560 - CHILDREN'S REHABILITATIVE SERVICES CARE COORDINATION AND SERVICE PLAN MANAGEMENT

EFFECTIVE DATES: 03/01/11, 09/27/17, 10/01/18, 09/27/24

APPROVAL DATES: 10/01/13, 09/21/17, 05/03/18, 07/05/24

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, DCS CHP (CHP), and DES DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), DES DDD Tribal Health Program (DDD/THP), Tribal ALTCS, Tribal Regional Behavioral Health Authorities (TRBHA); and all FFS populations, excluding Federal Emergency Services Program (FESP). (For FESP, refer to AMPM Chapter 1100). This Policy establishes requirements regarding care coordination for members designated as having a Children's Rehabilitative Services (CRS) condition and defines the process for development and management of the member's Service Plan.

II. DEFINITIONS

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

ACTIVE TREATMENT	**ADULT RECOVERY TEAM (ART)**	**CHILD AND FAMILY TEAM (CFT)**
CHILDREN'S REHABILITATIVE SERVICES (CRS)	**DESIGNATED REPRESENTATIVE (DR)**	**FIELD CLINIC**
HEALTH CARE DECISION MAKER (HCDM)	**MEMBER**	**MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)**
MULTI-SPECIALTY INTERDISCIPLINARY TEAM (MSIT)	**SERVICE PLAN**	

III. POLICY

A member who meets qualifying condition(s) for CRS, as defined in AAC R9-22-1303, and who require active medical, surgical, or therapy treatment for medically disabling or potentially disabling conditions, may submit an application to AHCCCS for the CRS designation consideration, for additional information refer to ACOM Policy 426.

The Contractor, subcontractors, TRBHAs, and FFS providers shall ensure the development and implementation of a service plan for members designated as having a CRS Condition. In addition, they are responsible for coordination of the member's health care needs and collaboration as needed with providers, communities, agencies, service systems, members/Health Care Decision Makers (HCDM), and Designated Representatives (DR) in development of the service plan.

The Contractor shall ensure the Service Plan is accessible to all service providers and contains the behavioral health, physical health, and administrative information necessary to monitor a coordinated and integrated treatment plan implementation.

The Service delivery shall be provided in a family-centered, coordinated and culturally competent manner to meet the unique physical, behavioral, and holistic needs of the member. Members with a CRS designation may receive care and specialty services from a Multi-Specialty Interdisciplinary Clinic (MSIC) or community-based provider in independent offices that are qualified to treat the member's condition. The Contractor shall educate members and HCDM about the value and benefits of receiving services at an MSIC. The Contractor shall ensure availability of alternative methods for providing services such as field clinics and telemedicine in rural areas.

A. CARE COORDINATION

1. The Contractor and FFS provider shall establish a process to ensure coordination of care for members that includes:
   a. Coordination of member health care needs through a Service Plan,
   b. Collaboration with members/HCDM, DR, and other individuals identified by the member, groups, providers, organizations, and agencies charged with the administration, support or delivery of services that is consistent with Federal and State privacy laws,
   c. Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements,
   d. Service coordination to ensure specialty services related to a member's CRS condition(s) are completed, as clinically appropriate prior to the member's 21st birthday,
   e. Appropriate service delivery and care coordination shall be provided as a member with a CRS designation transitions to adult services and ongoing as an adult with special healthcare needs, and
   f. Allowing members with a CRS designation turning 21 the choice to continue being served by an MSIC that is able to provide services and coordinate care for adults with special healthcare needs.

B. SERVICE PLAN DEVELOPMENT AND MANAGEMENT

The Contractor is responsible for ensuring that each member designated to have a CRS condition has a member-centered Service Plan and that the member's first provider visit occurs within 30 days of designation. Additionally, the Contractor is responsible for ensuring services are provided according to the Service Plan. The Service Plan serves as a working document which integrates the member's multiple treatment plans, including behavioral health, into one document in a manner and format that is easily understood by the member/HCDM, DR, and shared with the member/HCDM, DR upon request or as part of the Multi-Specialty Interdisciplinary Team (MSIT), Child Family Team (CFT), or Adult Recovery Team (ART) meetings.

The Service Plan identifies desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives. The Service Plan shall identify the immediate and long-term healthcare needs of each newly designated member and shall include an action plan.

The Contractor is responsible for ensuring that every member has an initial Service Plan developed by the Contractor within 14 days of the notice of designation utilizing information provided by AHCCCS DMPS. The Service Plan shall be monitored regularly and updated when there is a change in the member's health condition, desired outcomes, personal goals, or care objectives.

1. A comprehensive Service Plan shall be developed within 60 calendar days from date of the first appointment for the CRS qualifying condition and shall include, but is not limited to all the required elements as follows:
   a. Member demographics and enrollment data,
   b. Member diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies,
   c. Action plan,
   d. The member's current functional/clinical status, including present levels of functioning in physical, cognitive, social, behavioral, and educational domains,
   e. Barriers to treatment, such as member/HCDM, DR's inability to travel to an appointment,
   f. The member/HCDM, DR's strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the member,
   g. Services recommended to achieve the identified objectives, including the provider or person responsible and timeframe requirements for meeting desired outcomes, and
   h. The Contractor shall identify an (MSIT) to implement and update the Service Plan as needed.

2. The Contractor shall modify and update the Service Plan when there is a change in the member's condition or recommended services. This shall occur periodically as determined necessary by the member/HCDM, DR, or provider(s).

3. The Contractor shall identify a the individual responsible for ensuring implementation of interventions and the dates by which the interventions shall occur and who identifies organizations and providers with whom treatment must be coordinated.

C. SPECIALTY REFERRAL TIMELINES

The Contractor shall have written policies and procedures that ensure adequate access to care including monitoring of meeting appointment standards as specified in ACOM Policy 417.