TITLE Care Management	POLICY NUMBER HS-CC-02
RESPONSIBLE AREA Health Coordination and System of Care	EFFECTIVE DATE 08/31/2023
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STATEMENT/PURPOSE

This policy outlines DCS CHP procedures for early identification of health risk factors and members requiring assistance to ensure the provision of appropriate and timely coordination of care.

AUTHORITY

A.R.S. § 8-512, Comprehensive medical and dental care; guidelines.

A.R.S. § 8-514.05, Foster care provider and department access to child health information; consent to treatment.

A.A.C. R9-22-509, Transition and Coordination of Member Care

The Intergovernmental Agreement (IGA) between Arizona Health Care Cost Containment System (AHCCCS) and Arizona Department of Child Safety (DCS) for the Comprehensive Health Plan (CHP) outlines health plan operational requirements.

The contract between the Department of Child Safety (DCS) for the Comprehensive Health Plan (CHP) and its Managed Care Organization (MCO) contractor outlines the contractual requirements for compliance with continuity and quality of care coordination for all members.

DEFINITIONS

Care Coordination: Actions taken to ensure a member receives needed health care without interruption, such as assistance in obtaining care from practitioners and providers in various organizations or across a period of time. Care Management associates establish specific goals that can be reached with minimal member outreach. Typical methods of communication are by mail, telephone, and email.

Care Management: 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 care outcomes. Distinct from case management, Care Management does not include the day-to-day duties of service delivery.

Care Plan: A documented description of physical health services and behavioral health services expected to be provided to a resident, based on the resident's comprehensive assessment that includes measurable objectives and the methods for meeting the objectives.

Individualized Service Plan (ISP): 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 ISP is created and managed by the Child and Family Team (CFT). It is a dynamic document that is regularly updated to adequately match the strengths and needs of the member and family.

POLICY

DCS CHP and its contracted MCO apply clinical knowledge to conduct member specific care coordination activities. The MCO's Integrated Care Management program involves a multidisciplinary team to address the intensive comprehensive health care needs of members, including required medical, dental health, vision, and behavioral health support services.

DCS CHP and its contracted MCO are proactive in its approach to Care Management through coordination of quality, cost-effective care and focuses on improving outcomes based on early identification of health risk factors for members with complicated, long-standing or specific medical and/or behavioral health needs.

All members are enrolled in the contracted MCO, Mercy Care's Integrated Care Management Program. Members targeted for higher level care management include those with medically complex needs or escalated behavioral health needs, those who are Children's Rehabilitative Services (CRS) enrolled, or those with chronic disease states (e.g. asthma, diabetes).

Care Management identification and case finding activities include, but are not limited to:

- Early identification of health risk factors or special care needs;
- Participation in Child and Family Teams (CFTs) and service plan reviews; escalated behavioral health case reviews with Medical Directors;
- Review of Early & Periodic Screening, Diagnostic & Treatment (EPSDT) records, Enrollment Transition Information (ETI) forms and claims data;
- Post Emergency Department (ED) visit analysis by diagnosis for both physical and behavioral health triggers (e.g. asthma, suicide attempt, and diabetes);
- Internal Utilization Review (Prior Authorization, Concurrent Review) identifying multiple readmits and targeted diagnoses;
- Data analyses across payers for High Need/High Cost members; and
- Tracking members with multiple complaints regarding services or the AHCCCS program.

DCS CHP collaborates across health care systems, including coordination with custodial agency representatives and caregivers. The member's custodial agency representative assist to achieve member compliance with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) visits, facility referrals

to needed specialty services and post discharge services. Coordination occurs through the provision of appropriate services across settings that meet the member's needs in the most cost-effective manner.

Care Management utilizes member specific data to provide information, enhance coordination of care, and improve individual member outcomes. Individualized service plans are implemented and monitored to achieve member stabilization and wellness through advocacy, communication, education, identification of service resources and service facilitation. Appropriate services, providers, and facilities are identified throughout the continuum of services.

Care Management is short term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and other resources or materials related to wellness, lifestyle, and prevention.

PROCEDURE

Member Identification for Care Management

Members are identified for potential Care Management through the following care coordination activities:

- The Enrollment Transition Information (ETI) Form which identifies conditions, referrals, or patterns of utilization;
- Review of member-specific encounter and eligibility data including:
    - AHCCCS blind spot data;
    - AHCCCS 834 Enrollment File;
    - Pharmacy data for identification of outlier members; review of controlled substance medications filled, opioid use or antidote prescriptions indicating possible substance use disorder; and
    - Emergency Department notifications.
- Discharge planning, retrospective and concurrent review processes to identify frequent Emergency Department (ED) visits, prolonged hospital stays and readmissions patterns;
- Review of EPSDT tracking forms and developmental tool results and referrals;
- Prior Authorization (PA) requests noting chronic conditions or diagnoses of special health care needs (e.g. failure to thrive, potential CRS conditions);
- Member or custodial agency representative inquiries, or requests for assistance;
- Identification of High Needs/High Cost (HN/HC) members;
- Child and Family Teams (CFT) requests;
- Provider or other government agencies referrals;
- Case review for appeals, grievances, Notice of Adverse Benefit Determination (NOA), and
- Health Risk assessment upon entry into the health plan.

Health care professionals, custodial agency representatives, or other stakeholders may refer a member for Care Coordination. DCS CHP System of Care and Health Coordination function areas provide

support to custodial agency representatives for children/youth during CFTs, Team Decision Meetings (TDMs), or other clinical consultations by:

- Aiding in understanding the clinical needs of the child;
- Advocating for the review of quality of care concerns;
- Troubleshooting barriers to care; and
- Emphasizing an integrated approach to health care.

Ongoing identification for Care Management coordination occur through multiple sources. Members are identified based on health risk factors, special health care needs, or diagnoses and may be referred for Care Management by DCS Specialists, DCS CHP, contracted providers or others. The goal is to ensure through care coordination activities that members are receiving needed services in a timely manner.

Care Management Activities

The DCS CHP Resource Coordination function area provides member support through caregiver outreach and coordination to enhance a 'whole child' and family approach to healthcare service delivery. Resource Liaisons are DCS CHP employees who outreach caregivers telephonically upon health plan enrollment to identify and escalate the need for immediate care coordination and/or interventions from other DCS departments to ensure that children and youth in out-of-home care are receiving needed services in a timely manner. Information provided to caregivers includes but not limited to:

- Scheduling of medical, dental and behavioral health appointments needed within the first 30 days of entry into out of home care;
- Gaps in healthcare services including immunization;
- Contact information for health plan staff and other appropriate professionals who can support the caregiver and member if advocacy challenges occur; and
- Identification of any immediate escalated care coordination needs.

DCS CHP's contracted MCO's Integrated Care Management (ICM) program provides member support through caregiver outreach for identification of risk factors, support and care coordination. If needed, assistance is provided for scheduling of well-visits and dental visits for early identification of health care needs and connection to service providers for addressing those needs.

All members are enrolled in the ICM program. Care management staff outreach newly enrolled members to determine the stratification level of care management they may need through an interview with the caregiver, the administration of risk questionnaires and review of other health information sources such as ETIs and other health information systems. The stratification level is also determined through various methods, including population assessments, claims review, predictive modeling, individual member outreach, risk screenings, utilization, and referrals.

Once members are stratified for enrollment, they are outreached by trained care management staff who further assess members' medical, behavioral, psychosocial, cultural, and spiritual health needs. The care manager may initially reach out to the members' community or provider case manager to avoid duplication of services and member assessments.

Care coordination activities may include but are not limited to:

- Assistance with primary care provider (PCP), primary dental provider (PDP), behavioral health home assignment or locating specialty providers to meet the initial and ongoing needs of the member.
- Facilitation of care coordination between the PCP, PDP, behavioral health home assignment and/or specialty providers, CFT, provider care manager, high needs case manager, community supports etc. including out of network providers.
- Timely and confidential communication of clinical information among providers, as specified in the AHCCCS Medical Policy Manual (AMPM) 940, such as pertinent diagnoses and changes in condition to the PCP.
- Consultation with a member's inpatient and outpatient treatment team and/or coordination with the member/caregiver to facilitate the discharge coordination process.
- Facilitation and identification of needed services such as:
    - Medication assisted services;
    - Peer support services.
- Coordination of services to support and stabilize in-home or out-of-home dependency provided by DCS.
- Coordination of the care plan with the DCS case plan to avoid redundancies and inconsistencies;
- Providing DCS Specialist with preliminary findings and recommendations on services needs for court hearings;
- Attendance at team meetings, such as Team Decision Making (TDM) and/or CFT meetings and providing input about the child and family's behavioral health needs;
- Coordination of behavioral health services in support of family reunification and/or other permanency plans identified by DCS.
- Review of the needs identified within the behavioral health assessment and service plan to provide necessary behavioral health services, including support services to caregivers;
- Coordination of activities and service delivery to support the CFT service plan and facilitate adherence to established timeframes as identified within:
    - ACOM Policy 417,
    - ACOM Policy 449,
    - AMPM Policy 580, and
    - AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and CFT, Working with the Birth Through Five Population and Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age,
- Coordination of activities to include coordination with adult service providers rendering services to adult family members;
- Coordination with crisis providers for post crisis services to address the ongoing needs of the member and facilitate resolution of the crisis;
- Coordination with Tribal Regional Behavioral Health Authority (TRBHA) for members receiving behavioral health services through a TRBHA.

- Facilitation of care coordination between behavioral health providers who serve parents/families/caregivers referred through the Arizona Families F.I.R.S.T-AFF Program (AFF Program) and providers that participate in the CFT to coordinate services for the family and temporary caregivers;
- Coordination with the Arizona Department of Education (ADE), schools or other local education authorities to serve the needs of members who receive special education services to include information and recommendations contained in the Individualized Education Program (IEP) during the assessment and service planning process, participate in the CFT as appropriate;
- Inclusion of the behavioral health provider in the creation of the IEP;
- Support and facilitation of the use of the IEP and the creation of appropriate service plans and services;
- Support of accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973;
- Ensure that children found to require behavioral health services as part of the AzEIP evaluation process receive appropriate and timely service delivery;
- Ensure that, if an AzEIP team has been formed for the child, the behavioral health provider coordinates team functions to avoid duplicative processes between systems;
- Coordination with the Arizona Department of Corrections (ADOC), Arizona Department of Juvenile Corrections (ADJC), Administrative Office of the Court (AOC) and County Jail System.

Care coordination with a developed Individual Care Plan is initiated for identified members if the following is met:

- Multiple Emergency Department (ED) visits in a short span of time (greater than two (2) in past quarter or four (4) visits within six (6) months):
    - Interventions include: communication with providers, education on disease process, coordination of alternate setting/plans;
- Pregnancies identified (ED visit identifies pregnancy or other sources of identification received):
    - Interventions include: maternity health coordination for timely appointment and screening by Obstetrician, education including postpartum depression and family planning;
- Escalation is needed due to untimely health care services or lack of access to services;
- Uncontrolled Chronic Disease (Asthma/Diabetes Mellitus - DM);
    - Interventions include: disease management with education, coordination of medication management/adherence, coordination of appointments;
- Potential CRS Condition or other Special Health Care Needs (SHCN);
    - Interventions include: coordination of SHCN services, initiation of service plan and education on community resources.

As needed, DCS CHP and its contracted MCO participates in Care Conference Meetings, Child and Family Team (CFT) meetings or other multidisciplinary meetings to assist with the identification of appropriate Care Management, immediate and long term objectives to meet the member's needs in the most medically appropriate and cost effective manner available.

Based on information and member specific data received in the assessment process, the contracted MCO's Integrated Care Management team develops an Individualized Care Plan with objectives, interventions and measurement dates. The Individualized Care Plan includes verifying access to the appropriate specialists, coordination medication delivery, transportation and other needs. The Care Management team may conduct outreach phone calls, send education letters, refer members to behavioral health services, provide High Needs/High Cost (HN/HC) coordination, exclusive pharmacy program, disease management or provide resources related to social determinants of health.

The Care Management team monitors the member's progress in meeting the expected outcomes by maintaining communication with health care providers, custodial agency representatives, caregivers, and other stakeholders as deemed appropriate. Care Coordinators, nurses, or other appropriate staff assist the custodial agency representative in referring members to collateral agencies including, but not limited to:

- Division of Developmental Disabilities (DDD);
- Arizona Long Term Care System (ALTCS);
- Arizona Early Intervention Program (AzEIP);
- Women, Infants and Children (WIC) Program; and
- Head Start Program.

Pharmacy data is reviewed to identify any potential for misuse or risk for substance use disorder, in order to include the member in care coordination and identify need for possible coordination for substance use treatment services.

High Needs/High Cost (HN/HC)

DCS CHP and its contracted MCO reviews member utilization data to identify qualifications for the High Needs/High Cost program. Members having four or more emergency department (ED) visits and four or more inpatient admissions AND having $50,000 total cost in a six-month timeframe are considered eligible for the High Needs/High Cost Program.

The contracted MCO's Integrated Care Management team facilitates the High Needs/High Cost (HN/HC) program. Members are referred for interventions if they:

- Have four (4) or more ED visits within six (6) months;
- Have three (3) or more hospital readmissions within six (6) months;
- Have $50,000 or more of health care costs within six (6) months; or
- Are referred by health plan staff.

Common HN/HC interventions include:

- Custodial agency representative educated on the use of PCP/Medical Home;
- Assistance with selecting a strong PCP with expertise in the needed area;
- Referrals to System of Care Clinical Coordinator; and
- Referrals for Chronic Health management (Asthma/DM).

Justice System Reach-in Program

The Justice System Reach-in Program is carried out by DCS CHP's contracted MCO. Identification of DCS CHP members who are detained is carried out through notification to the health plan by detention and other entities, including probation officers, providers, DCS, family members, etc.

As incarcerated youth are identified, a Justice System Liaison designated by DCS CHP's contracted MCO notifies the assigned provider and begins gathering information for coordination of care, including scheduling of a CFT to begin release planning, and collecting information that allows determinations to be made about eligibility for grant funding in cases where AHCCCS is suspended.

Youth in detention may have their Medicaid coverage suspended if they are detained on a criminal complaint, however, Medicaid coverage is not suspended in cases where youth are detained on a non-criminal matter such as a violation of probation. If the Justice System Liaison becomes aware of an incarcerated youth who is detained on a criminal complaint and is not suspended, DCS CHP is notified for eligibility determination. Notifications are sent via email to MCDU Justice @azahcccs.gov with a copy sent to DCS CHP.

Reach In care coordination for members is carried out through the CFT process. The Justice System Liaison participates in CFT meetings as needed to ensure that appointments are scheduled with appropriate provider(s) based on member needs and preferences, within 7 days of member release.

The Justice System Liaison is also responsible for working collaboratively with the Care Management team. DCS CHP members are assigned a Care Manager who is included in communications regarding the youth. The Justice System Liaison and the Care Manager work together as members of the CFT to ensure the physical, behavioral health, criminal justice, and other social determinants of health needs of the youth are met, including Medication Assisted Treatment (MAT), care coordination and peer support services.

Members identified as being incarcerated are tracked by a Juvenile Justice Engagement Team, coordinated through DCS CHP's contracted MCO, and are identified as meeting the established parameters (individuals incarcerated for 20+ days with a release date and chronic and/or complex care needs) for Reach In pre-release care coordination and post-release care planning. Most youth do not meet criteria for Reach In eligibility, however, every youth who is in custody for more than 72 hours receives Reach In services and is tracked and included in quarterly reporting through the Justice Reach In AHCCCS deliverable.

Success of the Reach In Initiative is defined as an individual receiving a needed service within 7 days, or up to 30 days of release from incarceration. DCS CHP's contracted MCO tracks these outcomes through a monthly, claim based Critical Incident Report highlighting the services each person who received Reach In care coordination received within the first 30 days post release. The various types of claims include adverse events such as emergency department visits, IP hospitalization, crisis services, death, and reincarceration. The report also provides data reflecting those individuals who were successful in accessing a health promoting service within 7-30 days of release, which are defined as outpatient behavioral and physical health services.

System of Care Coordinator Activities

The DCS CHP System of Care Coordinator maintains a documentation system for collection, analysis and dissemination of data pertaining to member needs elevated and supported through SOC activities. *[See DCS CHP Policy HS-SOC-01, System of Care Program]*.

Based on escalated need for intervention on behalf of a member, common activities of the Health Coordination and System of Care function areas include:

- Participation in Child and Family Teams (CFT) to communicate concerns and make clinical recommendations;
- Clinical consultation when solicited by custodial agency representatives and other field staff;
- Attendance at regularly scheduled staffing meetings with, members, caregivers, and custodial agency representatives to provide care coordination and system navigation assistance;
- CFT assistance with appropriate discharge planning from Emergency Departments or hospital Inpatient Psychiatric Departments; and/or
- Attendance at Dependency or Delinquency court hearings in order to advocate for trauma informed, Evidence-Based services in the least restrictive environment.

Discharge from Care Management

Discharge from Care Management is considered when the member has completed all care plan goals including stabilization of their condition, successful links to community support and education, and improved member health.

Care Management Education for Members and Providers

DCS CHP and its contracted MCO educates members, caregivers and providers regarding the availability Care Management services and provides instructions on how to obtain services, including specific contact information for care management referral. Care Management information is published on the DCS CHP website and printed in various member outreach materials.

Reporting

A summary of Care Management activities and applicable outcomes are presented quarterly at the Quality Management/Performance Improvement (QM/PI) and the Medical Management (MM) Committee meetings.

REFERENCES

DCS CHP Policy HS-SOC-01, System of Care Program

DCS CHP Policy HS-CC-01, Transition of Members

DCS CHP Policy HS-CC-03, Identifying members with Special Health Care Needs

AHCCCS Medical Policy Manual (AMPM) Chapter 1000, Policy 1020, Medical Management Scope and Components

AHCCCS Medical Policy Manual (AMPM) Chapter 500, Policy 540 Coordination of Care with other Government Agencies

AHCCCS Medical Policy Manual (AMPM) Chapter 1000, Policy 1022 Justice System Reach-In (azahcccs.gov)

AHCCCS Medical Policy Manual (AMPM) Chapter 500 Policy 590 Behavioral Health Crisis Services and Care Coordination (azahcccs.gov)

RELATED FORMS
N/A