1023 – DISEASE/CHRONIC CARE MANAGEMENT

EFFECTIVE DATES: 10/01/22, 10/01/23

APPROVAL DATES: 06/01/21, 07/06/23

I. PURPOSE

This Policy applies to ACC, ACC-RBHA ALTCS E/PD, DCS/ CHP (CHP), and DES/DDD (DDD) Contractors; Fee-For-Service (FFS) Programs including: the American Indian Health Program (AIHP), Tribal ALTCS, TRBHA; and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). The Contractor shall implement a Disease/Chronic Care Management Program that focuses on members at high risk and/or with chronic conditions that have the potential to benefit from a concerted intervention plan. The Contractor is responsible for adhering to all requirements for medical management as specified in Contract, Policy, 42 CFR Part 457, and 42 CFR Part 438. The Division of Fee for Service (DFSM) Management provides care management for its at-risk members as specified in this Policy.

II. DEFINITIONS

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

CONTRACTOR	**DES/DDD TRIBAL HEALTH PROGRAM (DDD THP)**	**DIVISION OF FEE FOR SERVICE MANAGEMENT (DFSM)**
EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)	**MEDICAL MANAGEMENT (MM)**	**MEMBER**
TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)		

III. POLICY

REQUIREMENTS FOR DISEASE/CHRONIC CARE MANAGEMENT

1. The Division of Fee for Service Management (DFSM), in coordination with the TRBHAs, American Indians Medical Home (AIMH)s, Multispecialty Integrated Clinics (MSIC)s, and IHS/638 facilities provide care management services for FFS members determined to be at risk for, or already experiencing, poor health outcomes due to their disease burden or chronic conditions. FFS high risk member populations include:
   a. High Needs High Cost (HNHC) members,
   b. Members with a Serious Mental Illness (SMI) designation, and
   c. Tribal ALTCS members.

   For specific services provided by TRBHAs and Tribal ALTCS, refer to the applicable Intergovernmental Agreements (IGAs).

2. The Contractor's Medical Management (MM) Committee shall focus on selected disease/chronic conditions based on utilization of services, at risk population groups, and high need/high cost conditions to develop the Disease/Chronic Care Management Program. Refer to AMPM Policy 1021 for care management duties related to disease management.

3. The Contractor shall provide information to members regarding their Disease/Chronic Care Management Program.
   a. Members at risk or already experiencing poor health outcomes due to their disease burden or chronic conditions,
   b. Addressing member health care needs across the continuum of care,
   c. Health education that addresses the following:
      i. Appropriate use of health care services,
      ii. Health risk-reduction and healthy lifestyle choices, including tobacco cessation,
      iii. Screening for tobacco use with the Ask, Advise, and Refer model, and refer to the Arizona Smokers Helpline utilizing the proactive referral process,
      iv. Self-care and self-management tools for health conditions, including wellness coaching and health promotion areas including but not limited to:
         1) Healthy eating and weight maintenance,
         2) Encouraging physical activity,
         3) Managing stress,
         4) Avoiding at-risk drinking, and
         5) Identifying depressive symptoms.
      v. Self-help programs or other community resources that are designed to improve health and wellness, and
      vi. EPSDT services for qualified members including education and health promotion for dental/oral health services.

d. Maternity care programs and services for pregnant women, including family planning. Interventions and self-management tools shall be evidence-based,
e. At least annually evaluate the effectiveness of programs, including education specifically related to the identified members' ability to self-manage their disease/chronic conditions and measurable outcomes. Uses the results from the evaluation to identify and act upon opportunities for improvement,
f. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care, and
g. Components for coordination with providers include, but are not limited to:
    i. Education regarding the specific evidence-based guidelines and desired outcomes that drive the program,
    ii. Sharing data,
    iii. Involvement in the implementation of the program,
    iv. Methodology for monitoring provider compliance with the guidelines, and
    v. Implementation of actions designed to bring the providers into compliance with the practice guidelines.