Arizona Medicaid Supplemental Clinical Criteria

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Introduction & Instructions for Use

Introduction

The following State or Contract Specific Clinical Criteria defined by state regulations or contractual requirements are used to make medical necessity determinations, mandated for members of behavioral health plans managed by Optum and U.S. Behavioral Health Plan, California (doing business as Optum Health Behavioral Solutions of California ("Optum-CA")).

Other Clinical Criteria may apply when making behavioral health medical necessity determinations for members of behavioral health plans managed by Optum®. These may be externally developed by independent third parties used in conjunction with or in place of these Clinical Criteria when required, or when state or contractual requirements are absent for certain covered services.

Instructions for Use

When deciding coverage, the member's specific benefits must be referenced. All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using these Clinical Criteria. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this Clinical Criteria and the member's specific benefit, the member's specific benefit supersedes these Clinical Criteria.

These Clinical Criteria are provided for informational purposes and do not constitute medical advice.

Adult Behavioral Health Therapeutic Home (ABHTH) A licensed residence that provides behavioral health treatment, which maximizes the ability of an individual experiencing behavioral health symptoms to live and participate in the community and to function in an independent manner that includes assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Treatment Plan, as appropriate.

ABHTH is a residential setting in the community that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Service Plan and/or Treatment Plan as appropriate.

Programmatic support is available to the ABHTH Providers 24 hours per day, seven days per week by the CHI. Care and services provided in an ABHTH are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board (Arizona State Plan for Medicaid). Contractors shall refer to ACOM Policy 414 for information on timeframes and requirements regarding prior authorizations.

ABHTH Providers shall adhere to this Policy as well as procedure requirements as specified in A.A.C. R9-10-1801 et. Seq and the Arizona State Plan for Medicaid.

Admission Criteria

- The recommendation for ABHTH shall come through the ART process,
  - ART is a group of individuals that follows the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems. Working in collaboration and are actively involved in an individual's assessment, service planning, and service delivery.
- Following an Assessment by a licensed BHP, the member has been diagnosed with a behavioral health condition which reflects the symptoms and behaviors necessary for a request for ABHTH
- As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior which renders the member incapable of independent or age-appropriate self-care or self-regulation. This moderate functional and/or psychosocial impairment per Assessment by a BHP:
  - Cannot be reasonably expected to improve in response to a less intensive level of care, and
  - Does not require or meet clinical criteria for a higher level of care, or
  - Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
- At time of admission to an ABHTH, in participation with the Health Care Decision Maker and all relevant stakeholders, there is a documented plan for discharge which includes:
  - Tentative disposition/living arrangement identified, and
  - Recommendations for aftercare treatment based upon treatment goals.

Continued Stay Criteria

- All of the following shall be met:
  - The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to ABHTH,
  - The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or appropriate self-care or self-regulation,
  - Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to ABHTH, and treatment at the ABHTH is empowering the member to gain skills to successfully function in the community,
  - There is an expectation that continued treatment at the ABHTH shall improve the member’s condition so that this type of service shall no longer be needed, and

- The ART is meeting at least monthly to review progress, and have revised the Treatment Plan and/or Service Plan to respond to any lack of progress.

Discharge Criteria

- Sufficient symptom or behavior relief is achieved as evidenced by completion of the ABHTH treatment goals.
- The member's functional capacity is improved and the member can be safely cared for in a less restrictive level of care.
- The member can participate in needed monitoring and follow-up services or a Provider is available to provide monitoring in a less restrictive level of care.
- Appropriate services, Providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.
- There is no evidence to indicate that continued treatment in an ABHTH would improve member's clinical outcome.
- There is potential risk that continued stay in an ABHTH may precipitate regression or decompensation of member's condition.

Exclusionary Criteria

Admission to an ABHTH shall not be used as a substitute for the following:

- An alternative to detention or incarceration.
- As a means to ensure community safety in an individual exhibiting primarily conduct disordered behaviors.
- As a means of providing safe housing, shelter, supervision or permanent placement.
- A behavioral health intervention when other less restrictive alternatives are available and meet the member's treatment needs, including situations when the member/Health Care Decision Maker is unwilling to participate in the less restrictive alternative.

Treatment Expectations

Treatment outcomes shall align with:

- The Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as specified in AMPM Policy 100, and
- The member's individualized physical, behavioral, and developmentally appropriate needs.
- Treatment goals for members placed in an ABHTH shall be:
  - Specific to the member's behavioral health condition that warranted treatment,
  - Measurable and achievable,
  - Unable to be met in a less restrictive environment,
  - Based on the member's unique needs,
  - Inclusive of input from the member's family/Health Care Decision-Maker and
  - Designated Representative's choices where applicable, and
  - Supportive of the member's improved or sustained functioning and integration into the community.
- Active treatment with the services available at this level of care can reasonably be expected to:
  - Improve the member's condition in order to achieve discharge from the ABHTH at the earliest possible time, and
  - Facilitate the member's return to primarily outpatient care in a nontherapeutic/non-licensed setting.

Treatment Planning

The ABHTH Treatment Plan shall be developed by the CHI in collaboration with the ABHTH Provider and the ART within the first 30 days of placement:

- The Treatment Plan shall:
  - Describe strategies to address ABHTH Provider needs and successful transition for the member to begin service with ABHTH Provider, including pre-service visits when appropriate,
  - Compliment and not conflict with the ART Service Plan and other defined treatments, and shall also include reference to the member's:
    - Current physical, emotional, behavioral health and developmental needs,
    - Current educational placement and needs,
    - Current medical treatment,
    - Current behavioral health treatment through other Providers, and
    - Current prescribed medications.

- Address safety, social, and emotional well-being, discharge criteria, acknowledgement of member's permanency objectives and post-discharge services,
- Include short-term, proactive treatment goals that are measurable, time-limited, and in keeping with the ART Service Plan,
- Clearly identify responsible individuals from treatment team to implement each aspect of the ABHTH Treatment Plan and the timing of completion. The CHI has the responsibility to ensure the treatment team is implementing the ABHTH Treatment Plan,
- Include specific elements that build on the members' strengths while also promoting pro-social, adaptive behaviors, interpersonal skills and relationships, community, family and cultural connections, self-care, daily living skills, and educational achievement,
- Include specifics to coordinate with natural supports and informal networks as a part of treatment,
- Include plans for engagement of the member's family of choice and other natural supports that can support the member during ABHTH placement and after transition,
- Be reviewed by the ABHTH Provider and CHI at every home visit,
- Be reviewed by the CHI Clinical Supervisor at each staffing,
- Be revised as appropriate or quarterly at minimum, and ABHTH Provider and CHI.

- Contractors and providers shall ensure that members/Health Care Decision Maker and designated representatives receive a copy of the treatment plan and any updated treatment plans.

Applied Behavior Analysis

Behavior Analysis Services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. Behavior Analysis Services are designed to accomplish one or more of the following: increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health needs. Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Behavior Analysts Assessments

- Behavior Analysis Services shall be based upon assessment(s) that include Standardized and/or Non-standardized instruments through both direct and indirect methods.
  - Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g. Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).
  - Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors. This may also include functional behavioral analysis done in an inpatient or residential setting in preparation for ABA treatment as an outpatient.

Service Administration

- Behavior Analysis Services shall be rendered in accordance with an individualized behavior analysis treatment plan will:
  - Be developed by a Behavior Analyst, based upon an assessment completed of the member and their behaviors as described above.
  - Be person-centered and individualized to the member's specific needs.
  - Specify the setting(s) in which services will be delivered.
  - Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).
  - Identify the baseline levels of target behaviors.
  - Specify long- and short- term objectives that are defined in observable, measurable, and behavioral terms.
  - Specify the criteria that will be used to determine treatment progress and achievement of objectives.
  - Include assessment and treatment protocols for addressing each of the target behaviors.
  - Clearly identify the schedule of services planned and roles and responsibilities for service delivery.

- Include frequent review of data on target behaviors.
- Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member's response to treatment.
- Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.
- Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.
- Include care coordination activities involving the member's team in order to assist in the generalization and maintenance of treatment targets. This may include the Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, DCS, and/or other state-funded programs, and others as applicable.
- Result in progress reports at minimum, every six months. Progress reports shall include, but are not limited to, the following components:
- Member Identification,
- Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications),
- Assessment Findings (i.e. social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns),
- Outcomes (measurable objectives, progress towards goals, clinical recommendations, treatment dosage, family role and family outcomes, and nature of family participation), and
- Care Coordination (transition statement and individualized discharge criteria).
- Be consistent with applicable professional standards and guidelines relating to the practice of behavior analysis as well as Arizona Medicaid laws and regulations and Arizona state Behavior Analyst licensure laws and regulations (A.R.S. §32-2091).

Provider Qualifications

- Behavior Analysis services shall be directed and overseen by Behavior Analysts and supported, where applicable, by Behavior Analysis Trainees and/or Behavior Technicians.
- The Behavior Analyst is responsible for training Behavior Analysis Trainees and Behavior Technicians to implement assessment and intervention protocols with members. The Behavior Analyst is responsible for all aspects of clinical direction, supervision, and provider-level case management.
- The Behavior Analyst shall be responsible for ensuring that the extent, kind, and quality of the Behavior Analysis Services the Behavior Analysis Trainee and Behavior Technician performs are consistent with his or her training and experience.
  - The Behavior Analyst shall be responsible for Behavior Analysis Trainee and Behavior Technician compliance with this Policy and Arizona state rules and regulations including those provisions set forth in A.R.S. §32-2091.

Home Care Training Family (Family Support)

Home Care Training Family (Family Support) support services are directed toward restoration, enhancement, or maintenance of the Family functioning to increase the Family's ability to effectively interact and care for the member in the home and community. Family support services may involve activities such as assisting the Family to adjust to the members illness, developing skills to effectively interact and/or guide the member, understanding the causes and treatment of behavioral health issues, and understanding and effectively utilizing the healthcare system. Refer to AMPM Policy 964 for training and credentialing standards for Credentialed Parent/Family Support individuals providing Parent/Family Support Services,

- Support services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. Support services shall be provided by individuals who are qualified Behavioral Health Professional (BHP) or Behavioral Health Technician (BHTs)/Behavioral Health Paraprofessional (BHPPs) supervised by BHPs.
- More than one provider agency may bill for family support provided to a member at the same time if indicated by the member's clinical needs as identified through their Service Plan.

Admission Criteria

- Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer for children must:
  - Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs; and
  - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

- Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer for adults must:
  - Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs; and
  - Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.
- Home care training family services (family support) must be provided by certified behavioral health professionals, behavioral health technicians, or behavioral health para-professionals as defined by the following:
  - Behavioral Health Professional: An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
    - Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
    - Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in AAC. R4-6-101,
    - A psychiatrist as defined in A.R.S. §36-501,
    - A psychologist as defined in A.R.S. §32-2061,
    - A physician,
    - A behavior analyst as defined in A.R.S. §32-2091,
    - A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
    - A registered nurse with:
      - A psychiatric-mental health nursing certification, or
      - One year of experience providing behavioral health services
  - Behavioral Health Technician: an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:
    - If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
    - Are provided with clinical oversight by a behavioral health professional.
  - Behavioral Health Paraprofessional: An individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:
    - If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S, Title 32, Chapter 33; and
    - Are provided under supervision by a behavioral health professional.
    - Services are considered medically necessary regardless of a member's diagnosis, so long as there are documented behaviors and/or symptoms that will benefit from behavioral health services and a valid ICD-10-CM diagnostic code is utilized.

Service Delivery

Family Support services include the following:

- Communication Techniques:
  - Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
  - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
  - Using self-disclosure effectively; sharing one's story when appropriate.
- System Knowledge:
  - Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
  - Overview and history of the family and peer movements; the role of advocacy in systems transformation,
  - Rights of the caregiver/enrolled member
  - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and Team.
- Building Collaborative Partnerships and Relationships:
  - Engagement; Identifies and utilizes strengths;
  - Utilize and model conflict resolution skills, and problem solving skills,
  - Understanding individual and family culture; biases; perceptions; system's cultures;

    - The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;
- Empowerment
    - Empower family members and other supports to identify their needs, and promote self-reliance,
    - Identify and understand stages of change and
    - Be able to identify unmet needs.
- Wellness:
    - Understanding the stages of grief and loss; and
    - Understanding self-care and stress management;
    - Understanding compassion fatigue, burnout, and trauma;
    - Resiliency and recovery;
    - Healthy personal and professional boundaries.

Billing Limitations

- Where applicable, travel time by the provider is included in the rates. See core provider travel billing limitations in Section I.
- Family support services provided in a DLS licensed inpatient, residential or day program setting are included in the rate for those settings and cannot be billed separately, with certain exceptions. Please refer to the AHCCCS billing requirements.
- More than one provider agency may bill for home care training family services (family support) services provided to a behavioral health recipient at the same time if indicated by the person's clinical needs.

Provider Case Management

Provider Case Management is a supportive service provided to enhance treatment goals and effectiveness of treatment outcomes.

Admission Criteria

- Assistance is needed in maintaining, monitoring and modifying covered services;
- Brief telephone or face-to-face interactions with a person, family or other involved party are needed for the purpose of maintaining or enhancing a person's functioning;
- Assistance is needed in finding necessary resources other than covered services to meet basic needs;
- Communication and coordination of care are needed with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies;
- Coordination of care activities are needed related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling);
- Outreach and follow-up of crisis contacts and missed appointments are needed;
- Staffings, case conferences or other meetings with or without the person or their family participating are required; and
- Other activities as needed.

Service Delivery

- The responsible Provider Case Manager, in conjunction with the treatment team, completes an initial evaluation of the member's case management needs upon admission.
- The responsible Case Manager, in conjunction with the treatment team and, whenever possible, the member, develops a service plan that includes a description of the following:
    - The member's recovery and resiliency goals;
    - Strengths;
    - Problems;
    - Specific and measurable goals for each problem;
    - Interventions that will support the member in meeting the goals.
- The service plan may be informed by the findings of the initial clinical evaluation.
- With the member's permission, the Case Manager advocates for the member by sharing feedback about the member's experience with the treatment provider, as well as agencies or other programs with which the member is involved.

Limitations

For case management services the following billing limitations apply:

- Case management services provided by a DLS licensed inpatient, residential or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
- A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.
- Multiple provider agencies may bill for this service during the same time period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing.
- Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
- Transportation provided to an AHCCCS BEHAVIORAL HEALTH SERVICES enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

Therapeutic Foster Care

TFC is a covered behavioral health service that provides daily behavioral interventions within a licensed family setting. This service is designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's Individualized Service Plan (ISP) as appropriate (Arizona State Plan for Medicaid). Programmatic support is available to the TFC family providers 24 hours per day, seven days per week. TFC service can only be provided for no more than three children in a professional foster home (Arizona State Plan for Medicaid). The Contractor and TFC agency providers shall ensure appropriate notification is sent to the Primary Care Provider (PCP) and behavioral health home/agency/TRBHA/Tribal ALTCS program upon intake/admission to, and discharge from TFC. TFC family providers and TFC agency providers shall adhere to DCS policies and procedures for children involved with the Arizona Department of Child Safety (DCS).

Admission Criteria

- The recommendation for TFC shall come through the Child and Family Team (CFT) process,
- Following an assessment by a licensed Behavioral Health Professional (BHP), the member has been diagnosed with a behavioral health condition, which reflects the symptoms and behaviors necessary for a request for TFC,
- As a result of the behavioral health condition, there is evidence that the member has recently (within the past 90 days) had a disturbance of mood, thought, or behavior that renders the member incapable of independent or age-appropriate self-care or self regulation. This moderate functional and/or psychosocial impairment per assessment by a BHP:
- Cannot be reasonably expected to improve in response to a less intensive level of care, and
- Does not require or meet clinical criteria for a higher level of care, or
- Demonstrates that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care.
- At time of admission to TFC in participation of Health Care Decision Maker (HCDM) and all stakeholders, there are documented plans for discharge and transition which includes:
    - Tentative disposition/living arrangement identified, and

Recommendations for aftercare treatment based upon treatment goals.

Continued Stay Criteria

All of the following shall be met:

- The member continues to meet diagnostic threshold for the behavioral health condition that warranted admission to TFC,
- There is an expectation that continued treatment at the TFC shall improve the member’s condition so that this type of service shall no longer be needed, and
- The CFT is meeting at least monthly to review progress and have revised the TFC treatment plan ISP to respond to any lack of progress, and for members, the caregiver to whom the member shall be transitioned after discharge from a TFC has been identified and is actively involved in the member’s care/treatment, if applicable.

All of the following are met:

- The member continues to demonstrate (within the last 90 days) moderate functional or psychosocial impairment as a result of the behavioral health condition, as identified through disturbances of mood, thought, or behavior, which substantially impairs independent or age appropriate self-care or self-regulation, and

Active treatment is reducing the severity of disturbances of mood, thought, or behaviors, which were identified as reasons for admission to TFC, and treatment at the TFC is empowering the member to gain skills to successfully function in the community

Discharge Criteria

- Sufficient symptom or behavior relief is achieved as evidenced by completion of the TFC treatment goals.
- The member's functional capacity is improved and the member can be safely cared for in a less restrictive level of care.
- The member can participate in needed monitoring and follow-up services or a caregiver is available to provide monitoring in a less restrictive level of care.
- Appropriate services, providers, and supports are available to meet the member's current behavioral health needs at a less restrictive level of care.
- There is no evidence to indicate that continued treatment in TFC would improve member's clinical outcome.
- There is potential risk that continued stay in TFC may precipitate regression or decompensation of member's condition.

A current clinical assessment of the member's symptoms, behaviors, and treatment needs has been reviewed by the CFT and has established that continued care in TFC is setting no longer adequate to provide for the safety and treatment. The CFT will then discuss if a higher level of care is necessary.

Clinical Best Practices

TFC provides the following services:

- Meet the needs of the child/youth in their home as defined in the child's Service Plan. The TFC provider must be available to directly supervise the child/youth 24 hours per day, seven days a week for the entire duration that the child is receiving out of home treatment services.
- Receive ongoing training, supervision, and support, from the Professional Foster Care licensing agency and the behavioral health provider to ensure that professional foster homes delivering TFC services understand and commit to meeting each child's unique needs.
- Participate in planning processes such as CFTs, TFC discharge planning, Individualized Education Programs (IEPs), Team Decision Making, Juvenile Court hearings, and DCS Case Plan Staffing's.
- Keep documentation, per expectations of the Contractor or RBHA and licensing agency, of the child's behavior and progress toward specific outcomes as outlined in the Service Plan.
- Assist the child in maintaining contact with his/her family, including siblings in regular foster care and community settings, and work actively to enhance these relationships, unless contraindicated by the DCS case plan.
- Assist in meeting the child's permanency planning or TFC discharge planning goals.
- Advocate for the child in order to achieve goals within the Service Plan, obtain educational, vocational, medical, and other services needed to implement the plan, and ensure timely access to therapeutically indicated services and supports.
- At all possible times, the child's family and guardians should be included in all aspects of planning and treatment in accordance with legal requirements.
- When siblings require TFC services, the siblings should be served together unless precluded by safety, Juvenile Court orders, or other overriding clinical issues. If siblings must be placed separately, the Service Plan should provide opportunities that support, foster and encourage family ties through collaborative efforts between the respective professional foster home delivering TFC services, kinship or other caregivers by telephone, written and electronic communication, visitation arrangements, and social activities managed by the caregivers.
- TFC services should be delivered by a professional foster home most willing and able to meet the child's cultural and language needs.
- The child's past experiences with abuse, neglect, family and significant others, or environmental stressors can affect the child's success in treatment. The CFT needs to take into consideration the number, age, and gender of other children living in the professional foster family's home, other family members or adults who live in or frequent the professional foster family's home, and the likelihood that the makeup of the family will support the strengths and meet the needs of the child.
- Many children thrive in the presence of pets while others are fearful. Some children are aggressive towards vulnerable animals. The presence of pets in the professional foster home should be considered in the context of the safety of the child, the safety of the pets living in the home, and the professional foster home's willingness to accommodate the child's needs and desires relative to pets.

- The geographic location of the professional foster home delivering TFC services should be considered from multiple perspectives. The professional foster home's proximity to the child's current school and family home can affect the child's level of comfort, the accessibility of supportive and anchoring relationships, the reassurance that often accompanies familiarity, and the child's feelings of safety.
- Carefully assess the ability of the professional foster home to implement the Service Plan in the area in which they live, in proximity to the child's family, and in proximity to both positive and negative peer influences.
- The intensity of needs of every child and his/her presenting behavior challenges should be coordinated with the capabilities of the professional foster family's skills and experience.
- The medical needs of the child and the professional foster home's ability to respond to them on an ongoing basis and in crisis should be considered.
- Appropriate information is available from the professional foster home's OCLR home study that may provide additional information to the CFT about the professional foster home's ability to meet the individual needs of the child.
- If an acute hospital admission, arrest, or other occurrence (e.g. running away from the home providing TFC services) temporarily results in the child's removal from the professional foster home, the CFT should review the situation and implement appropriate interventions and services to ensure that the child can return to the same professional foster home if clinically appropriate.
- The event of a young person reaching his/her 18th birthday should not, by itself, require an end to needed and beneficial TFC service delivery. The CFT should address available options to continue TFC services prior to the child's 18th birthday.

Pre-Job Training and Development

Pre-Job Training and Development are psychoeducational services and ongoing support to maintain employment services. These services are designed to assist a person or group to choose, acquire, and maintain a job or other meaningful community activity (e.g., volunteer work)services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training (WAT); assistance in the use of educational resources necessary to obtain employment; attendance to Rehabilitation Services Administration (RSA)/Vocational Rehabilitaition (VR) Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum , time management, and assistance in finding employment.

Admission Criteria

The member is in need of pre-job training and development in the following areas:
- Career/educational counseling
- Job shadowing
- Assistance in the use of educational resources
- Training in resume preparation
- Job interview skills
- Study skills
- Work activities
- Professional decorum and dress
- Time management
- Assistance in finding employment
- Job Training
- Work Adjustment Training (WAT)
- Attendance to RSA/VR Info Sessions
- Attendance to Job Fairs

Peer and Recovery Support

Peer and Recovery Support Services are a distinct health care practice involving intentional partnerships to provide social and personal support, based on shared experiences of living with mental health disorders, substance use disorders, and/or other traumas associated with significant life disruption. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family or community level. These services can include a

variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

Peer Support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the individual's disability (e.g. support groups, coaching, role modeling and mentoring). These services may be provided to an individual, group, or family, and are aimed at assisting in the creation of skills to promote long-term, sustainable recovery. The Contractor shall ensure the provision of quality Peer Support services.

Service Delivery

An individual trained, credentialed and qualified to provide peer/recovery support services within AHCCCS programs provide services to members according to the following core elements:

- Concepts of Hope and Recovery:
  - Instilling the belief that recovery is real and possible,
  - The history of social empowerment movements, and their connection to Peer and Recovery Support, including but not limited to:
    - Self-Help,
    - Consumer/Survivor/Ex-Patient,
    - Neurodiversity,
    - Disability Rights, and
    - Civil Rights.
  - Varied ways that Behavioral Health has been viewed and treated over time and in the present,
  - Appreciating diverse paradigms and perspectives of recovery and other ways of thinking about Behavioral Health (e.g. Harm Reduction, 12-Step Recovery, Neurodiversity),
  - Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways,
  - Holistic approach to recovery addressing behavioral, emotional, and physical health, and
  - Member-driven/Person-centered service planning.
- Advocacy and Systems Perspective:
  - State and national health systems' infrastructure – the history of Arizona's health systems,
  - Confronting and countering discrimination, prejudice, bias, negative stereotypes and other social injustices against those with behavioral health and substance use disorders – combating internalized stigma and oppression,
  - Organizational change – how to utilize person-first and identity-first language to educate provider staff on recovery principles and the role and value of Peer Support,
  - Creating a sense of community in a safe and supportive environment,
  - Forms of advocacy and effective strategies – consumer rights and navigating health systems, and
  - The Americans with Disabilities Act, (ADA).
- Psychiatric Rehabilitation Skills and Service Delivery:
  - Strengths based approach, identifying one's own strengths and helping others identify theirs, building resilience,
  - Trauma-Informed Care
  - Distinguishing between sympathy and empathy emotional intelligence,
  - Understanding learned helplessness, how it is taught and how to assist others in overcoming it's effects,
  - Motivational interviewing, communication skills and active listening,
  - Healing relationships – building trust and creating mutual responsibility,
  - Combating negative self-talk – noticing patterns and replacing negative statements about one's self, using mindfulness to gain self-confidence and relieve stress,
  - Group facilitation skills, and
  - Culturally & Linguistically Appropriate Services (CLAS) standards, and the role of culture in recovery.
- Professional Responsibilities of the PRSS and Self Care in the Workplace:
  - Professional boundaries and codes of ethics unique to the role of a PRSS,
  - Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA) responsibilities of a mandatory reporter, what to report and when,
  - Understanding common signs and experiences of:
    - Mental health disorders,
    - Substance Use Disorders (SUD),

    - Opioid Use Disorder (OUD),
    - Addiction,
    - Dissociation,
    - Trauma, and
    - Abuse/exploitation and neglect
  - Familiarity with commonly used medications and potential side effects Informed Consent (Refer to AMPM Policy 320-Q)
  - Guidance on proper service documentation, billing and using recovery language throughout documentation.
  - Self-care skills:
    - Coping practices for helping professionals,
    - The importance of ongoing supports for overcoming stress in the workplace,
    - Using boundaries to promote personal and professional resilience, and
  - Preventing burnout using self-awareness to prevent compassion fatigue, vicarious trauma, and secondary traumatic stress.

Skills Training &Development & Psychosocial Rehabilitation

Skills Training and Development involves teaching independent living, social, and communication skills to persons and/or their families in order to maximize the person's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self-care, household management, social decorum, same- and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of individuals or their families with the person(s) present.

Skills training and development and psychosocial rehabilitation living skills training services must be provided by individuals who are qualified behavioral health professionals, behavioral health technicians or behavioral health para-professionals as defined in 9 A.A.C. 10. This may also include Licensed Practical Nurses (LPNs) who have training in providing these services as required by the person's service plan.

Skills Training and Development, may be billed up to 8 hours. Psychosocial Rehabilitation, cannot be billed if under 8 hours are needed and should be billed for the length of the service. Skills Training and Development and Psychosocial Rehabilitation cannot be billed on the same day, with certain exceptions.

Admission Criteria

The member is in need of training and development in the following areas:

- Self-care
- Household management
- Social decorum
- Same- and opposite-sex friendships
- Avoidance of exploitation
- Budgeting
- Recreation
- Development of social
- Support networks

Unskilled Respite

Unskilled Respite means short term behavioral health services or general supervision that provides rest or relief to a family member or other individual caring for the behavioral health recipient. Respite services are designed to provide an interval of rest and/or relief to the family and/or primary care givers and may include a range of activities to meet the social, emotional and physical needs of the behavioral health recipient during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays.

Respite services can be planned or unplanned. If unplanned respite is needed, agency personnel will assess the situation with the caregiver and recommend the appropriate setting for respite.

Admission Criteria

The member's condition indicates that the member's family or caregiver requires a temporary break from caregiving. Examples include:

- The stress of caregiving has put the member at imminent risk of abuse or neglect.
- Other responsibilities temporarily prevent the member's family or caregiver from assisting the member with Activities of Daily Living (ADLs).

Service Delivery

- The responsible provider evaluates the member and caregiver's need upon admission.
- The responsible provider, in conjunction with the member and/or member's family or caregiver, develops a service plan that includes the following:
- The goal(s) of Respite Care;
- Specific, measurable objectives aimed at achieving the goal(s) of Respite Care.
- The service plan incorporates instructions for medical care, special needs and emergencies.
- The service plan also addresses the need for other services and resources that become apparent during the provision of Respite Care. As needed, the provider assists the member with accessing other services and resources.
- The service plan may be informed by the findings of the initial clinical evaluation.
- The provider ensures that necessary medication, medical equipment, and assistive technology accompany the member when Respite Care is provided at a site other than the member's residence.

References

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Arizona Health Care Cost Containment System (AHCCCS), Medical Policy Manual, 320-W Treatment Foster Care. July 7, 2022.Arizona Department of Health Services, Behavioral Health Inpatient Facilities, Title 9 A.A.C.10, Article 1, March 2018.

Arizona Health Care Cost Containment System (AHCCCS), Covered Behavioral Services Guide, November 2017.

Arizona Health Care Cost Containment System (AHCCCS), Case Management Services, 2013.

Arizona Health Care Cost Containment System (AHCCCS), Children's Out of Home Services Home Care Training to Home Care Client Guidelines, July 2016.

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Arizona Health Care Cost Containment System (AHCCS), AMPM Policy 320-S, Behavior Analysis Services. Retrieved from: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320S.pdf

Arizona Health Care Cost Containment System (AHCCS), AMPM Policy 963, Peer and Recovery Support Service Provision Requirements. Retrieved from: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963.pdf

Revision History

Date	Summary of Changes
8/2019	Version 1
12/2019	Version 1 Revised
4/2020	Version 2

Date	Summary of Changes
6/2021	Version 3
5/2022	Version 4
6/2023	Version 5
6/2024	Version 6 with Long-Term Care Requirements