

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, 10/01/19, 10/01/20

APPROVAL 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, 09/19/19, 04/02/20

I. PURPOSE

This Policy applies to ACC, DCS/CMDP (CMDP), ALTCS E/PD and DES/DDD (DDD), RBHA Contractors; Fee-For-Services (FFS) Programs as delineated within this Policy including: American Indian Health Program (AIHP), Tribal ALTCS, TRBHAs; and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy outlines requirements for Contractors and FFS Programs 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 Advance Care Planning at any age or stage of illness. Contractors are responsible for adhering to all requirements for medical management as outlined in Contract, Policy, 42 CFR Part 457, and 42 CFR Part 438.

II. DEFINITIONS
ADVANCE CARE PLANNING

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/Health Care Decision Maker to:

1. Educate the member/Health Care Decision Maker and 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/Health Care Decision Maker’s choices for treatment, and
3. Share the member/Health Care Decision Maker’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.

CARE MANAGEMENT

A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

CASE MANAGEMENT

A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Contractor Case Management for DES/DDD is referred to as Support Coordination.

**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 specified in A.R.S. §13-3994.

**DRUG UTILIZATION
REVIEW
(DUR)**

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

**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:

1. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part as specified in 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 condition which occurs in any inpatient hospital setting and is not present on admission. (Refer to the current Centers for Medicare and Medicaid Services (CMS) list of Hospital-Acquired Conditions).

**HEALTH CARE DECISION
MAKER**

An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an un-emancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

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.

PEER-REVIEWED STUDY

Prior to publication, a medical study that has been subjected to the review of medical experts who:

1. Have expertise in the subject matter of the study,
2. Evaluate the science and methodology of the study,
3. Are selected by the editorial staff of the publication,
4. Review the study without knowledge of the identity or qualifications of the author, and
5. Are published in the United States.

**PRIOR AUTHORIZATION
(PA)**

A process by which the Division of Fee for Service Management, Tribal ALTCS programs, or Contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment as specified in A.A.C. R9-22-101 and A.A.C. R9-28-201.

**PSYCHIATRIC SECURITY
REVIEW BOARD
(PSRB)**

Consists of the following members who are appointed by the governor pursuant to A.R.S.§38-211 as specified in A.R.S. §31-501 experienced in the criminal justice system:

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

**SERVICE PLAN
(SP)**

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
(SHCN)**

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.

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, as specified in 42 CFR 457.1240(b), 42 CFR 457.1240(f), 42 CFR 457.1201(n)(2), and 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 shall be integrated throughout the organization. All such strategies shall have measurable outcomes that are reported in MM Committee minutes.

B. CONCURRENT REVIEW

Contractors shall have policies, procedures, processes, and criteria in place that govern the utilization of services during short-term and long-term hospital and institutional stays

to ensure that the member continues to receive reasonable, appropriate care in the right health care setting to meet the members healthcare needs. Contractors shall have procedures for review of medical necessity prior to a planned institutional admission (pre-certification) and for determination of the medical necessity for continuation of institutional care (concurrent review).

1. Policies and procedures for the concurrent review process shall:
 - a. Include relevant clinical information considered 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 working day after notification is provided to the Contractor by the hospital or institution (this does not apply to pre-certifications) as specified in 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 methodology for Contractor participation in proactive discharge planning for services available upon discharge for 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, Contractors 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 shall be assigned a new 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, as specified in Contract, the Inpatient Hospital Showings Report, signed by the Contractor's Medical Director 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.

Providers providing services to members enrolled with a FFS program, refer to AMPM Policy 810 Utilization Management.

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, as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i).

The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post-discharge services, reduce unnecessary institutional and 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, or as soon as possible upon admission.

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/Health Care Decision Maker/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 but are not limited to:
 - 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/Health Care Decision Maker 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.

FFS providers are responsible for discharge planning for FFS members, in accordance with the member's treatment/Service Plan.

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. Qualifications of staff members who may authorize long-term care home and community based services that are not considered skilled are specified in AMPM Policy 1630.

Information regarding emergency services is specified in AMPM Policy 310-F.

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 PA request is

denied. Contractors 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 timeframes for authorization determination.

1. Policies and procedures for approval of specified services shall:
 - a. Identify and communicate to providers, other Contractors, FFS Programs when appropriate, and to members/Health Care Decision Makers, for services that require and do not require PA and the relevant clinical criteria required for authorization decisions.

Contractors shall:

 - i. Specify methods of communication with members/Health Care Decision Makers to include newsletters, Contractor website, and/or Member Handbook, 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/Health Care Decision Makers, TRBHAs, Tribal ALTCS and providers 30 business 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, Tribal ALTCS and TRBHAs through the Contractor provider manual and Contractor website. Criteria shall be available to members/Health Care Decision Makers 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, expedited and medication authorization requests as specified in ACOM Policy 414 , 42 CFR 457.1230(d), and 42 CFR 438.210(b),
 - f. Provide for consultation with the requesting provider, other Contractors, or FFS Programs when appropriate, and
 - g. Review all PA requirements annually. The review shall be reported through the Contractor's MM Committee and shall include the rationale for changes made to PA requirements and shall be documented in the MM Committee meeting minutes.
2. Contractors shall develop and implement policies for processing and making determinations for PA requests for medications as specified in ACOM Policy 414. Contractors shall allow for at least a four-day supply of a covered outpatient prescription drug to be provided to the member in an emergent situation as specified in 42 CFR 457.1230(d) and 42 CFR 438.3(s)(6).

3. Contractor criteria for decisions on coverage and medical necessity for both physical and behavioral health services shall be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
 - a. Contractors 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. Contractors shall 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. Contractors 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 specified in ACOM Policy 414. Additional information regarding Contractor payment and cost sharing responsibilities are as specified in ACOM Policy 201 and 434.

FFS Providers shall follow PA Requirements specified in AMPM Policy 820.

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 PA, concurrent review, and retrospective review as specified in 42 CFR 457.1230(d) and 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) established by Contractors 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 as specified in 42 CFR 457.1230(d) and 42 CFR 438.210(b)(2)(i).
4. Guidelines for Provider-Preventable Conditions
 - a. Payment for services related to Provider-Preventable Conditions is prohibited, as specified in 42 CFR 447.26.

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

Providers providing services to members enrolled with a FFS program, refer to AMPM Policy 810 Utilization Management.

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 as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(1),
 - b. Have considered the needs of the Contractor's members as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(b)(2),
 - c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines as specified in 42 CFR 457.1233(c) and 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,
 - e. Are disseminated by the Contractor to all affected providers and, upon request, to members/Health Care Decision Makers 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 as specified in 42 CFR 457.1233(c) and 42 CFR 438.236(d).
2. Contractors shall annually evaluate the practice guidelines through a MM Committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards as specified in 42 CFR 457.1233(c) and 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 published or unpublished information sources that may establish that a new medical service or technology represents an advance that substantially improves the diagnosis or treatment of members, as specified in 42 CFR 412.87.
 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 that are 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 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 complex and require intensive physical, and or behavioral health support services.

Care Managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve improved health outcomes. Care Management should be short-term and time-limited in nature and may include assistance in making and keeping needed physical and/or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the member's immediate needs, PCP reconnection, and offering other resources or materials related to wellness, lifestyle, and prevention.

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 physical and behavioral 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.

Contractor Care Management shall occur at the Contractor level and is an administrative function. If the Contractor intends to delegate a portion of the Care Management functions, prior approval is required. Request for approvals must be submitted as specified in ACOM Policy 438.

Care Managers 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; however, Contractor Care Managers work closely with 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 member selection criteria for the Contractor Care Management model to determine the availability of services Contractor Care Managers shall work with the ALTCS Case Manager, provider Case Manager, TRBHA Case Manager, PCP and/or specialist(s) to coordinate and address member needs in a timely manner. The Contractor Care Manager shall continuously document interventions and changes in the plan of care.

Contractors shall develop a plan outlining short- and long- term strategies for improving care coordination. In addition, Contractors 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 utilizing Attachment F and Attachment G.

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, as specified in 45 CFR Part 160 and 164, Arizona statutes and regulations, and to the extent applicable in 42 CFR 457.1220, 42 CFR 438.100(a)(1), and 42 CFR 438.100(b)(2)(vi),
 - b. Allowing each member/Health Care Decision Maker 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 as specified in 42 CFR 457.1230(c) and 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, Tribal ALTCS Case Manager or provider Case Manager. The member/Health Care Decision Maker shall be provided information on how to contact their designated person or entity as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1),

- e. Specifying under what circumstances 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 as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(i),
- g. Coordinating covered services with the services the member receives from another Contractor and/or FFS as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(2)(ii) and (iii),
- h. Coordinating covered services with community and informal supports that are generally available through contracting or non-contracting providers, in the Contractor's service area as specified in 42 CFR 457.1230(c) and 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 among the PCP, AHCCCS Contractor(s), Tribal ALTCS and TRBHA. At a minimum, the PCP shall communicate all known primary diagnoses, comorbidities, and changes in condition to the Contractor and/or FFS and TRBHA when the PCP becomes aware of the Contractor, Tribal ALTCS, 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 specified in ACOM Policy 417,
- 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. Ensuring the member/Health Care Decision Maker is provided with information on how to contact their designated person or entity responsible for coordinating services as specified in 42 CFR 457.1230(c) and 42 CFR 438.208(b)(1), 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 directly engage the member/Health Care Decision Maker and designated representative as part of the Contractor Care Management program. 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 D, and prior to implementing changes to Contractor's Interventions and Parameters exclusive pharmacy and/or single prescriber process,

- 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 based on data analysis,
 - ii. Contractors may include additional criteria if the Contractor determines necessary,

Contractors shall submit an overview of the HNHC program, which must include the above requirements, in the annual MM Plan submission.

2. Contractors shall develop policies and implement procedures for members with SHCN, as specified in Contract and AMPM Policy 520, including:
 - a. Identifying members with SHCNs,
 - b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member,
 - 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 needs (e.g. a standing referral or an approved number of visits).
3. Contractors shall implement measures to ensure that members/Health Care Decision Makers and designated representatives involved in 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. The Contractor care management individualized care plan/service plan shall focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The Contractor Care Manager shall also assist the member/Health Care Decision Maker in identifying appropriate providers, TRBHAs or other FFS Programs, 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.
5. 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.
6. 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 Conditional Release Plan (CRP) issued by the PSRB, including but not limited to assignment to a Contractor Care Manager. Contractors shall 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 SP that complies with the CRP,
 - d. Member outreach and engagement at least once per month to assist the PSRB in evaluating compliance with the approved CRP,
 - e. Attendance in outpatient staffing at least once per month either telephonically or face-to-face,
 - 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 and AHCCCS MM,
 - h. Attendance in a monthly conference call with AHCCCS,
 - i. In the event of a member violating any term of his or her CRP, psychiatric decompensation, or use of alcohol, illegal substances or prescription medications not prescribed to the member, Contractors shall immediately notify the PSRB and provide a copy to AHCCCS and AzSH,
 - j. The Contractor further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth as specified in A.R.S. §13-3994.
 7. Contractors shall submit a monthly comprehensive status report for members on Conditional Release to the PSRB and AHCCCS, as specified in Contract, utilizing The Psychiatric Security Review Board GEI Conditional Release Monthly Report, Attachment A. Contractors shall provide additional documentation at the request of AHCCCS.
 8. Contractors shall utilize Attachment H to report their monitoring of members awaiting admission and those members who are discharge ready from AzSH. Contractors shall provide additional documentation at the request of AHCCCS.
 9. 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, Contractors shall arrange ongoing medically necessary nursing services in a timely manner.
 10. 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/Health Care Decision Maker on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

11. Contractor Care Management interventions to educate members/Health Care Decision makers shall 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,
 - f. Exclusive Pharmacy referrals, and
 - g. Social Determinants Of Health (SDOH) Resources.
12. Contractors shall submit the ED Diversion Summary, Attachment E, to AHCCCS as specified in Contract, identifying the number of times the Contractor intervenes with members utilizing the ED inappropriately.
13. Contractors shall monitor the length of time adults and children remain in the ED while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member who requires behavioral health placement or wrap around services is in the ED, Contractors 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. Contractors shall submit the 24 Hour Post Medical Clearance ED Report utilizing Attachment B as specified in Contract.
14. 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 resumed allowing for immediate care coordination activities. To support this initiative the Contractor shall participate in criminal justice system "reach-in" care coordination efforts.

Contractors 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 inform the identification of members who meet the Contractor's established parameters for reach-in care coordination for individuals with chronic and/or complex care needs, including assessment and identification of MAT eligible members prior to release.

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. Contractors shall collaborate with criminal justice partners (e.g. Jails, Sheriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC), Arizona Department of Corrections (ADOC), 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.

CMDP will conduct care coordination activities for members transitioning out of juvenile detention jails and prisons. Contractors shall conduct reach-in care coordination for members who have been incarcerated for 30 days or longer, and have an anticipated release date.

Contractors shall report a Reach-In Plan, as described below and in the annual MM Plan. Contractors shall monitor progress and the number of members involved in reach-in activities throughout the year and submit reporting 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.

15. 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 ADOC, County Jails, Sheriff's Office, Correctional Health Services, 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.

16. 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. Contractors shall utilize the 834 file data provided to the Contractor by AHCCCS to

- assist with identification of members. Contractors may also use additional data if available for this purpose,
- b. Strategies for providing member/Health Care Decision Maker and designated representative 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/Health Care Decision Maker 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.
17. 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. In addition to the care coordination requirements, Contractors shall also utilize the *Renewal Date Information Provided By AHCCCS* to identify incarcerated members that may have missed their eligibility redetermination date while incarcerated causing a discontinuance of benefits and provide assistance with reapplication for AHCCCS Medical Assistance upon release.
18. Contractors shall identify and coordinate care for members with Substance Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.
19. The Maricopa County RBHA Contractor shall develop policies and processes to collaborate with ADOC 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 breastfeeding women.

Contractors shall designate a Care Manager to provide Contractor care management to members enrolled in the Vivitrol treatment program.

Upon notification from ADOC 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 ADOC provider to determine the member's

- appropriateness for participation in the Vivitrol treatment program. To qualify for entry into the program, individuals shall 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 evidence-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 ADOC community supervision, and
 - k. Be released to Maricopa County.
20. The Contractor Care Manager shall also:
- a. Confirm that the member/Health Care Decision Maker received pre-release counseling and is scheduled for post release counseling and MAT related to Vivitrol treatment from ADOC provider,
 - b. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol,
 - c. Ensure the member has access to Naloxone and substance use treatment. Naloxone will be provided to the member, family members and/or caregiver with instructions for the purpose and use by the provider within 72 hours following release from incarceration,
 - d. Act as a liaison between the ADOC 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.
21. Contractor shall submit a Vivitrol Treatment Program Report to AHCCCS as specified in Contract.
- The report shall identify:
- a. The name of the member participating in the program,
 - b. The member's ADOC # 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 appointments (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.

For Tribal ALTCS Case Management services and requirements refer to AMPM Chapter 1600.

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 qualified 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 evidencebased 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

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

1. Criteria coverage for decisions based on 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 and DFSM shall manage a DUR program through the point-of-sale edits used by network pharmacies and the Pharmacy Benefit Manager's (PBM) electronic DUR system. The DUR system, at minimum, shall be able to identify and address the following areas of concurrent review that includes, but is not limited to:
 - a. Preferred and non-preferred federally and state reimbursable drugs prior to dispensing.
 - b. Drug-drug interactions;
 - c. Excessive doses;
 - d. High and suboptimal dosages;
 - e. Over and under utilization
 - f. Drug-pregnancy precautions;
 - g. Drug-disease interactions
 - h. Duplicate therapy; and
 - i. Drug-age precautions
3. Prospective Review Process for members to promote positive health outcomes through the use of prior authorization to ensure clinically effective medications are used in the most cost-efficient manner and AHCCCS Preferred Drugs are utilized in accordance with AMPM Policy 310-V. Prospective Utilization Review edits include but are not limited to the following:
 - a. Drug-allergy interactions,
 - b. Drug-disease contraindications,

- c. Therapeutic interchange,
 - d. Generic substitution,
 - e. Incorrect drug dosage,
 - f. Inappropriate duration of drug therapy,
 - g. Medication abuse/misuse, and
 - h. Agents preferred on the AHCCCS Drug List.
4. Retrospective Drug Utilization Review processes are completed to detect aberrant prescribing practice patterns, pharmacy dispensing patterns and medication administration patterns to prevent inappropriate use, misuse or waste. Retrospective Utilization Reviews include but are not limited to the following:
- a. Clinical appropriateness, use and misuse,
 - b. Appropriate generic use,
 - c. Drug-drug interactions,
 - d. Drug-disease contraindications,
 - e. Aberrant drug dosages,
 - f. Inappropriate treatment duration,
 - g. Member utilization for over and underutilization,
 - h. Prescriber clinician prescriptive ordering and practice patterns, and
 - i. Pharmacy dispensing patterns.

5. Contractors shall develop tracking and trending specific to CMDP members being prescribed psychotropic medications; Results shall be documented and reported to AHCCCS as specified in Contract, via the EPSDT and Adult Monitoring Report; refer to AMPM Appendix A.

If providers are found to be prescribing four or more concurrent psychotropic medications to CMDP members, CMDP 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).

6. Contractors shall evaluate prescribing practice patterns on drug therapy outcomes 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.
7. Contractors shall report results from adherence to AMPM Policy 310-FF Monitoring of Controlled and Non-Controlled Medication Utilization. Attachment D shall be used to report member results and submit as specified in Contract. The Contractor shall also provide prescribing clinician and dispensing pharmacy aberrant utilization.
8. Contractors shall perform DUR as required for the Federal Opioid Legislation (42 USC 1396A(OO)) and report DUR activities to AHCCCS in accordance with CMS DUR requirements as specified in Contract. AHCCCS and its Contractors shall implement automated processes to monitor the following:
- a. Opioid safety edits at the Point-of-Sale,

- b. Member utilization when the cumulative current utilization of opioid(s) is a Morphine Equivalent Daily Dose (MEDD) of greater than 90,
- c. Members with concurrent use of an opioid(s) in conjunction with benzodiazepine(s) and/or antipsychotic(s),
- d. Antipsychotic prescribing for children, and
- e. Fraud, Waste and Abuse by enrolled members, pharmacies and prescribing clinicians.

IMPLEMENTATION DATE 10/01/20