHA case manager;

e. Ensuring the Care Manager provides the Responsible Person with information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1);

f. Specifying under what circumstances services are coordinated by the Division, including the methods for

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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;

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k. Ensuring Care Managers establish timely and confidential communication of data and clinical information among providers that includes:

i. The coordination of Member care among the PCP, AdSS, and tribal entities;

ii. Working with the PCP to communicate all known primary diagnoses, comorbidities, and changes in condition to the Division or FFS provider and Tribal provider to include TRBHA when the PCP becomes aware of the Division, or TRBHA involvement in care.

l. Ensuring that the PCP ~~Division~~ is providing pertinent diagnoses and changes in condition to the Division ~~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

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ensure that the exchange occurs;

n. Ensuring Care Managers provide consultation to a Member's inpatient and outpatient treatment team and directly engages the Responsible Person as part of Division Care Management;

o. Ensuring individuals admitted to a hospital who are identified as in need of behavioral health services, are responded to as specified below:

i. Upon notification of an individual who is not currently receiving behavioral health services, the Division shall ensure a referral is made to a provider agency within 24 hours.

p. Ensuring that provider agencies attempt to initiate services with the individual within 24 hours of referral and that the provider agency schedules additional appointments and services with the individual prior to discharge from the hospital;

q. Ensuring coordination, transition, and discharge planning

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activities are completed consistent with providers orders to ensure cost effectiveness and quality of care consistent with providers orders to ensure cost effectiveness and quality of care for Members already receiving behavioral health services;

r. Ensuring policies reflect care coordination for Members presenting for care outside of the Division's provider network;

s. Identifying and coordinating care for Members with Substance Use Disorder (SUD) and ensuringe access to appropriate services such as Medication Assisted Treatment (MAT) and peer support services.

2. The Division shall develop policies and implement procedures for Members with SHCN, as specified in the contract with AHCCCS and AMPM Policy 520, including:

a. Identifying Members with SHCN;

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each Member;

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c. Ensuring adequate care coordination among providers or TRBHAs;

d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the Member's condition and identified needs (e.g., a standing referral or an approved number of visits); and

e. Additional care coordination activities based on the needs of the Member.

3. The Division shall implement measures to ensure that the Responsible Person is involved in Care Management:

a. Is informed of particular health care conditions that require follow-up;

b. Receives, as appropriate, training in self-care and other measures they may take to promote their own health; and

c. Is informed of their responsibility to comply with prescribed treatments or regimens.

4. The Division Care Management shall focus on achieving Member wellness and autonomy through:

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a. Advocacy,
b. Communication,
c. Education,
d. Identification of service resources, and
e. Service facilitation.

5. Care Managers shall also assist the Responsible Person in identifying appropriate providers, TRBHAs, or other FFS providers, and facilities throughout the continuum of services.

6. Care Managers shall ensure that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the Member and the Division.

7. The Division shall proactively provide care coordination for Members who have multiple complaints regarding services or the AHCCCS Program. This includes Members who do not otherwise meet the Division criteria for Care Management, as well as Members who contact governmental entities for assistance, including AHCCCS.

8. The Division shall report its monitoring of Members awaiting

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admission and those Members who are discharge-ready from Arizona State Hospital (ASH) utilizing the Arizona State Hospital Admission and Discharge Deliverable Template.

9. The Division shall demonstrate proactive care coordination efforts for all Members awaiting admission to, or discharge from ASH.

10. The Division's Health Care Services Complex Care team shall coordinate with ASH for discharge planning, including ensuring the Member with diabetes has appropriate diabetic monitoring equipment and supplies, and has been educated and trained to the use prior to discharge.

11. The Division shall not limit discharge coordination and placement activities based on pending eligibility for ALTCS.

12. The Division shall submit the following, in the case that a THP Member has been awaiting admission to, or discharge from ASH for an excess of 90 days:

    a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and

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b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.

13. The Division shall provide the AMPM 1021 Attachments A, B and E as specified in the contract with AHCCCS.

14. The Division shall arrange ongoing medically necessary nursing services consistent with providers orders to ensure cost effectiveness and quality of care in the event that a Member's mental status renders themself incapable or unwilling to manage their medical condition and the Member has a skilled medical need.

15. The Division shall identify, track and report Members who utilize Emergency Department (ED) services inappropriately four or more times within a six-month period.

16. The Division shall implement interventions to educate the Responsible Person on appropriate use of ED and divert Members to the right care in the appropriate place of service.

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17. The Division shall ensure Care Management interventions to educate Responsible Person include:
    a. Outreach phone calls or visits,
    b. Educational letters,
    c. Behavioral health referrals,
    d. HNHC program referrals,
    e. Disease or chronic Care Management referrals,
    f. Exclusive pharmacy referrals, or
    g. SDOH resources.

18. HCS shall submit AMPM Attachment 1021-A as specified in the contract with AHCCCS, identifying the number of times the AdSS intervenes with Members utilizing the ED inappropriately.

19. The Division shall monitor the length of time Members remain in the ED while awaiting behavioral health placement or wrap-around services.

20. The Division shall coordinate care with the ED and the Member's treatment team to discharge the Member to the most appropriate placement or wrap-around services immediately

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upon notification that a Member who requires behavioral health placement or wrap-around services is in the ED.

21. The Division's Chief Medical Officer shall be involved when THP members experience a delay in discharge from institutional settings or the ED.

22. The Division shall submit the 24 Hours Post Medical Clearance ED Report utilizing Attachment B to the Division as specified in the contract with AHCCCS.

23. The Division shall develop a plan specifying short-term and long-term strategies for improving care coordination and Care Management as specified in the Medical Management (MM) Program workplan.

24. The Division shall develop an outcome measurement plan to track the progress of the strategies in the MM Program workplan.

25. The Division shall report the plan specifying the strategies for improving care coordination and the outcome measurement in the annual MM Program Plan, and submitted as specified in the

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contract with AHCCCS, utilizing AMPM Policy 1010 Attachment A and Attachment B.

26. The Division Tribal Team shall facilitate the promotion of services and programs to improve the quality and accessibility of health care to eligible American Indian and Alaskan Native Members.

27. The Division Tribal Team shall collaborate with Care Management to ensure communication with all tribal programs are actively engaged in the Member's care coordination process.

28. The Division's Behavioral Health Complex Care Specialist and Support Coordinator shall coordinate with the AdSS to provide assistance with care coordination for Members who are awaiting placement into ASH by communicating with the Responsible Person, Support Coordinator, facilities, providers, and ASH.

D. DIVISION MONITORING AND OVERSIGHT

1. The Division shall ensure the AdSS provides the following, in the case that a Member has been awaiting admission to, or

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discharge from ASH for an excess of 90 days:

a. A barrier analysis report to include findings, performance improvement activities and implementation plan; and

b. A status report for each member who is continuing to await admission or discharge, as specified in the contract with AHCCCS.

2. The Division shall review the deliverables received from the AdSS and submit the following reports to AHCCCS:

a. Barrier analysis report,

b. Status report for each member awaiting admission or discharge.

3. The Division shall ensure the AdSS provides the AMPM 1021 Attachments A, B and E as specified in the contract.

4. The Division shall review AMPM 1021 Attachments A, B and E provided by the AdSS prior to sending to AHCCCS.

5. The Division HCS shall meet with the AdSS at least quarterly to provide ongoing evaluation including data analysis and

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recommendations to refine processes to optimize results.

6. The Division HCS shall meet with the AdSS quarterly to review the AdSS Medical Management Committee minutes, reports with data analysis and action plans, over and under-utilization, outliers, and opportunities for performance improvement.

7. The Division shall ensure the AdSS submit an overview of the Medical Management (MM) program plan checklist ~~High Needs/High Cost (HNHC) program in the Medical Management (MM Program Plan,~~ AMPM 1010 Attachment A and a MM workplan, AMPM 1010 Attachment B.~~, which includes the below requirements.~~

~~8. The Division 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.~~

1. The Division shall monitor the overall performance of Care Management services including:

   a. Tracking and trending performance metrics and outcomes,

   b. Data analysis,

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c. Identifying successful interventions and care pathways to optimize results, and

a. Making recommendations to refine processes and provide reports to the Division Medical Management Committee.

2. The Division shall perform an Operational Review of the AdSS to review compliance on an annual basis.

3. The Division shall develop a plan specifying short and long term strategies for improving care coordination and the Care Management program as specified in the MM Program workplan.

E. DIVISION RESPONSIBILITIES FOR THE HIGH NEEDS/HIGH COST PROGRAM

1. Health Care Services (HCS) shall annually review the list of Members from each AdSS that are identified as meeting the criteria for the HNHC program and approve Members to be monitored through the HNHC program. This is also to be done by HCS upon the AdSS proposing changes to the list.

2. HCS shall request additional Members identified by the Division

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to be added to the HNHC program when Members have high needs or high costs due to Long Term Services and Supports (LTSS) who also have high medical or behavioral needs.

3. The Division shall submit to AHCCCS an overview of the HNHC program in the Medical Management (MM) Program Plan submission, AMPM Attachment 1010-A as outlined in the contract.

4. The Division shall submit to AHCCCS counts of distinct members that are considered to have high cost behavioral health needs based on criteria developed by the AdSS and approved by the Division as outlined in the contract.

5. The Complex Care Manager shall annually review the High Cost Behavioral Health Reports (AMPM 1021 Attachment E) that the AdSS sends to the Compliance Unit, which is then forwarded to HCS.

6. The Complex Care Manager shall annually develop and submit an integrated High Cost Behavioral Health Report (AMPM 1021 Attachment E) reflecting data received from each AdSS to AHCCCS.

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7. The Complex Care Manager shall annually send the High Cost Behavioral Health Report (AMPM 1021 Attachment E) to DDDAHCCCSDeliverables@azdes.gov.

8. HCS shall coordinate with the AdSS to ensure the assigned Support Coordinator and Behavioral Health Complex Care Specialist are invited to the monthly HNHC meetings.

9. The HCS Complex Care Nurse, assigned Support Coordinators and Behavioral Health Complex Care Specialists shall attend the monthly HNHC meeting to participate in the collaborative care coordination between the Division, AdSS, Care Manager, and provider case manager.

10. All attendees shall discuss the following care coordination activities during the monthly HNHC meetings:

a. Identify Member specific interventions to be used to ensure:

i. Relevant and timely access to care;

ii. Care plan goals address the needs of the program

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iii. Ineffective medical, behavioral health, and long-term care interventions are adjusted as needed; and

~~i.~~iv. Progress toward treatment goals is being achieved.

b. Address barriers to improvement, additional resources needed, and changes to treatment goals in the following areas:

i. Medical,

ii. Environmental,

iii. Behavioral Health, and

iv. Psychosocial.

11. The HCS Complex Care Nurse in collaboration with the AdSS, shall monitor Member outcomes to transition Members out of the HNHC program when they meet the following criteria:

a. The Member has met treatment goals, or

b. The Member's physical and behavioral needs have been stabilized, or

~~11.~~c. The Member no longer meets the AdSS HNHC criteria.

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595 Signature of Chief Medical Officer:

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