1020 - MEDICAL MANAGEMENT SCOPE AND COMPONENTS

EFFECTIVE DATES: 10/01/94, 11/01/05, 10/01/08, 03/01/11, 01/01/11, 04/01/12, 02/01/15, 03/01/15, 10/01/15, 04/05/17, 07/01/17, 10/01/18

REVISION DATES: 10/01/94, 11/01/05, 10/01/08, 03/01/11, 01/01/11, 04/01/12, 02/01/15, 03/01/15, 10/01/15, 01/19/17, 07/26/17, 07/10/18

I. PURPOSE

This Policy applies to AHCCCS Complete Care (ACC), DCS/CMDP (CMDP), DES/DDD (DDD), ALTCS E/PD, RBHA Contractors; Fee-For-Service (FFS) Programs as delineated within this Policy including: TRBHAs. This Policy outlines requirements for the Contractor to develop an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from prevention to hospice, including Advanced Care Planning at any age or stage of illness.

II. DEFINITIONS

ADVANCE CARE PLANNING

Advance care planning is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

1. Educate the member/guardian/designated representative about the member's illness and the health care options that are available to them,
2. Develop a written plan of care that identifies the member's choices for treatment, and
3. Share the member's wishes with family, friends, and his or her physicians.

ARIZONA STATE HOSPITAL (AZSH)

Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

CONDITIONAL RELEASE PLAN (CRP)	If the psychiatric security review board finds that the person still suffers from a mental disease or defect or that the mental disease or defect is in stable remission but the person is no longer dangerous, the board shall order the person's conditional release. The person shall remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers shall specify the conditions of the person's release. The board shall continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan shall be in place, including the necessary funding to implement the plan as outlined in A.R.S. §13.3994.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].
END-OF-LIFE CARE	A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.
HEALTH CARE-ACQUIRED CONDITION (HCAC)	A Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/ Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.
INFORMAL SUPPORT	Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to; housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.
MEDICATION ASSISTED TREATMENT (MAT)	The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

OTHER PROVIDER-PREVENTABLE CONDITION (OPPC)

A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.

PSYCHIATRIC SECURITY REVIEW BOARD (PSRB)

The psychiatric security review board is established consisting of the following members who are appointed by the governor pursuant to A.R.S. §38-211 as outlined in A.R.S. §31-501 experienced in the criminal justice system:

1. One psychiatrist,
2. One psychologist,
3. One person who is experienced in parole, community supervision or probation procedures,
4. One person who is from the general public,
5. One person who is either a psychologist or a psychiatrist.

SERVICE PLAN

A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

SPECIAL HEALTH CARE NEEDS

Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

VIVITROL

An opioid antagonist that blocks opioid receptors in the brain for one month at a time, helping patients to prevent relapse to opioid dependence, following detoxification, while they focus on counseling and treatment.

III. POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

Contractors shall have in effect mechanisms to review utilization and detect both underutilization and over utilization of services [42 CFR 438.330(b)(3)]. Contractors shall develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the Contractor's Medical Management (MM) Committee shall review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. The evaluation shall include a review of the impact to both service quality and outcome. The MM Committee shall determine, based on its review, if action (new or

changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address both over and underutilization of services must be integrated throughout the organization. All such strategies shall have measurable outcomes that are reported in MM Committee minutes.

Refer to AMPM Policy 810 for FFS Utilization Management policies.

B. CONCURRENT REVIEW

Contractors shall have policies, procedures, processes, and criteria in place that govern the utilization of services in institutional settings. Contractors shall have procedures for review of medical necessity prior to a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

1. Policies and procedures for the concurrent review process shall:
   a. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to symptoms, diagnostic test results, diagnoses, and required services,
   b. Specify timeframes and frequency for conducting concurrent review and decisions:
      i. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed, and
      ii. Admission reviews shall be conducted within one business day after notification is provided to the Contractor by the hospital or institution (this does not apply to pre-certifications) [42 CFR 456.125].
   c. Provide a process for review that includes but is not limited to:
      i. Necessity of admission and appropriateness of the service setting,
      ii. Quality of care,
      iii. Length of stay,
      iv. Whether services meet the member needs,
      v. Discharge needs, and
      vi. Utilization pattern analysis,
   d. Establish a method for Contractor participation in the proactive discharge planning of all members in institutional settings.

2. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
   a. Medical criteria shall be approved by the Contractor MM Committee. Criteria shall be adopted from national standards. When providing concurrent review, the Contractor shall compare the member's medical information against medical necessity criteria that describes the condition or service,
   b. Initial institutional stays are to be based on the Contractor adopted criteria, the member's specific condition, and the projected discharge date,
   c. Continued stay determinations are to be based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay must be assigned a review date each time the review occurs. Contractors shall ensure that each continued stay review date is recorded in the member's record,

d. Contractors shall submit the Contractor Quarterly Showing Report for Inpatient Hospital Services. The Quarterly Showing Report for Inpatient Hospital Services shall be signed by the Contractor's Medical Director and submitted as specified in Contract to attest that:
   i. A physician has certified to the necessity of inpatient hospital services,
   ii. The services were periodically reviewed and evaluated by a physician,
   iii. Each admission was reviewed or screened under a utilization review program, and
   iv. All hospitalizations of members were reviewed and certified by their medical utilization staff.

C. DISCHARGE PLANNING

Contractors shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)].

The intent of the discharge planning process is to increase the management of inpatient admissions, improve the coordination of post-discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge.

Contractors shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

In the event that a covered behavioral health service is temporarily unavailable for persons in an inpatient or residential facility who are discharge-ready and require covered, post-discharge behavioral health services, policies and procedures shall be in place which stipulate the process for allowing the member to remain in that setting until the service is available or ensure Contractor care management, intensive outpatient services, provider case management, and/or peer service are available to the member while waiting for the appropriate covered behavioral health service.

A proactive assessment of discharge needs shall be conducted prior to admission when feasible.

Discharge planning shall be performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post-discharge to ensure a timely, effective, safe and appropriate discharge.

1. Contractor staff participating in the discharge planning process shall ensure the member/guardian/designated representative, as applicable:
   a. Is involved and participates in the discharge planning process,
   b. Understands the written discharge plan, instructions and recommendations provided by the facility, and
   c. Is provided resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

2. Discharge planning, coordination, and management of care shall include:
   a. Follow-up appointment with the PCP and/or specialist within seven business days,
   b. Coordination and communication by the Contractor with inpatient and facility providers for safe and clinically appropriate discharge placement, and community support services,
   c. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, other Contractors, and FFS Programs when appropriate,
   d. Prescription medications,
   e. Medical Equipment,
   f. Nursing services,
   g. End of Life Care related services such as Advance Care Planning,
   h. Informal supports,
   i. Hospice,
   j. Therapies (See AMPM Policy 310-X for limitations),
   k. Referral to appropriate community resources,
   l. Referral to Contractor Disease Management or Contractor care management (if needed),
   m. A post-discharge follow-up call to the member within three business days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed and anticipated clinical (behavioral and physical health) and social needs,
   n. Additional follow-up actions as needed based on the member's needs, and
   o. Proactive discharge planning when the Contractor is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

Contractors shall have Arizona licensed Prior Authorization (PA) staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the Contractor's medical criteria or make medical decisions.

Refer to AMPM Policy 1630, for qualifications of staff members who may authorize long term care home and community based services that are not considered skilled.

Refer to AMPM Policy 310-F for additional information regarding emergency services.

Refer to AMPM Policy 820 for FFS PA Requirements.

Contractors shall develop and implement a system that includes at least two modes of delivery for providers to submit PA requests such as telephone, fax, and/or electronically through a portal on the Contractor's website.

Contractors shall ensure providers who request authorization for a service are notified of the option to request a peer to peer discussion with the Contractor's Medical Director when additional information is requested by the Contractor or when the prior authorization request is denied. The Contractor shall coordinate the discussion with the requesting provider when appropriate.

Contractors shall develop and implement policies and procedures, coverage criteria and processes for approval of covered services, which include required time frames for authorization determination.

1. Policies and procedures for approval of specified services shall:
    a. Identify and communicate to providers, other Contractors, and FFS Programs when appropriate, and members those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization shall also be identified,
        i. Specify methods of communication with members to include newsletters, Contractor website, and/or Member Handbook; and methods of communication with providers other Contractors, and FFS Programs to include but are not limited to newsletters, Contractor website, and/or provider manual,
        ii. Provide for communication of changes in the coverage criteria to members, TRBHAs and providers 30 days prior to implementation of the change,
    b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria shall be made available to providers and TRBHAs through the Contractor provider manual and Contractor website. Criteria shall be available to members upon request,
    c. Authorize services in a sufficient amount, duration or scope to achieve the purpose for which the services are furnished,
    d. Ensure consistent application of review criteria,
    e. Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in ACOM Policy 414 and 42 CFR 438.210(b),
    f. Provide decisions and notice as expeditiously as the member's health condition requires and no later than 72-hours after receipt of an expedited service request not involving medications pursuant to 42 CFR 438.210(d)(2)(i),
    g. Provide for consultation with the requesting provider, other Contractors, or FFS Programs when appropriate, and
    h. Review all PA requirements for services, items or medications annually. The review shall be reported through the Contractor's MM Committee and shall include the rationale for changes made to prior authorization requirements and shall be documented in the MM Committee meeting minutes.

2. Contractors shall develop and implement policies for processing and making determinations for prior authorization requests for medications. Contractors shall ensure the following:
   a. A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization,
   b. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request,
   c. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation [42 CFR 438.3(s)(6)].

3. Contractor criteria for decisions on coverage and medical necessity for both physical and behavioral services shall be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.
   a. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member,
   b. The Contractor may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome, and
   c. The Contractor shall have criteria in place to make decisions on coverage when the Contractor receives a request for service involving Medicare or other third party payers. The fact that the Contractor is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes established in ACOM Policy 414. Refer to ACOM Policy 201 and 434 for additional information regarding Contractor payment and cost sharing responsibilities.

E. INTER-RATER RELIABILITY

Contractors shall have in place a process to ensure consistent application of review criteria in making medical necessity decisions which include prior authorization, concurrent review, and retrospective review [42 CFR 438.210(b)]. Inter-rater Reliability testing of all staff involved in these processes shall be performed at least annually. A corrective action plan shall be developed and implemented for staff who do not meet the minimum compliance standard of 90%.

F. RETROSPECTIVE REVIEW

Contractors shall conduct a retrospective review which is guided by the following.

1. Policies and procedures that:
   a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,
   b. Describe services requiring retrospective review, and

c. Specify time frame(s) for completion of the review.

2. Criteria for decisions on medical necessity shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

3. A process for consistent application of review criteria [42 CFR 438.210(b)(2)(i)].

4. Guidelines for Provider-Preventable Conditions.

   Title 42 CFR 447.26 prohibits payment for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a HCAC or an OPPC.

   A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

   If it is determined that the HCAC or OPPC was a result of a mistake or an error by a hospital or medical professional, the Contractor shall conduct a Quality of Care (QOC) investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

G. CLINICAL PRACTICE GUIDELINES

1. Contractors shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field [42 CFR 438.236(b)(1)],
   b. Have considered the needs of the Contractor's members [42 CFR 438.236(b)(2)],
   c. Are adopted in consultation with contracted health care professionals and National Practice Standards [42 CFR 438.236(b)(3)], or
   d. Are developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale,
   e. Are disseminated by the Contractor to all affected providers, upon the request, to members and potential members, and
   f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply [42 CFR 438.236(d)].

2. Contractors shall annually evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards [42 CFR 438.236(b)(4)].

3. Contractors shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM Committee meeting minutes.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. Contractors shall develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology. The policies and procedures shall include both a mechanism for committee review on a quarterly basis and a timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request shall be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request.

2. Contractors shall include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

3. Contractors shall evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature shall include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature shall also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. Contractors shall establish:
   a. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the member's medical needs to be met,
   b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received, and
   c. A process for documenting the coverage determinations and rationale in the MM Committee meeting minutes.

I. CONTRACTOR CARE MANAGEMENT

Contractors shall establish a process to ensure coordination of member physical and behavioral health care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the Contractor. Coordination shall ensure the provision of appropriate services in acute, home, chronic and alternative care settings that meet the member's needs in the most cost-effective manner available.

Contractor care managers are expected to have direct contact with members for the purpose of providing information and coordinating care, but are not performing the day-to-day duties of the ALTCS Contractor case manager, the provider case manager, or TRBHA and Tribal ALTCS case managers. Contractor care management shall occur at the Contractor level and cannot be delegated down to the provider level. Contractor care management is an administrative function.

Care managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Contractor care managers work closely with ALTCS Contractor case managers and provider case managers to ensure the most appropriate plan and services for members.

ALTCS Contractors and Tribal ALTCS shall also refer to the additional ALTCS Case Management Standards as specified in AMPM Policy 1620.

Contractors shall develop a plan outlining short- and long- term strategies for improving care coordination using the physical and behavioral health care data available regarding members with behavioral health needs. In addition, the Contractor shall develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement shall be reported in the annual MM Plan, Evaluation and Work Plan submitted to AHCCCS as specified in Contract.

1. Contractors shall establish policies and procedures that reflect integration of services to ensure continuity of care by:
   a. Ensuring that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements including, but not limited to, [45 CFR Parts 160 Subpart A and 164 Subpart E], Arizona statutes and regulations, and to the extent applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224],
   b. Allowing each member to select a PCP, TRBHA, and a behavioral health provider, if appropriate, who is formally designated as having primary responsibility for coordinating the member's overall health care,
   c. Ensuring each member has an ongoing source of care appropriate to his or her needs 42 CFR 438.208(b)(1),
   d. Ensuring each member receiving care coordination has a person or entity that is formally designated as primarily responsible for coordinating services for the member, such as the Contractor care manager, ALTCS Contractor case manager or provider case manager. The member shall be provided information on how to contact their designated person or entity [42 CFR 438.208(b)(1)],
   e. Specifying under what circumstance services are coordinated by the Contractor, including the methods for coordination and specific documentation of these processes,
   f. Coordinating the services for members between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)],
   g. Coordinating covered services with the services the member receives from another Contractor and/or FFS [42 CFR 438.208(b)(2)(ii) and (iii)],

h. Coordinating covered services with community and social support services that are generally available through contracting or non-contracting providers, in the Contractor's service area [42 CFR 438.208(b)(2)(iv)],
i. Ensuring members receive End of Life Care and Advance Care Planning as specified in AMPM Policy 310-HH,
j. Establishing timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940. This includes the coordination of member care between the PCP, AHCCCS Contractor(s), and TRBHA. At a minimum, the PCP shall communicate all known primary diagnoses, comorbidities, and changes in condition to the AHCCCS Contractor(s) or TRBHA when the PCP becomes aware of the Contractor or TRBHA involvement in care,
k. Ensuring that Contractors are providing pertinent diagnoses and changes in condition to the PCP in a timely manner. Contractors shall facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:
    i. "Urgent" – Requests for intervention, information, or response within 24 hours, and
    ii. "Routine" – Requests for intervention, information, or response within 10 business days.
l. Educating and communicating with PCPs who treat behavioral health conditions within their scope of practice. Such treatment shall include but not be limited to substance use disorders, anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). Requirements shall include but are not limited to:
    i. Expectations described in "d" of this section, and
    ii. Monitoring the member's condition to ensure timely return to the PCP's care for ongoing treatment, when appropriate, following stabilization by a Contractor.
m. Ensuring that Contractor care managers provide consultation to a member's inpatient and outpatient treatment team and/or directly engage the member as part of the Contractor care management program,

    n. Ensuring policies reflect care coordination for members presenting for care outside of the Contractor's provider network,
n. Monitoring controlled and non-controlled medication. Contractors shall restrict members to an exclusive pharmacy or prescriber as specified in AMPM Policy 310-FF. Contractors shall report, as specified in Contract, members assigned to an exclusive pharmacy, provider or both utilizing Attachment E, and
o. Coordinate care for members with high needs and/or high costs who have physical and/or behavioral health needs. Care coordination and interdisciplinary team meetings shall occur at least monthly, or more often, as needed, to affect change and if needed to discuss barriers and outcomes. Contractors shall implement the following, which includes planning interventions for addressing appropriate and timely care for the identified members as well as:
    i. Outlining methodologies, inclusion criteria, interventions and member outcomes as specified in AMPM Appendix C,
    ii. Identifying high need/high cost members utilizing Attachment D,
    iii. Submit member lists as specified in Contract utilizing Attachment G.

For DCS/CMDP and DES/ DDD, the Contractors must continue to coordinate care with the associated RBHAs for mutual members in the High Need/High Cost Program. DES/DDD and DCS/CMDP shall maintain the Program's prior exclusion criteria, member list and due dates for deliverables for new and existing high need/high cost members.

2. Contractors shall develop policies and implement procedures for members with special health care needs, as specified in AMPM Policy 520 and Contract, including:
   a. Identifying members with special health care needs,
   b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care needs or conditions,
   c. Ensuring adequate care coordination among providers or TRBHAs, and
   d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g. a standing referral or an approved number of visits).

   Contractors shall report as specified in Contract members with Special Health Care Needs utilizing Attachment D.

3. Contractors shall implement measures to ensure that members receiving Contractor care management:
   a. Are informed of particular health care conditions that require follow-up,
   b. Receive, as appropriate, training in self-care and other measures they may take to promote their own health, and
   c. Are informed of their responsibility to comply with prescribed treatments or regimens.

4. Contractors shall have in place a Contractor care management process with the primary purpose of application of clinical knowledge to coordinate care needs for members who are medically, physically and/or behaviorally complex and require intensive medical and psychosocial support.

   Contractors shall develop member selection criteria for the Contractor care management model to determine the availability of services, and work with the member's provider(s) or TRBHA. The Contractor care manager works with the ALTCS Contractor case manager, provider case manager, and TRBHA case manager, PCP and/or specialist to coordinate and address member needs in a timely manner. The Contractor care manager must continuously document interventions and changes in the plan of care.

5. The Contractor care management individualized care plan/service plan must focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The Contractor care manager must also assist the member in identifying appropriate providers, TRBHAs, or FFS Program and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the Contractor.

6. In addition to care coordination as specified in Contract, Contractors shall proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes members who do not otherwise meet the Contractor criteria for Contractor care management, as well as, members who contact governmental entities for assistance, including AHCCCS.

7. Contractors shall develop and implement policies and procedures to provide high touch Contractor care management or other behavioral health and related services to members on Conditional Release from the AzSH consistent with the CRP issued by the PSRB, including but not limited to assignment to a Contractor care manager. Contractors may not delegate the Contractor care management functions to a subcontracted provider.

   The Contractor care manager is responsible for at minimum the following:
   a. Coordination with AzSH for discharge planning,
   b. Participating in the development and implementation of the CRP,
   c. Participation in the modification of an existing or the development of a new Service Plan (SP) that complies with the CRP,
   d. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
   e. Attendance in outpatient staffing at least once per month,
   f. Coordination of care with the member's treatment team, TRBHA, and providers of both physical and behavioral health services to implement the SP and the CRP,
   g. Routine delivery of comprehensive status reporting to the PSRB,
   h. Attendance in a monthly conference call with AHCCCS MM,
   i. In the event a member violates any term of his or her CRP the Contractor shall immediately notify the PSRB and provide a copy to AHCCCS and AzSH, and
   j. The Contractor further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3994.

   Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member shall be reported to the PSRB and the AzSH immediately.

   Contractors shall submit a monthly comprehensive status report for members on Conditional Release to the PSRB and AHCCCS MM, as specified in Contract utilizing Attachment A. Contractors shall provide additional documentation at the request of AHCCCS MM.

8. In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the Contractor shall arrange ongoing medically necessary nursing services in a timely manner.

9. Contractors shall identify and track members who utilize Emergency Department (ED) services inappropriately four or more times within a six month period. Interventions shall be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

Contractor care management interventions to educate members should include, but are not limited to:

a. Outreach phone calls/visits,
b. Educational Letters,
c. Behavioral Health referrals,
d. High Need/High Cost Program referrals,
e. Disease Management referrals, and
f. Exclusive Pharmacy referrals.

Contractors shall submit the ED Diversion Summary (Attachment F) to AHCCCS as specified in Contract identifying the number of times the Contractor intervenes with members utilizing the ED inappropriately.

10. The RBHA and ACC Contractors shall monitor the length of time adults and children wait to be discharged from the ED while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member who needs behavioral health placement or wrap around services is in the ED the Contractor shall coordinate care with the ED and the member's treatment team to discharge the member to the most appropriate placement or wrap around services. Additionally, the Contractor shall submit the Adult and Child ED Wait Times Report utilizing Attachment B as specified in Contract.

11. Contractors (excluding CMDP) shall develop and implement policies and procedures to conduct reach-in care coordination for members who have been incarcerated. Contractors shall utilize 834 file data to develop a process for identifying members who meet the established parameters for reach-in care coordination (e.g. definition of chronic and/or complex care needs, including assessment and identification of MAT eligible members prior to release).

    Criminal Justice System reach-in care coordination facilitates the transition of members transitioning out of jails and prisons into communities. AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in criminal justice system "reach-in" care coordination efforts.

    Contractors shall conduct reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release.

Contractors shall report a Reach-In Plan to AHCCCS, as described below, in the annual Medical Management Plan and report outcome summaries in the Medical Management Evaluation, as specified in AMPM Appendix C and Appendix G. The Contractor shall monitor progress and the number of members involved in reach-in activities throughout the year and submit quarterly reporting to AHCCCS, utilizing Attachment C as specified in Contract. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

Reach-in Plan Administrative Requirements:

a. Designation of a Justice System Liaison responsible for the reach-in initiative and who:
    i. Resides in Arizona,
    ii. Is the single point of contact to communicate with the court and justice systems and the Contractor, including interaction with Mental Health Courts, Drug Courts, and other jail diversion programs, including serving as the single point of contact for law enforcement engaging in opioid-related diversion and incarceration alternative projects, and
    iii. Is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC) and Probation Departments.
b. Identification of the name(s) and contact information for all criminal justice system partner(s),
c. Description of the process for coordination with jails, when necessary for identification of those members in probation status,
d. Designation of parameters for identification of members requiring reach-in care coordination (e.g. definition of chronic and/or complex care needs) through agreement with reach-in partners,
e. Description of the process and timeframes for communicating with reach-in partners,
f. Description of the process and timeframes for initiating communication with reach-in members, and
g. Description of methodology for assessment of anticipated cost savings to include analysis of medical expense for these identified members prior to incarceration and subsequent to reach-in activities and release.

Reach-in Plan Care Coordination Requirements:

a. Develop process for identification of members meeting the established parameters for reach-in care coordination with chronic and/or complex care needs, including assessment and identification of MAT eligible members prior to release. The Contractor shall utilize the 834 file data provided to the Contractor by AHCCCS to assist with identification of members. The Contractor may also use additional data if available for this purpose,
b. Strategies for providing member education regarding care, services, resources, appointment information and Contractor care management contact information,

c. Requirements for scheduling of initial appointments with appropriate provider(s) or TRBHA based on member needs, appointment to occur within seven business days of member release,
d. Strategies regarding ongoing follow up with the member after release from incarceration to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three FDA approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate,
e. Should re-incarceration occur, strategies to reengage member and maintain care coordination,
f. Strategies to improve appropriate utilization of services,
g. Strategies to reduce recidivism within the member population, and
h. Strategies to address social determinants of health

Contractors shall notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Contract.

12. Contractors shall identify and coordinate care for members with Opioid Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.

13. The Maricopa County RBHA Contractor shall develop policies and processes to collaborate with the Arizona Department of Corrections (ADC) to provide Contractor care management to members enrolled in the Governor's Vivitrol Treatment Program, as required by Executive Order 2017-01. The Vivitrol treatment program will only be initiated for individuals being released from prison to Maricopa County. Individuals who have been determined eligible for Vivitrol treatment will receive a monthly injection of Vivitrol for up to 12 months to treat opioid dependence. Vivitrol will not be prescribed to pregnant or breast feeding women.

    The Contractor shall designate a care manager to provide Contractor care management to members enrolled in the Vivitrol treatment program.

    Upon notification from the ADC Reentry Planner that a member is enrolled in the program and will be released in 30 days, the designated Contractor care manager shall collaborate with the Reentry Planner and the ADC provider to determine the member's appropriateness for participation in the Vivitrol treatment program. To qualify for entry into the program individuals must be eligible for Medicaid, commit to participate in the program both pre- and post- release and sign necessary releases of information and consent to participate, as well as:
    a. Have a history of opioid dependence,
    b. Be identified as a potential candidate for the program at least 30 days prior to release,
    c. Commit to participate in substance use counseling and MAT pre- and post- release,
    d. Be screened using evidenced based American Society of Addiction Medicine (American Society of Addition Medicine (ASAM), Third Edition 2013) criteria,

e. Pass urinalysis tests,
f. Pass the Naloxone challenge test (to be done three to seven days prior to first injection),
g. Be screened for physical and/or behavioral health comorbidities that may make the member ineligible for Vivitrol,
h. Be free from any medical conditions which contraindicate participation,
i. Be administered the Vivitrol two to three days prior to release,
j. Be released to the community under either county or ADC community supervision, and
k. Be released to Maricopa County.

The Contractor care manager shall also:
a. Confirm that the member received pre-release counseling and is scheduled for post release counseling and MAT related to Vivitrol treatment from the ADC provider,
b. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol,
c. Provide accessibility to Naloxone and substance use treatment. Naloxone will be provided to whoever supports the member. If the member has no formal or informal support, the Naloxone will be provided directly to the member with instructions for the purpose and use by the provider within 72 hours following release from incarceration
d. Act as a liaison between the ADC provider responsible for administering the first injection of Vivitrol and the MAT specialist,
e. Schedule a post release appointment with the MAT specialist within seven days of administration of last injection,
f. Schedule counseling and other needed behavioral health services as applicable, and
g. Support the MAT specialist in identifying an alternate treatment if Vivitrol is not the appropriate course of treatment.

The Contractor shall submit a semi-annual Vivitrol Treatment Program Report to AHCCCS as specified in Contract.
The report must identify:
a. The name of the member participating in the program,
b. The member's ADC # and AHCCCS ID,
c. The date of the member's first injection,
d. The date the member was released from prison,
e. The name of the post release prescriber,
f. First appointment and then track monthly appointment (Received second shot and engaged in treatment in the first month),
g. Length of stay in treatment (e.g. end date),
h. Vivitrol end date and reason,
i. If member decides to change medication,
j. Compliance with treatment (e.g., regular drug screens),
k. Report on data monthly,
l. Member satisfaction,
m. Overdose/death and reason,
n. Successfully completed their term of supervision,
o. Recidivism,

p. Positive drug screen,
q. Emergency department, and
r. Hospital admission.

J. DISEASE/CHRONIC CARE MANAGEMENT

Contractors shall implement a Disease/Chronic Care Management Program that focuses on members with high risk and/or chronic conditions that have the potential to benefit from a concerted intervention plan. The goal of the Disease/Chronic Care Management Program is to increase member self-management and improve practice patterns of providers, thereby improving healthcare outcomes for members.

1. The Contractor MM Committee shall focus on selected disease conditions based on utilization of services, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.

2. The Disease Management Program shall include, but is not limited to:
   a. Members at risk or already experiencing poor health outcomes due to their disease burden,
   b. 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 management of health conditions, including wellness coaching,
      v. Self-help programs or other community resources that are designed to improve health and wellness,
      vi. EPSDT services for members including education and health promotion for dental/oral health services, and
      vii. Maternity care programs and services for pregnant women including family planning.
   c. Interventions with specific programs that are founded on evidence based guidelines,
   d. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members' ability to self-manage their disease and measurable outcomes,
   e. 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
   f. Components for providers include, but are not limited to:
      i. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program,
      ii. Involvement in the implementation of the program,
      iii. Methodology for monitoring provider compliance with the guidelines, and
      iv. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

K. DRUG UTILIZATION REVIEW

Drug Utilization Review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of DUR is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.

Contractors shall develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

1. Criteria for decisions on coverage and medical necessity shall be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.

2. Contractors shall manage a DUR program that includes, but is not limited to:
   a. Prospective review process for:
      i. All drugs prior to dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at minimum, shall be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts, and
      ii. All non-formulary drug requests.
   b. Concurrent drug therapy of selected members to assure positive health outcomes,
   c. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The review process serves as a means of identifying and developing prospective standards and targeted interventions,
   d. Pattern analyses that evaluates clinical appropriateness, over and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications,
   e. Tracking and trending shall be implemented specific to CMDP members being prescribed psychotropic medications:
      i. Results should be documented and reported to AHCCCS on a quarterly basis, via the EPSDT/Adult Quarterly Monitoring Report AMPM Appendix A,
      ii. If providers are found to be prescribing four or more concurrent psychotropic medications to CMDP members, the Contractor shall conduct a comprehensive chart review for each CMDP member. The chart reviews shall be completed by a subject matter expert (board eligible or certified child and adolescent psychiatrist).
   f. Provision for education of prescribers and Contractor professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program shall include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.