Chapter 2

UNIQUE FEATURES OF CMDP

All CMDP members have an assigned custodial agency representative, parole or probation officer, or a representative from one of the following custodial agencies:

- DCS/Department
- DES/Division of Developmental Disabilities (DDD)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Courts (AOC)/County Juvenile Probation Offices (JPO)
- Casey Family Program

The custodial agency representative is the member's case manager/legal guardian. These representatives are not medical managers for the members. CMDP has Care Coordinators who assist with coordinating care for members. *Please refer to Chapter 5 for additional information.*

Custodial Agency's Role

The custodial agency's responsibility is to give consent to, or to assist with obtaining consent for, treatment of the member. In some cases, court orders or state laws delegate the responsibility of consent to treatment to the out-of-home caregivers. The custodial agency representative can provide clarification on a case-by-case basis. The custodial agency representative can also assist medical providers with accessing services the child needs. The custodial agency representative may be able to provide additional medical history information about the member.

CMDP Provider Services staff can assist you with contacting the child's custodial agency representative.

Court-Ordered Treatment

In certain circumstances, the court may dictate specific treatment for children under the court's jurisdiction. Prior authorization may be required for some of the services, and authorization should be obtained prior to rendering services. The child's custodial agency representative will inform CMDP of court-ordered treatment, which may include specific timeframes for completion. Please submit standard claim forms to CMDP Claims, Attn: Claims Manager.

CMDP Provider Services can assist you with claims questions.

Dual Enrollment with an AHCCCS Health Plan

Children placed in out-of-home care may be enrolled in another AHCCCS Health Plan (e.g., APIPA, Mercy Care) at the time services are rendered. While the child is transitioning from another AHCCCS Health Plan to CMDP, the providers must seek reimbursement for AHCCCS covered services from the AHCCCS Health Plan assigned to that child. To confirm the correct payer, please refer to the AHCCCS website at www.azahcccs.gov.

Member Services staff can assist with identifying which health plan the child is enrolled in, and whom to call regarding prior authorization and claims submission..

Dual Eligible Members

AHCCCS members who are eligible for Medicare and Medicaid services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible. If a member is dual eligible, Medicare is considered the primary payer and CMDP is the secondary payer. CMDP pays the members deductible, coinsurance, and co-payments.

CMDP payment will be the difference between the AHCCCS fee-for-service schedule and the amount paid by Medicare. CMDP shall have no cost-sharing responsibility if the Medicare payment exceeds the AHCCCS fee-for-service schedule for services rendered.

NOTE: Services covered by AHCCCS that are not covered by Medicare, such as certain home health services, may be reimbursed by CMDP provided the services are medically necessary and all reimbursement/prior authorization requirements have been met.

Coordination of Benefits (COB) / Third Party Liability (TPL)

CMDP is the payer of last resort. Providers are required to bill any known primary insurer prior to submitting a claim to CMDP. Upon receipt of reimbursement or denial from the third party, submit the claim and the explanation of benefits (EOB) from the third party to CMDP. If a third party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance, or deductible, **CMDP is responsible for making these payments.**

CMDP members, caregivers, representatives, legal guardians, and birth parents are not responsible for payment of any fees or co-pays.

In accordance with A.R.S § 36-2903.01(K), billing or attempting to collect payment through a collection agency is prohibited and any action is to be terminated immediately. Failure to do so is in violation of federal and state law and is just cause for assessing a civil penalty.

Additionally, Arizona Administrative Code (A.A.C.) R6-5-6006(2) states that the Department shall not pay for that portion of the cost of any covered service which exceeds the charges set by the fee schedule and that the medical/dental provider is prohibited from rendering a bill for additional amounts to the Department, its representatives, the member, foster parents, legal guardians, and birth parents.

If you have any questions regarding third party coverage, please contact Provider Services at (602) 351-2245 or (800) 201-1795.

Consent to Treat

A custodial agency representative must give consent for treatment of a CMDP member.

When making health care decisions, custodial agency representative-the DCSS, will consult with the biologic parent, if possible.

DCS will obtain a parent's consent, if possible, for surgery, general anesthesia, blood transfusion, or unusual medical procedure.

If it is not possible to obtain written or verbal parental consent, DCS will provide a copy of the Temporary Custody Notice or other court order granting custody to the Department to the medical providers.

When parental rights have not been severed, and it is safe to involve the parent in decisions about the child's medical and behavioral health care. The DCSS will:

- consult with the parent(s) prior to seeking medical treatment or services unless an emergency situation exists; and
- encourage the foster parent to include the parent(s) in the child's medical and behavioral health appointments

A minor may request and consent to an emergency medical examination and treatment, if the hospital, upon examination, determines that emergency treatment is necessary. If it is determined that emergency treatment is not necessary, then Department/parental consent is required, if possible.

A minor may consent to medical care or treatment for venereal disease.

The CMDP member's custodial agency representative- the DCSS or legal representative must give consent, or obtain consent through the court, for any non-routine service including, but not limited to:

- Pregnancy termination (see Chapter 5); Parental consent (written and notarized) or court order is required for a child in out-of-home care to receive an abortion.
- General Anesthesia
- Surgery
- Clinical trials, including clinical trials for HIV/AIDS treatment
- Blood transfusions.

The out-of-home provider (foster parent) is authorized to consent to:

- evaluation and treatment for emergency conditions that are not life-threatening;
- routine medical treatment and procedures;
- immunizations, unless the parents object based on religious beliefs;
- routine dental treatment and procedures;
- Early Periodic Screening Diagnosis and Treatment (EPSDT) services (e.g., developmental and behavioral health intakes, screenings, treatment and procedures);
- services by health care providers to relieve pain or treat symptoms of common childhood illness or conditions; and
- testing for the presence of the human immunodeficiency virus (HIV)

Emergency Consent by an Out-of-home Care Provider (foster parent)

The out-of-home care provider may provide emergency consent if required, when the hospital and the emergency room physician or medical provider advises that immediate treatment is necessary and delay of treatment (in order to notify the Department) is potentially harmful to the child. DCS should be notified as soon as possible.

HIV/AIDS Testing of a Child in Out-of-Home Care

HIV testing is available to all children who are eligible for CMDP services. HIV testing must be deemed medically necessary and ordered by a qualified physician or practitioner to determine the diagnosis and identify the child's medical needs. An out-of-home care provider can consent for testing

The DCSS will:

- Personally communicate to the child's health care provider any factors that would place the child at risk for HIV/AIDS exposure, including intravenous drug use, sexual abuse, and voluntary risk behavior of either the mother or the child.
- To the extent possible, consult with each biological parent of the child whose parental rights have not been terminated, when making decisions about HIV testing for a child in the Department's custody.
- Request court approval for a child age 12 or older, when the child meets the testing criteria and testing is determined to be medically necessary, but the child refuses to give consent for testing

Members 12 years or older are allowed to consent to his or her own HIV/AIDS testing if the youth meets the criteria for testing. No additional consent is required, nor does the parent need to be informed, if the minor requests testing.

Pregnancy Termination

Pregnancy terminations must be *medically necessary.* AHCCCS Medical Policy defines the termination as medically necessary if one of the following conditions exists:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
- creating a serious physical or mental health problem for the pregnant member;
- seriously impairing a bodily function of the pregnant member;
- causing dysfunction of a bodily organ or part of the pregnant member;
- exacerbating a health problem of the pregnant member; or
- preventing the pregnant member from obtaining treatment for a health problem.

The child's custodial agency representative – the DCSS and CMDP will assist with obtaining the necessary documentation.

Behavioral Health Services

CMDP is not the payor for BH services for TXIX and TXXI members. However, due to the unique population that comprise CMDP membership, CMDP has a Behavioral Health unit that assists with the

coordination of care for the comprehensive needs for the child and family to be considered in service planning for the member.

CMDP has integrated 12 principles to maintain the integrity of best practices and approaches to providing Behavioral Health services for children into the provision of services to our members.

These Principles are:

1. Collaboration with the child and family:
   Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parent and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. Functional Outcomes:
   Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. Collaboration with Others:
   When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Member centered teams plan and deliver services. Each child's team includes the child, parents, any foster parent, and any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child's teacher, the child's Child Protective Service and/or Division of Developmental Disabilities case worker, and the child's probation officer. The team develops a common assessment of the child's and family's strengths and needs, develops an Individualized Service Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.
4. Accessible Services:
   Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available
5. Best Practices:
   Behavioral health services are provided by competent individuals who are adequately trained and supervised. Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the class members' lives, especially class members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. Most appropriate setting:
   Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to meet the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. Timeliness:
   Children identified as needing behavioral health services are assessed and served promptly.
8. Services tailored to the child and family:
   The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. Stability:
   Behavioral health service places strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crisis that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. Respect for the child and family's unique cultural heritage:
    Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. Independence:
    Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.
12. Connection to natural supports:
    The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations

Provider Services staff are always available to assist you in delivering covered services to CMDP members. Effective communication between medical providers and CMDP is essential to the delivery of appropriate medical services to our children. If you have any questions, please call Provider Services or Medical Services units at (602) 351-2245 or (800) 201-1795.