570 – PROVIDER CASE MANAGEMENT

EFFECTIVE DATES: 10/01/21, 10/01/22, 02/12/24

APPROVAL DATES: 07/13/21, 04/21/22, 08/17/23

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, DCS/CHP (CHP), and DES/DDD (DDD) Contractors; and Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), TRBHA; and all FFS providers, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements for provider case management for behavioral health providers.

For members who are enrolled with an ALTCS E/PD Contractor, case management is provided by the Contractor.

For Tribal ALTCS, case management is provided by the tribal case manager as specified in AMPM Chapter 1600.

Provider case management is not a reimbursable service for ALTCS E/PD or Tribal ALTCS.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

CHILD AND FAMILY TEAM (CFT)	**DESIGNATED REPRESENTATIVE (DR)**	**HOME AND COMMUNITY BASED SERVICES (HCBS)**
HEALTH CARE DECISION MAKER (HCDM)	**INTERGOVERNMENTAL AGREEMENT (IGA)**	**MEDICAL MANAGEMENT (MM)**
MEMBER	**QUALITY MANAGEMENT (QM)**	**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)**
SERIOUS MENTAL ILLNESS (SMI)		

III. POLICY

The Contractor shall develop protocols that specify how provider case management for behavioral health providers will be managed and coordinated. The Contractor shall be responsible for ensuring a provider network with a sufficient number of qualified and experienced provider case managers, regardless of their job title at the provider agency, who are both trained in and available to provide case management services to all enrolled members.

The Contractor shall ensure that providers are orienting new staff who provide/bill case management services to the fundamentals of providing effective case management services, evaluating their competency to provide effective case management, and providing basic and ongoing training in the specialized subjects relevant to the populations served by the provider, and as specified in ACOM Policy 407.

A. PROVIDER CASE MANAGER ROLE AND RESPONSIBILITIES

Provider case management is a supportive service provided to improve treatment outcomes and meet member's service or treatment plan goals. Provider case management services may be provided outside of the role of an assigned case manager by those who are providing services or are involved with a member's care in a case management capacity and in accordance with A.A.C. R9-10.

As defined in A.A.C. R9-10, provider Case Managers, regardless of their job/position title at the provider agency, who are carrying a caseload and providing services as specified in Attachment A are responsible for monitoring the member's current needs, services required to address those needs, and progress in achieving goals or desired outcomes through regular and ongoing contact with the member/HCDM. The frequency and type of contact between the provider case manager and the member/HCDM is determined during the treatment planning process and is adjusted as needed by routine discussion that evaluates and considers clinical need and member preference.

1. Case Management Activities

Case Management activities may include but are not limited to:

a. Assistance in identifying, implementing, maintaining, monitoring, and/or modifying behavioral health services on a routine basis,
b. Assistance in identifying, finding, and starting/implementing necessary resources that support activities of daily living and/or respond to the needs of other Social Determinants of Health (SDOH) other than behavioral health services,
c. Coordination of care with the member, their Health Care Decision Maker (HCDM) if one exists, healthcare providers, family of origin and/or choice, community resources, and other natural support systems and/or people including educational, social, judicial, community, and other State agencies,
d. Coordination of care activities related to ensuring continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal care services, housing services, nursing services, and family counseling) and providers, and

e. Assisting members in applying for social security benefits when using the Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) approach in accordance with policies and expectations from AMPM Policy 310-B.
   i. SOAR activities may include:
      a) Face-to-face meetings with member,
      b) Phone contact with member, and
      c) 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).
   ii. SOAR services shall only be provided by staff who have been certified in SOAR through Substance Abuse and Mental Health Services Administration (SAMHSA) SAMHSA SOAR Technical Assistance Center. Additionally, when using the SOAR approach, billable activities do not include:
      a) Completion of SOAR paperwork without member present,
      b) Copying or faxing paperwork,
      c) Assisting members with applying for benefits without using the SOAR approach, or
      d) Email.
f. Outreach and follow-up to members after report of a crisis event and/or missed appointments as specified in AMPM Policy 590 and AMPM Policy 1020, and
g. Participation and engagement in formal and informal case staffing, case conferences, and other meetings with or without the member/HCDM, DR, or their family participating as specified in AMPM Policy 320-O and AMPM Policy 320-R.

2. Coordination of Care

It is the responsibility of the provider case manager to coordinate care on behalf of members to ensure they receive treatment and support services that will most effectively meet the member's specific, identified needs. Coordination of care is required to:

a. Coordinate with member/HCDM, social rehabilitation, vocational/employment and educational providers, supportive housing and residential providers, crisis providers, Primary Care Providers (PCP), other health care providers, peer and family supports, other state agencies (e.g., parole/probation officer, school), significant others and any other natural supports as applicable,
b. Obtain input from providers and other involved parties in the assessment and service planning process,
c. Provide 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,
d. Obtain information about the member's course of treatment from each provider at the frequency needed to monitor the member's progress,
e. Participate and engage in all provider staffing and treatment/service planning meetings.
f. Obtain copies of provider treatment plans and enter those plans as part of the medical record,
g. Ensure the completion of the special assistance assessment as required in AMPM Policy 320-R and enter the assessment into the medical record,

h. Provide education and support to members, family members, HCDM, significant others, and any other natural supports regarding the member's diagnosis and treatment with the member/HCDM's consent,
i. Provide a copy of the member's service plan to other involved providers and involved parties with the consent of the member/HCDM's,
j. Provide medication and laboratory information to residential and independent living service providers or other caregivers involved with the consent of the member/HCDM consent,
k. Coordinate care with contractor care management as applicable,
l. For child members, refer to guidelines specified in AMPM Policy 580 as applicable, and
m. In crisis situations, provider case managers shall:
    i. Identify, intervene, and/or follow-up with a potential or active crisis situation in a timely manner as specified in AMPM Policy 590,
    ii. Provide information and contact information, including any "on-call" 24/7 availability of services and how to access the crisis system and any other natural supports to respond to member crisis as needed,
    iii. Provide follow-up with the member/HCDM after crisis situations, including contact with the member within 72 hours of discharge from a crisis setting,
    iv. Assess for, provide, and coordinate additional supports and services as needed to accommodate the member's needs during and after the crisis event, and
    v. Ensure the member's annual crisis and safety plan is regularly updated as clinically indicated and based on criteria as specified in AMPM Policy 320-O. Crisis and safety plans shall be made readily available to the crisis system, clinical staff, and also shared with individuals involved in development of the crisis and safety plan.

3. Provider Case Management Intensity
    a. Assertive Community Treatment (ACT) Case Management: One component of a comprehensive model of treatment based upon fidelity criteria developed by the SAMHSA. ACT case management focuses upon members living 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 (e.g., social services, housing services, health care),
    b. High Needs Case Management: Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements 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:
        i. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
        ii. Children 0 through five years of age with two or more of the following:
            1) Other agency involvement; specifically: AzEIP, DCS, and/or DDD, and/or
            2) Out of home placement for behavioral health treatment (within past six months), and/or
            3) Psychotropic medication utilization (two or more medications), and/or
            4) Evidence of severe psycho-social stressors (e.g., family member serious illness, disability, death, job loss, eviction).
    c. Supportive Case Management: Focuses upon members for whom less intensive case management would likely impair or unduly limit 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, and

d. Connective Case Management: Focuses 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 (SUD) as clinically indicated.

B. CONTRACTOR RESPONSIBILITIES

The Contractor shall ensure that an adequate number of qualified and trained provider case managers are available within their provider network to meet the needs of members. The Contractor shall ensure that providers meet the caseload ratios as specified in Attachment A except as otherwise specified and approved by AHCCCS on an as needed basis. The Contractor shall ensure that children who require high needs case management and all members with a Serious Mental Illness (SMI) designation are assigned to a case manager in accordance with A.A.C. R9-21-101 et. seq and that all other members are assigned a provider case manager as needed, based upon a determination of the member's service acuity needs.

The Contractor shall not allow its subcontracted providers to blend or otherwise combine caseload ratios, as specified in Attachment A, without express written approval from AHCCCS.

1. Time Management

   The Contractor shall require that provider case managers are not assigned duties unrelated to member's specific case management for more than 10% of their time when they have a full caseload, as specified in Attachment A.

2. Conflict of Interest

   The Contractor shall require that provider case managers are not:
   a. Related by blood or marriage to a member, or any paid caregiver of a member on their caseload,
   b. Financially or otherwise legally responsible for a member on their caseload,
   c. Empowered to make financial or health-related decisions on behalf of a member on their caseload,
   d. In a position to financially benefit from the provision of services to a member on their caseload, or
   e. Providers of paid services (e.g., Home and Community Based Services (HCBS), private sold chores, etc.) for any members on their caseload.

   Exceptions to the above may be made under limited circumstances, and as specified in the case management plan. A limited circumstance may include a geographic area where it is unavoidable to have a provider case manager who may also have a conflict of interest.

3. Supervision
   a. The Contractor shall require that providers ensure a supervisor-to-provider case manager ratio be established that is conducive to providing consistent, quality supervision by a qualified supervisor. The qualified supervisor shall be able to effectively support case managers, regardless of their job title, including establishing a process for routine review and monitoring supervisor staff assignments or the need for reassignments in order to adhere to the Contractor's designated supervisor-to-case manager ratio, if applicable, and
   b. The Contractor shall ensure that provider case manager supervisors have adequate time to train and review the work of newly hired provider case managers as well as provide support and guidance to established provider case managers.

4. Inter-Departmental Coordination

   The Contractor shall establish and implement mechanisms to promote coordination and communication between provider case management and contractor care management teams within their own organization, with particular emphasis on ensuring coordinated approaches with the Contractor's Chief Medical Officer (CMO), Medical Management (MM) and Quality Management (QM) teams as appropriate.

5. Accessibility
   a. The Contractor shall ensure that the member/HCDM, and DR, if applicable, shall be provided adequate information in order to be able to contact the provider case manager or Contractor for assistance. The Contractor shall also ensure that adequate information is provided to the member/HCDM, and DR for what to do in cases of emergencies and/or after hours, and
   b. The Contractor shall require that providers have a system of back-up provider case managers in place for members who contact an office when their assigned case manager is unavailable and that members be offered the opportunity to speak to the back-up provider case manager for assistance. The Contractor shall ensure members/ HCDM, and DR, if applicable, are called back when messages are left for case managers, within but not to exceed, two business days.

C. CONTRACTOR REPORTING REQUIREMENTS

The Contractor shall submit, as specified in Contract, a provider case management plan that addresses how the Contractor will collaborate with other Contractors to implement and monitor provider case management standards and ensure adherence to caseload ratios for adult and child members. The provider 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 Contractor's provider case management plan from the previous year. The provider case management plan shall include the most recently reported caseload ratios for each case manager by subcontracted provider, for each case management ratio as specified in Attachment A. The Contractor shall attest to the accuracy of this data at the time of submission.

IV. BILLING AND CODING FOR PROVIDER CASE MANAGEMENT

For billing and coding requirements, refer to AHCCCS Behavioral Health Services Matrix. Billing and coding may differ by AHCCCS eligibility category, service type (e.g., Child and Family Team [CFT], SOAR), individual provider type, and other guidelines under licensure.

For ALTCS E/PD, care coordination activities for provision of case management services, refer to AMPM Policy 320-O.

For members enrolled in DDD, case management may be provided by the DDD Case Manager, as well as through a behavioral health provider, depending upon the preference of the member/HCDM, or DR, if applicable. Case management provided by a DDD Case Manager is not a reimbursable service.

For FFS members, case management may be provided by a TRBHA case manager or through a behavioral health provider, as applicable. If case management is being provided by a behavioral health facility, case managers shall work with the TRBHAs on care coordination. Refer to the TRBHA Intergovernmental Agreement (IGA) for care management/care coordination requirements.