

## 1020 MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 13.3994, A.R.S. § 31-501, A.R.S. § 38-211; 42 CFR 438.210, 236, and 240(b)(3), 42 CFR 447.26, 42 CFR 456.125; Section F3, Contractor Chart of Deliverables; AMPM Policy 310, AMPM Attachment 1020-A, AMPM Attachment 1020-B

DELIVERABLES: Adult and Child Emergency Department (ED) Wait Times; Diabetic Diagnosis Report; Emergency Department Diversion Summary; Inappropriate Emergency Department (ED) Utilization Report; Inpatient Hospital Showings Report; Members in Need of Care Manager; Notification of All Hospital Admissions; Pressure Ulcer Report; Psychiatric Security Review Board (PSRB)/Guilty Except Insane (GEI) Conditional Release Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop an integrated process or system that is designed to assure appropriate use 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.

### **Definitions**

- A. 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.
  - 3. Share the member's wishes with family, friends, and his or her physicians.
- B. Arizona State Hospital (AZSH) - Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.
- C. Autism Spectrum Disorder - Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges.
- D. 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 must order the person's conditional release. The person must remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers must specify the conditions of the person's release. The board must continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan must be in place, including the necessary funding to implement the plan as outlined in A.R.S. § 13.3994.

- E. 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 [42 CFR 438.114(a)].
- F. 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.
- G. 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.
- H. Lennox-Gastaut Syndrome - A progressive disorder that includes refractory seizures, cognitive decline, and functional and behavioral deterioration.
- I. Medication Assisted Treatment (MAT) - The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.
- J. 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
  3. Wrong site surgery.
- K. Practical 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.
- L. 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.
- M. 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.

### **Utilization Data Analysis and Data Management**

The AdSS must have in effect mechanisms to review utilization and detect both underutilization and overutilization of services [42 CFR 438.240(b)(3)]. The AdSS must develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the AdSS's Medical Management (MM) Committee must review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. Evaluation must include a review of the impact to both service quality and outcome. The MM Committee must 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 overutilization and underutilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in AdSS MM Committee minutes.

For ASD: This measure is used to assess the combined number of child and adolescent psychiatrists, neurodevelopmental pediatricians, and developmental-behavioral pediatricians who have provided any outpatient care to at least one enrolled child, per 1,000 eligible children.

The quarterly deliverable will be a rate that will be expressed in terms of 1,000 eligible children (number of providers/1,000 enrolled children). The eligible population includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3 consecutive months) within the measurement year and classified to counties of Arizona. Taxonomy codes identify specialists: Child and Adolescent Psychiatrist (2084P0804X), Neurodevelopmental Pediatricians (2080P0008X) and Developmental-Behavioral Pediatricians (2080P0006X). The deliverable will be used to identify critical gaps for effective recognition and treatment for these specific providers.

For Lennox-Gastaut Syndrome: This deliverable is used to collect data on seizure type/syndrome classification which is salient for quality treatment through early identification for those with epilepsy. Infantile spasms are at higher risk to developing Lennox-Gastaut syndrome connected with intellectual disability.

Reportable data to be reported quarterly will be obtained from the population which includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3

consecutive months) within the measurement year and classified to counties of Arizona. Members meeting this criterion will be identified by the ICD-10 codes for Infantile Spasms (G40.822) and Lennox-Gastaut Syndrome (G40.812).

### **Concurrent Review**

The AdSS must have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings. The AdSS must have procedures for review of medical necessity before a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

- A. Policies and procedures for the concurrent review process must:
1. 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.
  2. Specify timeframes and frequency for conducting concurrent review and decisions:
    - a. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed
    - b. Admission reviews must be conducted within one business day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) (42 CFR 456.125)
  3. Provide a process for review that includes but is not limited to:
    - a. Necessity of admission and appropriateness of the service setting
    - b. Quality of care
    - c. Length of stay
    - d. Whether services meet the member needs
    - e. Discharge needs
    - f. Utilization pattern analysis.
  4. Establish a method for the AdSS's participation in the proactive discharge planning of all members in institutional settings.
- B. Criteria for decisions on coverage and medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
1. Medical criteria must be approved by the AdSS's MM Committee. Criteria must be adopted from national standards. When providing concurrent review, the AdSS must compare the member's medical information against medical necessity criteria that describes the condition or service.

2. Initial institutional stays are based on the AdSS's adopted criteria, the member's specific condition, and the projected discharge date.
3. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member's record.
4. The AdSS concurrent review staff must coordinate with the inpatient facility's Utilization Review Department and Business Office, when there is any change to the CRS authorization status or level of care required for CRS members,
5. The AdSS concurrent review staff must notify the AIHP, or DDD concurrent review staff when they become aware that a member who receives CRS is admitted to the hospital.
6. Conversely, the Division's concurrent review staff will notify the AdSS's concurrent review staff when they become aware that a member eligible for CRS services is admitted to the hospital,
7. Coordination will include proactive discharge planning between all potential payment and care sources upon completion of the CRS related service, and
8. AdSS must submit the "Contractor Quarterly Showing Report for Inpatient Hospital Services" as specified in Contract. Confirming there were methods and procedures in place as required.

### **Discharge Planning**

The AdSS must have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the ADSS furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

The intent of the discharge planning policy and procedure 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. The AdSS must 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. A proactive assessment of discharge needs must be conducted before admission when feasible. Discharge planning must 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.

The AdSS staff participating in the discharge planning process must 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
- C. Is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge.

Discharge planning, coordination and management of care must include:

- A. Follow-up appointment with the PCP and/or specialist within 7 days
- B. Safe and clinically appropriate 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, TRBHA and other contractor when appropriate)
- D. Prescription medications
- E. Medical Equipment
- F. Nursing Services
- G. End of Life Care related services such as Advance Care Planning
- H. Practical supports
- I. Hospice
- J. Therapies (There are limits for outpatient physical therapy visits for members 21 years of age and older. See Policy 310-X in this Policy Manual.)
- K. Referral to appropriate community resources
- L. Referral to AdSS's Disease Management or Care Management (if needed)
- M. A post discharge follow-up call to the member within three days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed clinical, behavioral, physical health, and social needs
- N. Additional follow-up actions as needed based on the member's needs
- O. Proactive discharge planning when the AdSS is not the primary payer.

### **Prior Authorization and Service Authorization**

The AdSS must have an Arizona-licensed prior authorization 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 AdSS's medical criteria or make medical decisions.

Prior authorization is required in certain circumstances.

The AdSS must develop and implement a system that includes at least two modes of delivery for providers to submit prior authorization requests such as telephone, fax, or electronically through a portal on the AdSS's website.

The AdSS must ensure providers who request authorization for a service are notified that they have the option to request a peer to peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS must coordinate the discussion with the requesting provider when appropriate.

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

- A. Policies and procedures for approval of specified services must:
1. Identify and communicate, to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS website, and/or provider manual. Changes in the coverage criteria must be communicated to members, TRBHAs and providers 30 days before implementation of the change.
  2. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria must be available to members upon request.
  3. Authorize services in a sufficient amount, duration, or scope to achieve the purpose for which the services are furnished.
  4. Ensure consistent application of review criteria.
  5. Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Chapter Overview in this Policy Manual, AdSS Operations Policy Manual, 414, and 42 CFR 438.210.
  6. 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 pursuant to 42 CFR 438.210(d)(2)(i).
  7. Provide for consultation with the requesting provider when appropriate.
  8. Review all prior authorization requirements for services, items, or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for

those changes must be documented in the MM Committee meeting minutes.

- B. AdSS must develop and implement policies for processing and making determinations for prior authorization requests for medications. The AdSS must ensure the following:
1. 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,
  2. 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 must be rendered within seven business days from the initial date of the request,
  3. 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)].
- C. The AdSS Criteria for decisions on coverage and medical necessity for both physical and behavioral services must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.
1. The AdSS 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.
  2. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.
  3. The AdSS must have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS's obligation to render a determination regarding coverage within the timeframes established in this policy.

### **Inter-rater Reliability**

The AdSS must 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. Inter-rater reliability testing of all staff involved in these processes must be done at least annually. A corrective action plan must be included for staff that do not meet the minimum compliance goal of 90%.

## **Retrospective Review**

The AdSS must conduct a retrospective review, which is guided by the following.

- A. Policies and procedures
  - 1. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews.
  - 2. Describe services requiring retrospective review.
  - 3. Specify time frame(s) for completion of the review.
- B. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
- C. A process for consistent application of review criteria
- D. Guidelines for Provider-Preventable Conditions

Title 42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

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 AdSS must conduct a quality of care investigation and report the occurrence and results of the investigation to the Division's Quality Management Unit and the AHCCCS' Clinical Quality Management Unit.

## **Clinical Practice Guidelines**

- A. The AdSS must develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
  - 1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field
  - 2. Consider the needs of the AdSS's members
  - 3. Are either:
    - a. Adopted in consultation with contracting health care professionals and National Practice Standards, or

- b. 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 must 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.
  4. Are disseminated by the AdSS to all affected providers and, upon the request, to members and potential members
  5. 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).
- B. The AdSS must 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.
- C. The AdSS must document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

#### **New Medical Technologies and New Uses of Existing Technologies**

- A. The AdSS must develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology. The policies and procedures must include the process and timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request must be made as expeditiously as the member's condition warrants and not later than 72 hours from receipt of request.
- B. The AdSS must include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.
- C. The AdSS must evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

- D. The AdSS must establish:
1. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met
  2. 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.
  3. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.

### **Care Coordination**

The AdSS must 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 AdSS. Coordination must 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.

AdSS care managers are expected to have direct contact with members for the purpose of providing information and coordinating care, but they are not performing the day-to-day duties of the assigned Support Coordinator. AdSS care management must occur at the MCO level or TRBHA level and cannot be delegated down to the provider level. AdSS 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. AdSS care managers work closely with assigned Support Coordinator to ensure the most appropriate plan and services for members.

The AdSS must develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the AdSS must 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 must be reported in the annual MM Plan, Evaluation and Work Plan submitted to the Division as specified in contract.

- A. AdSS must establish policies and procedures that reflect integration of services to ensure continuity of care by:
1. 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 and 164, Subparts A and E], Arizona statutes and regulations, and to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224]
  2. Allowing each member to select a Primary Care Provider (PCP) who is formally designated as having primary responsibility for coordinating the member's

overall health care, and a behavioral health provider, if appropriate

3. Ensuring each member has an ongoing source of care appropriate to his or her needs 438.208(b)(1)
4. 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 assigned Support Coordinator

The member must be provided information on how to contact their designated person or entity [438.208(b)(1)].

5. Specifying under what circumstance services are coordinated by the AdSS, including the methods for coordination and specific documentation of these processes
6. 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)]
7. Coordinating covered services with the services the member receives from another contractor and/or FFS [42 CFR 438.208(b)(2)(ii) and (iii)]
8. Coordinating covered services with community and social services that are generally available through contracting or non-contracting providers, in the AdSS's service area
9. Ensuring members receive End of Life Care and Advance Care Planning as specified in Policy 310-HH in this Policy Manual
10. Establishing timely and confidential communication of clinical information among providers, as specified in this Policy Manual

This includes the coordination of member care between the PCP, AdSS, and Tribal Regional Behavioral Health Authority (TRBHA) providers. At a minimum, the PCP must communicate all known primary diagnoses, comorbidities, and changes in condition to the AdSS or TRBHA providers when the PCP becomes aware of the AdSS or TRBHA provider's involvement in care.

11. Ensuring the AdSS are providing pertinent diagnoses and changes in condition to the PCP in a timely manner

The AdSS must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:

- a. "Urgent" – Requests for intervention, information, or response within 24 hours
- b. "Routine" – Requests for intervention, information, or response within 10 days.

12. Educating and communicating with PCPs who treat any member with diagnoses of depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD) that care requirements include but are not limited to:
    - a. Expectations described in "4" of this section
    - b. Monitoring the member's condition to ensure timely return to the PCP's care for ongoing treatment, when appropriate, following stabilization by an AdSS.
  13. Ensuring that behavioral health providers provide consultation to a member's inpatient and outpatient treatment team and/or directly engage the member as part of the AdSS care management program
  14. Ensuring policies reflect care coordination for members presenting for care outside of the AdSS's provider network
  15. Monitoring controlled and non-controlled medication. The AdSS must restrict members to an exclusive pharmacy or prescriber as specified in Policy 310-FF in the Policy Manual
  16. Meeting regularly with the AdSS to coordinate care for members with high behavioral and physical health needs and/or high costs

High level AdSS meetings must occur at least every other month or more frequently if needed to discuss barriers and outcomes. Care coordination meetings and staffing meetings must occur at least monthly, or more as often as necessary, to affect change. The AdSS must implement the following:

    - a. Identification of High Need/High Cost members as required in contract
    - b. Plan interventions for addressing appropriate and timely care for these identified members
    - c. Report of outcome summaries to the Division, as specified in Section F3, Contractor Chart of Deliverables.
- B. The AdSS must develop policies and implement procedures specific to members who are eligible for the Division, including:
1. Identifying members with special health care needs
  2. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care needs or conditions
  3. Ensuring adequate care coordination among providers
  4. 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).

- C. The AdSS must implement measures to ensure that members receiving care Management:
1. Are informed of particular health care conditions that require follow-up
  2. Receive, as appropriate, training in self-care and other measures they may take to promote their own health
  3. Are informed of their responsibility to comply with prescribed treatments or regimens.
- D. The AdSS must have in place a care management process whose primary purpose is the 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.
- The AdSS must develop member selection criteria for care management model to determine the availability of services, and work with the member's provider(s) or TRBHA. The care manager works with the assigned Support Coordinator, and TRBHA, PCP and/or specialist to coordinate and address member needs in a timely manner. The care manager must continuously document interventions and changes in the plan of care.
- E. The AdSS care management individualized care plan will focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The AdSS care manager must also assist the member in identifying appropriate providers, TRBHAs, 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 AdSS.
- The AdSS must provide oversight and monitoring of AdSS care management that is subcontracted or inclusive in a providers' contractual agreement. The AdSS care management role must comply with all Division and AHCCCS requirements.
- F. In addition to care coordination as specified in their contract with the Division, the AdSS must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes members who do not meet the AdSS criteria for care management, as well as, members who contact governmental entities for assistance, including the Division and AHCCCS.
- The AdSS must identify and coordinate care for members with Opioid Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.
- G. The AdSS must develop and implement policies and procedures to provide high touch care management or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (AzSH) consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board PSRB, including but not limited to assignment to a AdSS care manager. The AdSS may not delegate the care management functions to a subcontracted provider.

The AdSS care manager is responsible for at minimum the following:

1. Coordination with AzSH for discharge planning,
2. Participating in the development and implementation of Conditional Release Plans,
3. Participation in the modification of an existing or the development of a new Individual Service Plan (ISP) that complies with the Conditional Release Plan (CRP),
4. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
5. Attendance in outpatient staffing at least once per month, and
6. Care coordination of care with the member's treatment team, assigned Support Coordinator, TRBHA, and providers of both physical and behavioral health services to implement the ISP and the CRP,
7. Routine delivery of comprehensive status reporting to the PSRB,
8. Attendance in a monthly conference call with Division Health Care Services,
9. If a member violates any term of his or her CRP, the AdSS must immediately notify the PSRB and provide a copy to the Division and AzSH, and
10. The AdSS further agrees and understands it must 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 must be reported to the PSRB and the AzSH immediately.

The AdSS must submit a monthly comprehensive status report for members on Conditional Release to the PSRB and Division Health Care Services, as specified in Contract using AHCCCS Medical Policy Manual (AMPM) Attachment 1020-A. The AdSS must provide additional documentation at the request of the Division's Health Care Services. If 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 AdSS must arrange ongoing medically necessary nursing services in a timely manner.

- H. The AdSS must identify and track members who use Emergency Department (ED) services inappropriately four or more times within a six-month period. Interventions must 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.

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

1. Outreach phone calls/visits
2. Educational Letters
3. Behavioral Health referrals
4. High Need/High Cost Program referrals
5. Disease Management referrals
6. Exclusive Pharmacy referrals.

The AdSS must submit the bi-annual ED Diversion Report to the Division as specified in Contract. The report must identify the number of times the AdSS intervenes with members.

- I. The AdSS must monitor the length of time adults and children wait to be discharged from the Emergency Department (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 AdSS must coordinate care with the ED and the member's treatment team including the assigned Support Coordinator to discharge the member to the most appropriate placement or wrap around services. Additionally, the AdSS must submit the Adult and Child ED Wait Times Report using AMPM Attachment 1020-B as required in the AdSS Contract, Section F3, Contractor Chart of Deliverables.
- J. The Division will lead reach-in care coordination efforts due to the low volume of members with justice system involvement. However, the Contractor is required to assist the Division in justice system "reach-in" care coordination efforts as directed by the Division. Reach-in care coordination activities are conducted for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. The Division initiates reach-in care coordination activities, with the assistance of the Contractor, when notified of a member's anticipated release date. The Contractor's care management protocols for members involved in reach-in care coordination shall be consistent with the Division's Medical Policy Manual, Chapter 500.

The Contractor must notify the Division upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended. The Division adjusts eligibility dates based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division, and capitation is adjusted as specified in Contract. In addition to the care coordination requirements, the Contractor shall also utilize the renewal date information 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.

- K. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections (ADC) in Maricopa County to provide 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 AdSS must designate a care manager to provide 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 AdSS care manager will 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:

1. Have a history of opioid dependence.
2. Be identified as a potential candidate for the program at least 30 days before release.
3. Commit to participate in substance use counseling pre and post release and Medication Assisted Treatment (MAT).
4. Be screened using evidenced based American Society of Addiction Medicine (ASAM, Third Edition) criteria.
5. Pass urinalysis tests.
6. Pass the Naloxone challenge test (to be done three to seven days before first injection).
7. Be screened for physical and/or behavioral health comorbidities that may make the member ineligible for Vivitrol.
8. Be free from any medical conditions which contraindicate participation.
9. Be administered the Vivitrol two to three days before release.
10. Be released to the community under either county or ADC community supervision
11. Be released to Maricopa County.

The AdSS care manager must also:

1. 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.
2. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol.

3. 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.
4. Act as a liaison between the ADC provider responsible for administering the first injection of Vivitrol and the MAT specialist.
5. Schedule a post release appointment with the MAT specialist within seven days of administration of last injection.
6. Schedule counseling and other needed behavioral health services as applicable.
7. Support the MAT specialist in identifying an alternate treatment if Vivitrol is not the appropriate course of treatment.

The AdSS must submit a semi-annual Vivitrol Treatment Program Report to the Division as specified in Contract. The report must identify:

1. The name of the member participating in the program
2. The member's ADC # and AHCCCS ID
3. The date of the member's first injection
4. The date the member was released from prison
5. The name of the post release prescriber
6. First appointment and then track monthly appointment (Received second shot and engaged in treatment in the first month)
7. Length of stay in treatment (e.g., end date)
8. Vivitrol end date and reason
9. If member decides to change medication
10. Compliance with treatment (e.g., regular drug screens)
11. Report on data monthly
12. Member satisfaction
13. Overdose/death and reason
14. Successfully completed their term of supervision
15. Recidivism

16. Positive drug screen
17. Emergency department
18. Hospital admission.

### **AdSS Disease/Chronic Care Management**

The AdSS must 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

- A. The AdSS's MM Committee must focus on selected disease conditions (e.g., Diabetes, Pneumonia admissions/ER visits, or constipation admissions/ER visits) based on use of services, needs and trends, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program. )
- B. The Disease Management Program must include, but is not limited to:
  1. Members at risk or already experiencing poor health outcomes due to their disease burden
  2. Health education that addresses the following:
    - a. Appropriate use of health care services
    - b. Health risk-reduction and healthy lifestyle choices including tobacco cessation
    - c. Screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline using the proactive referral process
    - d. Self-care and management of health conditions, including wellness coaching
    - e. Self-help programs or other community resources that are designed to improve health and wellness
    - f. EPSDT services for members including education and health promotion for dental/oral health services
    - g. Maternity care programs and services for pregnant women including family planning
  3. Interventions with specific programs that are founded on evidence based guidelines
  4. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members' ability to self-manage their

disease and measurable outcomes

5. 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
6. Components for providers include, but are not limited to:
  - a. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program
  - b. Involvement in the implementation of the program
  - c. Methodology for monitoring provider compliance with the guidelines
  - d. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

### **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.

The AdSS must develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

- A. Criteria for decisions on coverage and medical necessity must 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.
- B. AdSS must manage a DUR program that includes, but is not limited to:
  1. Prospective review process for:
    - a. All drugs before dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at minimum, must be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts
    - b. All non-formulary drug requests.
  2. Concurrent drug therapy of selected members to assure positive health outcomes
  3. 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.

4. 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
5. Provision for education of prescribers and AdSS professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.