570 – PROVIDER CASE MANAGEMENT[1]

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 Program (FESP). (For FESP, 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)		

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

[1] Policy deleted in its entirety and replaced with revised Policy immediately below.

~~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 AAC 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. The 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. The 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. The 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 zero 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 AAC 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 Attachment B High Needs Case Management Provider Caseloads and Attachment C Adult Provider Case Management Caseloads. These deliverables shall also include a cover letter that outlines the Contractor's performance outcomes, lessons learned, and improvement strategies for Provider Case Management and submit as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall submit a Provider Case Management Ratio Exemption Request utilizing Attachment D as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables when a provider has exceeded caseload ratios as outlined in Attachment A.

III. 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.

570 – PROVIDER CASE MANAGEMENT[2]

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

APPROVAL DATES: 07/13/21, 04/21/22, 08/17/23, 10/28/25, XX/XX/XX

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 providers serving FFS members, excluding Federal Emergency Services Program (FESP). (For FESP, 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.

II. DEFINITIONS

Refer to the AHCCCS ACOM and AMPM Dictionary for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

PROVIDER CASE MANAGER	The individual at a behavioral health provider agency who is primarily responsible for locating, coordinating, and monitoring the provision of all behavioral health services for members identified as requiring Assertive Community Treatment (ACT), Supportive, Connective, or High-Needs Case Management and are assigned to the individuals caseload.

[2]This policy was issued as a comprehensive rewrite rather than a redline due to the significant volume of stakeholder feedback requesting greater clarification, consistency, and operational guidance regarding Provider Case Management requirements. The revisions substantially reorganized and expanded the policy to provide clearer expectations and improve implementation. Because the extent of the changes would have reduced the usefulness of a traditional redline, AHCCCS elected to publish a complete rewrite while maintaining the policy's overall intent.

CASE MANAGEMENT	A medically necessary, person-centered service that encompasses service planning, implementation, care coordination, monitoring, engagement, advocacy, and support activities. These services are intended to assist members in accessing and effectively utilizing medical, behavioral health, and related support services to meet their identified health needs. Case management services may be provided by qualified members of the clinical team, acting within their scope of practice, and are not restricted to individuals formally designated as Provider Case Managers.
SIBLING	Any child that resides in the same household or is a biological member of the same family even if they do not reside in the same household.

~~I.~~III. POLICY

Case Management is a critical component of the AHCCCS behavioral health system of care and is intended to ensure that members receive coordinated, person-centered, medically necessary services that support recovery, resiliency, community integration, and improved health outcomes. Case Management facilitates access to behavioral health, physical health, social, educational, vocational, housing, and other supportive services necessary to meet the member's identified needs.

AHCCCS requires that Case Management services be available to members whose behavioral health needs indicate a need for ongoing care coordination, service planning, monitoring, engagement, advocacy, or support. The intensity and level of Case Management shall be based on the member's assessed clinical and functional needs, preferences, strengths, and goals, and shall be adjusted as those needs change over time. All determinations regarding assignment to a Provider Case Manager caseload and level of care shall be documented in the member's medical record.

Case Management shall be delivered in a manner that emphasizes member choice, culturally responsive practices, family and natural support involvement when appropriate, coordination across systems of care, and the integration of physical and behavioral health services. These services are intended to assist members in accessing needed services, reducing barriers to care, promoting engagement in treatment, managing transitions between levels of care, and supporting long-term stability and wellness in the least restrictive setting appropriate to the member's needs.

Contractors are responsible for ensuring that Case Management services are available through a sufficient network of qualified Provider Case Managers and are delivered in accordance with the requirements established in this Policy.

A. AHCCCS APPROVED LEVELS OF PROVIDER CASE MANAGEMENT BY POPULATION

AHCCCS recognizes multiple levels of Case Management to ensure members receive services that are responsive to their clinical needs, functional needs, level of functioning, and recovery or resiliency goals. Assignment to a level of Case Management on a Provider Case Manager Caseload shall be based upon assessment findings, medical necessity, member choice, and ongoing reassessment of the

member's needs.

1. Adult members with a Serious Mental Illness (SMI) Designation:
   Contractor and providers shall ensure that all adults with an SMI Designation, in accordance with AAC R9-21-101, are assigned to a Provider Case Manager in one of the following three levels of Provider Case Management (Assertive Community Treatment [ACT], Supportive, Connective) in accordance with the clinical assessment findings and the member's choice and preference(s):
   a. ACT Case Management- One component of a comprehensive model of treatment based upon fidelity criteria developed by Substance Abuse and Mental Health Service Administration (SAMHSA). Refer to AMPM Policy 930 for specific SAMHSA Fidelity Requirements and expectations for ACT and all Evidence Based Practice (EBP) caseload ratios,
   b. Supportive Case Management- Supportive Case Management focuses on adult members who require ongoing, structured support to maintain functioning and engagement in services, but who do not require the intensity of ACT Case Management. This level of care is appropriate for individuals whose functional stability would be at risk without regular support, guidance, and monitoring. Supportive Case Management provides coordinated assistance to improve daily functioning, enhance service engagement, and supports progress toward recovery goals. Caseloads may include adult members with an SMI designation, as well as members with a general mental health condition or Substance Use Disorder (SUD), when clinically indicated and not as a standard practice. The role of the Provider Case Manager at this level emphasizes active support, skill development, and coordination of care to address ongoing needs and prevent deterioration in functioning. Key components of Supportive Case Management include:
      i. Engagement and Monitoring: Maintaining regular contact to assess stability, monitor symptoms, and ensure ongoing participation in treatment and services,
      ii. Care Coordination: Facilitating communication among providers, discharge planning, referring members to behavioral health, medical, and social services, and addressing barriers to access,
      iii. Skill Development and Support: Assisting members in building skills related to daily living, coping strategies, and self-management of mental health and substance use conditions,
      iv. Service Plan Implementation: Supporting progress toward individualized goals through structured follow-up and reinforcement of treatment plan objectives,
      v. Risk Assessment and Risk Mitigation: Identifying early signs of destabilization or increased risk and evaluating the need for a higher level of Case Management or services, with timely coordination of appropriate interventions, and
      vi. Progressive Transition Planning: Supporting movement toward greater independence, including step-down to Connective Case Management when clinically appropriate.
   c. Connective Case Management: Provider Case Management services for individuals who have largely achieved their recovery goals focus on maintaining stability, preventing relapses, and promoting long-term wellness. The Connective Case Management caseloads may include adult members with an SMI designation as well as members with a general mental health condition or SUD~~)~~ as clinically indicated and not as a standard practice. The Connective Case Management process includes periodic check-ins, resource coordination, and support in navigating services to support ongoing needs related to mental health and substance use recovery. At this stage, the role of the Provider Case Manager shifts from intensive intervention to fostering empowerment, self-sufficiency, and sustained engagement in community and social support. Key components of this approach include:
      i. Monitoring and Maintenance: Ensuring continued adherence to treatment plans and identifying potential challenges early on,

ii. Care Coordination and Supportive Services: Referring individuals to community resources such as peer support groups, employment assistance, and housing stability programs,
iii. Crisis Prevention Planning: Helping develop strategies to manage stressors and prevent setbacks, monitoring for signs of increased need and evaluating whether a higher level of Case Management is clinically indicated,
iv. Wellness Promotion: Encouraging participation in healthy activities, self-care, and ongoing personal growth, and
v. Graduated Transition: Transitioning from active Case Management to self-directed care while ensuring access to support when needed.

2. Adult Members with a General Mental Health or Substance Use Disorder (GMHSU):
   a. Case Management services are available to all adult members with a GMHSU designation. The GMHSU members are not required to be automatically added to a Provider Case Manager's caseload unless the member is under Court Ordered Treatment (COT). The GMHSU Members under COT shall be assigned to a Provider Case Manager and shall receive, at a minimum, monthly contact, and must meet all requirements specified in the court order,
   b. Contractors and Providers shall establish and implement policies and procedures to assess whether GMHSU members, who are not under COT, require assignment to a Provider Case Manager based on medical necessity and clinical need. These processes shall be integrated within the member's assessment and service planning process and shall include:
      i. A standardized methodology for determining the need for assignment to a Provider Case Manager based on the member's current clinical presentation, functional needs, and identified service gaps,
      ii. A determination of the appropriate level of Provider Case Management (e.g., ACT, Supportive, Connective) based on the intensity of the member's needs,
      iii. Defined timeframes and clinical triggers for reassessment of the member's need for assignment to a Provider Case Manager caseload, including but not limited to significant clinical changes, transitions in care, or changes in service utilization, and
      iv. A documented process for adjusting, escalating, or de-escalating the level of Provider Case Management based on reassessment findings.

3. Children:
   a. High Needs Case Management (HNCM): Focuses on 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. An HNCM Provider Case Manager is required to provide Child and Family Team practice as outlined in AMPM Policies 580 and 582. An HNCM shall be explained and offered to the Health Care Decision Maker (HCDM) for any children with complex needs. The children with complex needs are identified as:
      i. Children six through 17 years of age: Child and Adolescent Level of Care Utilization System (CALOCUS) level of 4, 5, or 6. Behavioral Health Professionals (BHPs) shall ensure that CALOCUS scores appropriately reflect the member's needs when reviewing assessments. Providers need to use clinical judgement in completion of the CALOCUS and shall use clinical justification to align CALOCUS score with the identified needs. The CALOCUS is an optional resource and is not required for providers serving FFS members. The providers serving FFS members not utilizing the CALOCUS shall have a clearly identified methodology by which the program identifies children needing HNCM,

ii. Children 0 through five years of age with two or more of the following:
1) Other agency involvement; including but not limited to Arizona Early Intervention Program (AzEIP), Arizona Department of Child Safety (DCS), Special Education and/or DDD,
2) Out - of-home placement for behavioral health treatment (within the past six months),
3) Psychotropic medication utilization,
4) Expulsion or at-risk of expulsion from a childcare setting, and/or
5) Evidence of severe psycho-social stressors (e.g., severe primary caregiver stress, family member serious illness, disability, death, job loss, eviction).

iii. Children with a CALCOUS score of a three, at the providers' discretion, based on the assessed clinical needs of the child, and

iv. Child in the HNCM Transition Phase outlined in AMPM Policy 582, may have a CALOCUS score of less than four and remain assigned to the same Provider Case Manager for up to 120 days for clinically appropriate transition to a lower level of care3.

~~a.~~b. Enrolled siblings of a child with complex needs who are also in need of Case Management services should be assigned to the same Provider Case Manager. Siblings that do not meet criteria for complex needs shall not be counted in the ratio outlined in Attachment A for HNCM.

4. Children that do not meet criteria for HNCM:
a. Shall receive Child and Family Team (CFT) practice as outlined in AMPM Policy 580,
b. Do not require assignment to a Provider Case Managers caseload, however, when clinically indicated Provider Case Management shall be added to the member's service plan and provided, and
c. For children receiving a less intensive level of Case Management, there is no maximum caseload ratio, and caseloads can be blended with other levels of Provider Case Management, including adult members, as determined appropriate by the Contractor and Provider. The inclusion of these children in blended caseloads does not require prior approval from AHCCCS; however, Contractors and Providers shall ensure that Provider Case Manager workloads remain reasonable and that required care coordination, service planning, and CFT practices are maintained. In the absence of an assigned Provider Case Manager, the treating provider shall be responsible for CFT practice.

B. PROVIDER CASE MANAGER ROLE AND RESPONSIBILITIES

Provider Case Managers are responsible for coordinating, monitoring, and supporting the provision of services identified in the member's service plan as necessary to meet member's assessed needs. The Contractor and Providers shall ensure Provider Case Managers perform activities necessary to promote service access, care coordination, engagement and progress toward individualized goals and outcomes

Case Management activities include but are not limited to:

1. Facilitating treatment team meeting, service plan development meetings and other multidisciplinary meetings as needed.

[3] Added Members in the High Needs Case Management (HNCM) transition phase may remain assigned to the same Provider Case Manager for up to 120 days to support continuity of care and transition to a lower level of service.

2. Obtaining input from providers and team members in the assessment and service planning process.

3. Ensuring required documentation is within the member's medical record within timelines as specified in AMPM Policy 320-O and AMPM Policy 940.

4. Prioritizing the member/HCDM's voice and preferences.

5. Providing coordination of the services specified in the member's service plan and each provider/program's treatment plan, to include physical and behavioral health services and care.

6. Identifying and referring for behavioral health services on the member's service plan and then monitoring, and/or modifying behavioral health services on a routine basis.

7. Identifying and implementing necessary resources that support activities of daily living.

8. Working directly with members on service plan goals that encompass medically necessary skills training, health promotion, and other services.

9. Identifying and implementing necessary resources for Social Determinants of Health (SDOH).

10. Assisting members with securing transportation to and from appointments.

11. Coordination of care with the member, their HCDM, or DR (if applicable), and with the member/HCDM's consent any other team members identified by the member and/or HCDM including but not limited to: the behavioral health providers, primary care provider, other healthcare providers, vocational/employment providers, supportive housing, residential providers, peer and family supports, crisis providers, natural supports, family of origin and/or choice, community resources, and other State agencies (e.g., parole/probation officer, school).

12. The coordination of care shall include the following activities with member/HCDM consent:
    a. Provide education and support to the member and team members, regarding the member's diagnosis and treatment,
    b. Provide a copy of the member's service plan and safety plan to the member and all team members,
    c. Referral(s) to medically necessary services, and
    d. Provide medication and laboratory information.

13. Obtaining information about the member's course of treatment from each provider and team member involved in the member's treatment at the frequency needed to monitor the member's progress.

14. Obtaining copies of all provider treatment plans and entering those plans as part of the member's medical record.

15. Ensuring the completion of the special assistance assessment as required in AMPM Policy 320-R and entry of the assessment into the member's medical record.

16. Assisting or connecting members to assistance in applying for social security benefits when needed using the Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) approach, as directed in the AHCCCS Fee-For-Service Provider Billing Manual.

17. Participation and engagement in case staffing, case conferences, and other meetings required to coordinate care as specified in AMPM Policy 320-R.

~~1.~~18. For children receiving Provider Case Management refer to guidelines specified in AMPM Policy 580 and AMPM Policy 582 as applicable.

~~2.~~19. Engaging in outreach and follow-up to incarcerated members with high incidence or prevalence of behavioral health issues and refer to guidelines specified in AMPM Policy 1022 as applicable.

~~3.~~20. For FFS members, Case Management may be provided by a TRBHA case manager, through a behavioral health provider or both, as applicable. If Case Management is provided to a TRBHA enrolled member by a behavioral health provider other than the TRBHA, Provider Case Management case load ratio attachments shall be sent to the TRBHAs for all TRBHA enrolled members and to AHCCCS DFSM Care Management for AIHP members not enrolled with a TRBHA. Provider Case Management shall ensure that TRBHA case managers are included on the members treatment team and collaborate with the TRBHAs on care coordination. Refer to the TRBHA Intergovernmental Agreement (IGA) for care management/care coordination requirements.

21. Providers shall implement outreach, engagement, and re-engagement activities as integral components of Provider Case Management, including but not limited to:
    a. Enhanced and persistent re-engagement efforts, consistent with AMPM Policy 1040, for all members who are not actively engaged in treatment, and
    b. Re-engagement efforts shall continue until the member is re-engaged in services, the member's status is clearly determined, or a clinical review supports an alternative disposition. Disengagement or inability to contact a member shall not, by itself, constitute sufficient justification for closure of Provider Case Management for members who:
        i. Have an Serious Mental Illness (SMI) designation, or
        ii. Demonstrate clinical risk, instability, or significant barriers to care, including all members under court ordered treatment.
    c. If a Provider has conducted outreach and re-engagement efforts for a period of 12 months without successful contact or service utilization for members with an SMI designation or members under court ordered treatment, the Provider shall notify the Contractor or, for FFS members, the AIHP Care Management Team, and request a formal clinical review to determine whether closure of Provider Case Management is clinically appropriate.~~,~~ The clinical review shall evaluate, at a minimum:
        i. The member's clinical history and known or anticipated risk factors,
        ii. Prior service utilization and treatment engagement,
        iii. Barriers to engagement, and
        iv. The continued need for Case Management services.
        v. During the clinical review process, if it is identified that the member is receiving

services through another provider, the Provider shall coordinate with the Contractor, or the AIHP Care Management Team when applicable, to support an appropriate transfer of care ,

22. Case closure shall not occur unless the clinical review supports that closure is appropriate and documentation substantiates the determination, and
23. AHCCCS registered providers delivering Case Management services to AIHP members with an SMI designation are required to notify the AIHP Care Management Team prior to the closure of Case Management services. Notification must be submitted through the AHCCCS Solution Center before the case is formally closed and must include documentation of outreach attempts.

~~4.~~

C. REQUIRED CASE MANAGEMENT FOLLOWING A CRISIS OR MISSED APPOINTMENT

As specified in AMPM Policy 590, the Contractor shall receive notification from the ACC-RBHA that an assigned member has experienced a crisis event. The Contractor shall notify the behavioral health provider responsible for the member's Case Management within 24 hours and ensure the following coordination of care (In instances in which the member is not receiving behavioral health services, the assigned health plan's care management team shall provide the following coordination of care):

1. Follow-up with a member that experiences a significant and/or critical event in a timely manner as specified in AMPM Policy 1040 including within 72 hours of a crisis event.

2. Provide coordination of care for additional support and services as needed to accommodate a member's needs following a crisis event. For those members not receiving behavioral health services, Contractor care managers are permitted to connect the member to a provider that can complete the required coordination of care.

3. The member's crisis safety plan is updated at minimum annually and as clinically indicated in AMPM Policy 320-O and AMPM Policy 590.

4. Share crisis and safety plans with individuals involved in development of the crisis and safety plan as specified in AMPM Policy 320-O.

5. For members with an SMI designation and children receiving HNCM, provide telephonic contact with the member, within 24 hours, following any missed appointment. If the member/HCDM cannot be reached telephonically, a face-to-face/home visit is completed within 72 hours, following a missed appointment. These timeframe requirements are the minimum; based on the member's needs, additional outreach attempts and activities may be clinically indicated.

D. PROVIDER CASE MANAGER SUPERVISION REQUIREMENTS

Effective supervision is essential to supporting quality Provider Case Management services, staff development, clinical oversight, and compliance with AHCCCS requirements. Contractors and Providers shall ensure supervision structures support Provider Case Managers in fulfilling their responsibilities and maintaining appropriate professional competencies:

1. The Contractor and Provider Agencies serving FFS populations shall ensure that policies and procedures are in place that ensure supervisor to Provider Case Manager ratio's are established in a manner that is conducive to providing consistent, quality supervision by a qualified supervisor. The qualified supervisor shall be able to effectively support Provider Case Managers, including establishing a process for routine review and monitoring supervisor staff assignments or the need for reassignments.

2. The Contractor and Provider Agencies serving FFS populations 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 at regular, pre-planned intervals, preferably completed in-person.

E. CONTRACTOR RESPONSIBILITIES

Contractors are responsible for ensuring Provider Case Management services are available, accessible, and delivered in accordance with AHCCCS requirements. Contractors shall maintain oversight of Provider Case Management activities and support provider agencies in meeting the standards established in this Policy:

1. The Contractor shall develop policies and procedures 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, who are both trained in and available to meet the needs of all enrolled members.

2. The Contractor shall monitor that provider agencies contracted to provide any of the four Evidence-Based Practices (EBP): ACT, Supported Employment, Permanent Supportive Housing (PSH), and/or Consumer Operated Services (COS)/Peer Run Organizations (PRO), have caseload ratios in alignment with AMPM Policy 930.

3. For members with behavioral health needs that are not already established with a provider, the Contractor shall be responsible for ensuring the provision of the activities outlined in this Policy including, but not limited to, connecting the member to an appropriate service provider and actively coordinating with the service provider to establish Provider Case Management.

4. The Contractor shall ensure that agencies contracted for Provider Case Management:
   a. Are trained in the fundamentals of providing effective and timely Provider Case Management services including but not limited to best practices, activities, and ethics,
   b. Evaluate the competency of their staff to provide effective Provider Case Management on a regular basis, and
   c. Receive ongoing training in the specialized subjects relevant to the populations served by the provider, as specified in ACOM Policy 407.

5. The Contractor shall support best practices and all statutory requirements for Provider Case Management. The Contractor shall ensure:
   a. An adequate number of qualified and trained Provider Case Managers are available within their provider network to meet the needs of members and consider the professional needs and reasonable workloads of Provider Case Managers,

b. The Provider Case Managers 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 and HCDM,
c. The Provider Case Managers that have full caseloads as specified in Attachment A are not assigned duties unrelated to member-specific Case Management and care coordination for more than 10% of their time,
d. The Provider Case Managers should not be fulfilling duties typically assigned to other job positions, such as administrative assistants, front desk personnel, or other duties not related to the delivery of Case Management Services,
e. Maximum caseload ratios, as identified in Attachment A, shall be adjusted to less than the maximum based on the amount of time an employee is dedicated as a Provider Case Manager,
f. The providers meet the caseload ratios and contact requirements outlined in Attachment A for the Levels of Provider Case Management,
g. The provider's maximum caseload ratios outlined in Attachment A shall be calculated by individual Provider Case Managers. It is not acceptable to calculate caseload ratios using an average caseload size by outpatient clinic,
h. The level of Provider Case Management is determined by member needs identified in the assessment and treatment planning process. The member's preference shall be considered throughout the assessment and treatment planning process,
i. The frequency and type of contact between the Provider Case Manager and the member/HCDM is determined during the service planning process and is adjusted based on clinical need and member preference. Attachment A does include minimum contact requirements by Level of Provider Case Management,
j. The Coordination and communication between the Provider Case Management and the Contractor care management teams with an emphasis on ensuring coordinated approaches with the Contractor's Chief Medical Officer (CMO), the Medical Management (MM) and the Quality Management (QM) teams as appropriate,
k. The member, HCDM, and Designated Representative (DR) when applicable, are provided:
    i. Adequate information to contact the Provider Case Manager, the Provider Case Manager supervisor, and the Contractor for assistance,
    ii. Information about what to do in cases of emergencies and/or during after-hours including crisis line information,
    iii. Contact information for the Provider Case Manager or supervisor that will be the member's point of contact any time the assigned Provider Case Manager is on leave, out of the office or unavailable due to training, and-
    iv. A return call within 48 business hours of leaving a voicemail,
l. The providers have policies and procedures for coverage of Provider Case Management when a provider is on leave, out of the office, or otherwise unavailable,
m. The providers have policies and procedures that ensure timely contact and follow up with members, and
n. Regarding conflict of interest, the Contractor shall require that the Provider Case Managers are not:
    i. Related by blood or legally (i.e., adoption or marriage), current or previously, to a member, or any paid caregiver of a member on their caseload,
    ii. Financially or otherwise legally responsible for a member on their caseload,
    iii. Empowered to make financial or health-related decisions on behalf of a member on their caseload,

iv. In a position to financially benefit from the provision of services to a member on their caseload, or
v. Providers of paid services [e.g., Home and Community Based Services (HCBS), private household chores] for any members on their caseload.

6. The Contractor shall not create, implement, or permit providers to establish additional levels of Case Management that modify the standards established in this policy, including contact requirements, caseload maximums, service intensity, or documentation expectations, without prior notification to AHCCCS and obtaining AHCCCS approval.

   For any additional Case Management levels currently in use that modify the standards established in this policy, the Contractor shall:
   a. Define the clinical and operational criteria for assignment to that level of care and the ongoing assessment process,
   b. Maintain written standards describing the services and expectations associated with that level, and
   c. Require Providers to report all members assigned to a Provider Case Manager in Attachment C.

7. The Contractor may permit Provider Case Managers to maintain blended caseloads that include members assigned to different levels of Provider Case Management. The Contractor shall report all members assigned to each Provider Case Manager, including those with an SMI designation and those receiving GMHSU services:
   a. Contractors shall ensure that the composition of any blended caseload complies with the maximum thresholds and composition requirements established in Attachment A. Specifically, Contractors shall ensure that blended caseloads:
      i. Support reasonable workload expectations, and
      ii. Enable Provider Case Managers to meet all applicable contact requirements, care coordination responsibilities, and documentation standards established in this policy.

~~1.~~8. Contractors and provider agencies shall ensure alignment with the requirements outlined in Attachment A, Case Management assignments must not compromise the delivery of required services or the ability of Provider Case Managers to meet established policy standards.

9. The Contractor shall ensure Providers implement outreach, engagement, and re-engagement activities as integral components of Provider Case Management, including but not limited to:
   a. Enhanced and persistent re-engagement efforts, consistent with AMPM Policy 1040, for all members who are not actively engaged in treatment, and
   b. Re-engagement efforts shall continue until the member is re-engaged in services, the member's status is clearly determined, or a clinical review supports an alternative disposition. Disengagement or inability to contact a member shall not, by itself, constitute sufficient justification for closure of Provider Case Management for members who:
      i. Have an SMI designation, or
      ii. Demonstrate clinical risk, instability, or significant barriers to care, including all members under court ordered treatment.
   c. If a Provider has conducted outreach and re-engagement efforts for a period of 12 months without successful contact or service utilization for members with an SMI designation or members

under court ordered treatment, the Provider shall notify the Contractors and request a formal clinical review to determine whether closure of Provider Case Management is clinically appropriate,

d. The clinical review shall evaluate, at a minimum:
   i. The member's clinical history and known or anticipated risk factors,
   ii. Prior service utilization and treatment engagement,
   iii. Barriers to engagement, and
   iv. The continued need for Case Management services.
e. During the clinical review process, if it is identified that the member is receiving services through another provider, the Provider shall coordinate with the Contractor to support an appropriate transfer of care and Provider Case Manager rather than closing,
f. Case closure shall not occur unless the clinical review supports that closure is appropriate and documentation substantiates the determination, and
g. Contractors shall ensure this requirement is applied consistently across delivery systems, including RBHAs, ALTCS Contractors, and DES/DDD Contractors, as applicable.

~~B.~~F. CONTRACTOR REPORTING REQUIREMENTS

Reporting requirements support AHCCCS oversight of Provider Case Management capacity, caseload distribution, compliance with policy requirements, and system performance. Contractors shall submit required reports and deliverables in accordance with Contract requirements and timelines.

1. The Contractor shall submit Attachment B ~~–~~and Attachment C as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables~~-~~. These deliverables shall also include a cover letter that outlines the Contractor's performance outcomes, lessons learned, and improvement strategies for Provider Case Management~~ and submit as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables~~.

2. ~~-~~The Contractor shall submit Attachment D as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables when a provider has exceeded caseload ratios as outlined in Attachment A.

3. The Contractor shall ensure that all members assigned to a Provider Case Manager are counted toward the Case Manager's total caseload, regardless of:
   a. Program designation (SMI, GMHSU, Children), and
   b. Service level (e.g. ACT, Supportive or Connective).

   Contractors shall ensure that Attachment B and C accurately reflects the total number of members assigned to each Provider Case Manager, consistent with this requirement.

~~C.~~G. BILLING AND CODING FOR PROVIDER CASE MANAGEMENT

Billing and reimbursement requirements for Provider Case Management vary based on eligibility category, delivery system, provider type, and covered service. Contractors and Providers shall comply with applicable billing requirements as outlined below.

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 1600. Provider Case Management is not a reimbursable service for ALTCS E/PD or Tribal ALTCS.

For members enrolled in DDD, Case Management may be provided by the DDD Support Coordinator, as well as through a behavioral health provider, depending upon the preference of the member/HCDM, or DR, if applicable. Case management activities and services provided by a DDD Support Coordinator are not reimbursable.