1010 - MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATES: 10/01/94, 10/01/18, 10/01/21, 10/01/24, 07/22/25

APPROVAL 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, 04/06/21, 06/03/24, 04/29/25

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), and DES DDD (DDD) Contractors. This Policy specifies the Medical Management (MM) administrative requirements.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common term found in this Policy.

III. POLICY

A. MEDICAL MANAGEMENT PROGRAM PLAN, WORK PLAN AND EVALUATION

The MM Program Plan, including the Work Plan, and Evaluation components, shall address the monitoring of MM activities and the Contractor's proposed approaches to meet or exceed the minimum Contractor standards and requirements as specified in Contract and policies found within AMPM Chapter 1000. The MM Program Plan may be combined or written separately, as long as the required components are addressed.

1. Medical Management Program Plan

   The Contractor shall develop a written MM Program Plan that includes a written narrative describing the Contractor's planned methodologies to meet or exceed the MM standards and requirements of the Contract and Policies found within AMPM Chapter 1000. The Contractor shall submit the MM Program Plan, and any subsequent modifications, to AHCCCS for review and approval prior to implementation; refer to Attachment A for the MM Program Plan Checklist as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables. At a minimum, the MM Program Plan shall describe, in detail, the Contractor's MM program and how program activities will assure appropriate management of physical and behavioral service delivery for enrolled members following Attachment B.

2. Medical Management Work Plan

   The Contractor shall include a Work Plan for the current contract year that formally documents the Contractor's MM Program goals, objectives, strategies, activities, and methodology for improvement utilizing Plan-Do-Study-Act (PDSA) cycle, and monitoring efforts proposed to meet or exceed the MM standards and requirements of the Contract and Policies found within AMPM Chapter 1000. The Contractor shall utilize the MM Work Plan as a working document, refer to Attachment B.

3. Medical Management Evaluation

The Contractor shall include an MM Work Plan Evaluation that provides an annual written detailed Evaluation of the effectiveness of the previous year's MM strategies and activities. The Evaluation of the previous year's Work Plan shall include but is not limited to:

a. A summary of the MM activities performed throughout the year with:
   i. Goals/objective of each activity,
   ii. Established goals/objective related to each activity,
   iii. The Contractor's staff positions involved in the activities,
   iv. Analysis of results that include identified barriers and opportunities for improvement,
   v. The rationale for actions taken or changes made, and
   vi. A statement describing whether the goals/objectives were met, partially met or not met.
b. Review, evaluation, and approval by the MM Committee of any changes to the MM Plan,
c. Review and approval by the Contractor's governing or policy-making body, and
d. Necessary follow-up with targeted timelines for revisions made to the MM Plan and Work Plan.

B. MEDICAL MANAGEMENT ADMINISTRATIVE OVERSIGHT

1. The Contractor's MM program shall be administered through a clear and appropriate administrative structure. The Contractor's governing or policy-making body shall oversee and be accountable for the MM program. The Contractor 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 Contractor 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 meeting minutes shall reflect that MM issues and topics are presented, discussed, and acted upon:
   a. At a minimum, MM Committee membership shall include:
      i. The Medical Director or senior level physician appointed designee as the chairperson of the MM Committee, who is responsible for the implementation of the MM Program Plan, Work Plan, and Evaluation (and shall have substantial involvement in the assessment and improvement of MM activities),
      ii. The designated behavioral healthcare practitioner involvement in the implementation of the behavioral healthcare aspects of the MM program,
      iii. The MM Manager,
      iv. The representation from the functional areas within the organization, and
      v. The representation of contracted or affiliated providers.
   b. The MM Committee shall ensure that each of its members are 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 MM Committee meetings shall be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the MM Committee shall meet on a quarterly basis,

d. The MM Committee meeting minutes shall include the data that is reported to the MM Committee as well as analysis and recommendations made by the MM Committee. Data, including utilization data, shall be attached to the MM Committee meeting minutes as separate documents as long as the documents are noted in the MM Committee meeting minutes. Recommendations made by the MM Committee shall be discussed at subsequent MM Committee Meetings. The MM Committee shall review the MM program objectives and policies annually or more frequently to ensure:
   i. The MM responsibilities are clearly documented for each MM function/activity,
   ii. The Contractor's staff and providers are informed of the most current MM requirements, policies, and procedures in a timely fashion 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 (e.g., provider profiling data), and
   iv. The MM policies and procedures, and any subsequent modifications to them, are available upon request by AHCCCS.

3. The MM Program shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in policies found within AMPM Chapter 1000:
   a. The 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 (QM) staff in grievance resolution.
   c. A current organizational chart shall be maintained that indicates staff reporting channels and responsibilities for the MM Program.

4. The Contractor shall maintain records that document MM activities and make the information available to AHCCCS upon request. The required documentation shall include, but is not limited to:
   a. Policies and procedures,
   b. Reports,
   c. Clinical 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 Program Plan.

5. The Contractor shall have written policies and procedures and quarterly evaluation of:
   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 members and provider information protected by Federal and State law,
   d. Communicating to providers and appropriate staff regarding:
      i. The 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.

6. The Contractor shall annually evaluate and update its MM program.

7. The Contractor shall annually review PA requirements.

8. The Contractor shall have in place processes which ensure:
   a. As specified in 42 CFR 457.1230(d) and 42 CFR 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 ARS 36-2907(B) and AAC R9-22-201 et seq, as specified in this Policy.
   b. As specified in 42 CFR 457.1260 and 42 CFR 438.406(b)(2) 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. The Contractor shall have written job descriptions with qualifications for qualified health care professionals who render decisions or review denials. These include but are not limited to:
      i. Physician,
      ii. Podiatrist,
      iii. Optometrist,
      iv. Chiropractor,
      v. Psychologist,
      vi. Dentist,
      vii. Physician assistant,
      viii. Physical or Occupational Therapist,
      ix. Speech-Language Pathologist,
      x. Audiologist,

xi. Registered or Practical Nurse including:
    1) Nurse Practitioner,
    2) Clinical Nurse Specialist,
    3) Certified Registered Nurse Anesthetist, and
    4) Certified Nurse Midwife.
xii. Licensed Social Worker,
xiii. Registered Respiratory Therapist,
xiv. Licensed Marriage and Family Therapist, and
xv. Licensed Professional Counselor.

Decision making includes determinations involving excluded or limited services under ARS 36-2907 and AAC R9-22-201 et seq.

d. The Contractor shall use board-certified consultant to assist in making medical necessity determinations and must be able to provide evidence of their use,
e. In addition to those providers listed above ALTCS Case Management staff, as specified 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,
f. 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 as specified in AMPM Policy 1020. A plan of action shall be developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%,
g. There is prompt notification to the requesting provider, the member/Health Care Decision Maker (HCDM), and Designated Representative (DR), as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice shall include information as specified in ACOM Policy 414 and 9 AAC 34,
h. The Contractor provides access to staff for members and providers seeking information about the MM process and service authorizations, and
i. The Contractor may not utilize Artificial Intelligence to make medical necessity denial decisions or any appeal decisions.

9. The Contractor 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.

10. The Contractor shall oversee and maintain accountabilities for all functions or responsibilities specified in policies found within AMPM Chapter 1000 including those 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. If the Contractor intends to delegate a portion of its Care Management functions to an Administrative Services Subcontractor, prior approval from AHCCCS is required,

b. Delegated agreements shall be submitted with the Administrative Services Subcontracts and Checklist, as specified in ACOM Policy 438,
c. Executed delegated agreements shall specify 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, and
d. The Contractor shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation.

11. The Contractor shall ensure that:
    a. Compensation to individuals or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured 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.