

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: 10/01/94, 10/01/18

REVISION DATES: 11/01/05, 10/01/08, 10/01/10, 04/01/12, 07/01/12, 12/18/14, 02/01/15,
10/01/15, 06/27/18

I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. This Policy outlines the Medical Management (MM) administrative requirements.

II. DEFINITIONS

PLAN-DO-STUDY-ACT (PDSA) METHOD A four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guides the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

III. POLICY**A. MEDICAL MANAGEMENT ANNUAL PLAN**

Contractor shall develop a written MM Plan that describes the Contractors' methodology to meet or exceed the standards and requirements of Contract and AMPM Chapter 1000. Contractors shall submit the MM Plan, and any subsequent modifications, to AHCCCS MM Unit for review and approval prior to implementation; refer to Appendix C for the MM Plan Checklist and to Appendix G for the MM Work Plan Guide and Template. At a minimum, the MM Plan must describe, in detail, the Contractors' MM program and how program activities will assure appropriate management of physical and behavioral service delivery for enrolled members. The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and are easily located within the document(s) submitted.

B. MM WORK PLAN

The Contractor is responsible for developing a work plan that identifies the Contractor's goals, methodology for improvement utilizing PDSA method, and monitoring efforts related to the MM program requirements outlined in AMPM Policy 1020. Refer to Appendix G for the MM Work Plan Guide and Template.

C. MM EVALUATION

An annual narrative evaluation of the effectiveness of the previous year's MM strategies and activities shall be submitted to MM after being reviewed and approved by the

Contractor's governing or policy-making body. The narrative summary of the previous year's work plan shall include but is not limited to:

1. A summary of the MM activities performed throughout the year with:
 - a. The title/name of each activity,
 - b. The desired goal and/or objective(s) related to each activity,
 - c. The Contractor staff positions involved in the activities,
 - d. Trends identified and the resulting actions implemented for improvement,
 - e. The rationale for actions taken or changes made, and
 - f. A statement describing whether or not the goals/objectives were met.
2. Review, evaluation, and approval by the MM Committee of any changes to the MM Plan, and
3. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

D. MM ADMINISTRATIVE OVERSIGHT

1. The Contractor's MM program shall be administered through a clear and appropriate administrative structure. The governing or policy-making body shall oversee and be accountable for the MM program. Contractors shall ensure ongoing communication and collaboration between the MM program and the other functional areas of the organization (e.g., quality management, member and provider services and grievances).
2. The Contractors shall have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if combined with the Quality Management Committee, the agenda items and minutes shall reflect that MM issues and topics are presented, discussed and acted upon.
 - a. At a minimum, Committee membership shall include:
 - i. The Medical Director or appointed designee as the chairperson of the committee, who is responsible for the implementation of the MM Plan (Appendices C and G), and shall have substantial involvement in the assessment and improvement of MM activities,
 - ii. The MM Manager,
 - iii. Representation from the functional areas within the organization, and
 - iv. Representation of contracted or affiliated providers.
 - b. The MM Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM Committee sign-in sheets with requirements noted).
 - c. The frequency of Committee meetings shall be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the Committee shall meet on a quarterly basis,
 - d. Committee meeting minutes shall include the data that is reported to the Committee as well as, analysis and recommendations made by the Committee. Data, including utilization data, may be attached to the Committee meeting

minutes as separate documents as long as the documents are noted in the Committee meeting minutes. Recommendations made by the Committee shall be discussed at subsequent Committee Meetings. The MM Committee shall review the MM program objectives and policies annually and update them as necessary to ensure:

- i. The MM responsibilities are clearly documented for each MM function/activity,
 - ii. The Contractor staff and providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community,
 - iii. The providers are informed of information related to their performance (i.e., provider profiling data), and
 - iv. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS MM Unit.
3. The MM Program shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in AMPM Chapter 1000.
- a. Staff qualifications for education, experience and training shall be developed for each MM position,
 - b. The grievance process shall be part of the new hire and annual staff training including, but not limited to:
 - i. What constitutes a grievance,
 - ii. How to report a grievance, and
 - iii. The role of the Contractor's Quality Management staff in grievance resolution.
 - c. A current organizational chart shall be maintained to show reporting channels and responsibilities for the MM program.
4. The Contractors shall maintain records that document MM activities, and make the information available to AHCCCS MM Unit upon request. The required documentation shall include, but is not limited to:
- a. Policies and procedures,
 - b. Reports,
 - c. Practice guidelines,
 - d. Standards for authorization decisions,
 - e. Documentation resulting from clinical reviews [e.g. notes related to concurrent review, retrospective review, and Prior Authorization (PA)],
 - f. Meeting minutes including analyses, conclusions, and actions required with completion dates,
 - g. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the MM program such as inter-rater-reliability, and
 - h. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.

5. The Contractors shall have written policies and procedures pertaining to:
 - a. Receiving information/data from providers,
 - b. Reviewing reported information/data for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented,
 - c. Confidentiality of all member and provider information protected by Federal and State law,
 - d. Communicating to providers and appropriate staff regarding:
 - i. MM requirements and updates,
 - ii. Utilization data reports, and
 - iii. Profiling results.
 - e. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services,
 - f. Quarterly evaluations as specified in Contract, and:
 - g. Annual review of PA requirements that encompasses the analysis of PA decision outcomes, including but not limited to, the rationale for requiring PA for types of services such as high dollar, high risk, or case finding for care management.

6. Contractors shall have in place processes which ensure:
 - a. Under 42 C.F.R. 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, will render decisions to:
 - i. Deny an authorization request based on medical necessity,
 - ii. Authorize a request in an amount, duration, or scope that is less than requested, or
 - iii. Make a decision involving excluded or limited services under A.R.S. §36-2907(B) and A.A.C.R9-22-201 et seq, as specified in this Policy.
 - b. Under 42 C.F.R. 438.406(a)(2)(i), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:
 - i. Appeals involving denials based on medical necessity,
 - ii. Grievances regarding denial of expedited resolution of an appeal, or
 - iii. Grievances and appeals involving clinical issues.
 - c. Qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice. These include but are not limited to: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist, and licensed professional counselor. Decision making includes determinations involving excluded or limited services under A.R.S. §36-2907 and A.A.C R9-22-201 et seq.,

- d. In addition to those providers listed above ALTCS Case Management staff, as defined in AMPM Chapter 1600, shall have the appropriate clinical expertise to render decisions for non-skilled Home and Community Based Service (HCBS) such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care,
 - e. Ensure consistent application of Contractor standards and clinical criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action shall be developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%, and
 - f. There is prompt notification to the requesting provider and the member/guardian/designated representative or Medical Power of Attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice shall include information as specified in the ACOM Policy 414 and 9 A.A.C. 34.
7. All Contractors shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements shall include but are not limited to:
 - a. Member demographics,
 - b. Provider characteristics,
 - c. Services provided to members, and
 - d. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.
8. Contractors shall oversee and maintain accountability for all functions or responsibilities described in AMPM Chapter 1000 that are delegated to other entities. Documentation shall be kept on file, for AHCCCS review, and the documentation shall demonstrate and confirm that the following requirements have been met for all delegated functions:
 - a. A written agreement shall be executed that specifies the delegated activities and reporting responsibilities of the entity to the Contractor and shall also include provisions for revocation of the delegation or imposition of sanctions for inadequate performance,
 - b. Contractors shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement shall be submitted with the contractor review checklist (refer to ACOM Policy 438).
 - c. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractors annually, at a minimum, and
 - d. The following documentation shall be submitted to AHCCCS:
 - i. Annual evaluation reports to be included in the MM Plan, and
 - ii. Notification of the issuance of corrective action plans, documentation related to sanctions, notices of non-performance, and deficiencies and notices to cure within 30 days of issuance. The actual documents shall be kept on file and available for AHCCCS review.

9. Contractors shall ensure that:
 - a. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services, and
 - b. Providers are not prohibited from advocating on behalf of members within the service provision process.