1020 UTILIZATION MANAGEMENT

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REFERENCES: A.R.S. § 13-3994, A.R.S. § 31-501, A.R.S. § 36-551, A.R.S. § 38-211, A.A.C. R9-22-101, A.A.C. R9-28-201, 42 CFR 412.87, 42 CFR Part 437, 42 CFR Part 438, 42 CFR 447.26, 42 CFR 456.125, 42, CFR Part 457, 45 CFR Parts 160 and 164

PURPOSE

This policy outlines the oversight responsibilities of the Division of Developmental Disabilities (Division) to ensure effective treatment services, coordination of care to achieve optimal health outcomes for members served by the Division and identify opportunities for improvement in utilization management. This policy is specifically targeted to the Division's roles and responsibilities related to utilization management and oversight of the AdSS.

DEFINITIONS

1. "Behavioral Health Inpatient Facility (BHIF)" means a health institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

a. Have a limited or reduced ability to meet the individual's basic physical needs;

b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;

c. Be a danger to self;

d. Be a danger to others;

e. Be an individual with a persistent or acute disability as specified in A.R.S § 36-501; or

f. Be an individual with a grave disability as specified in A.R.S. § 36-501.

2. "Behavioral Health Residential Facility (BHRF)" means, as specified in A.A.C. R9-10-101, is a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

a. Limits the individual's ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

3. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health outcomes. Distinct from Support Coordination, Care Management does not include the day-to-day duties of service delivery.

4. "Concurrent Review" means the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional Level of Care (LOC). Reviewers assess the appropriate use of resources, LOC, and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates for Quality Of Care (QOC).

5. "Denial" means the decision to deny a request made by, or on behalf of, an individual for the authorization and/or payment of a covered service.

6. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
   a. Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions;
   c. Serious dysfunction of any bodily organ or part as specified in 42 CFR 438.114(a); or
   d. Serious physical harm to another individual (for behavioral health conditions).

7. "Health Care Acquired Condition (HCAC)" means a Hospital Acquired Condition (HAC) 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).

8. "Institution for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases as specified in 42 CFR 435.1010.

9. "Institutional Setting" means:

   a. A nursing facility as specified in 42 U.S.C. 1396 r(a);

   b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older;

   c. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36- 401;

d. A Behavioral Health Inpatient Facility (BHIF) as specified in A.A.C. R9-10-101;

e. A Behavioral Residential Setting (BHRF) as specified in A.A.C. R9-10-101.

10. "Inter-Rater Reliability (IRR)" means the process of monitoring and evaluating qualified healthcare professional staff's level of consistency with decision making and adherence to clinical review criteria and standards.

11. "Other Provider-Preventable Condition (OPPC)" means a condition occurring in the inpatient and outpatient health care setting which the Division and AHCCCS has limited to the following:

a. Surgery on the wrong member,

b. Wrong surgery on a member,

c. Wrong site surgery.

12. "Peer-Reviewed Study" means prior to publication, is a medical study that has been subjected to the review of medical experts who:

a. Have expertise in the subject matter of the study,

b. Evaluate the science and methodology of the study,

c. Are selected by the editorial staff of the publication,

d. Review the study without knowledge of the identity or qualifications of the author, and

e. Are published in the United States.

13. "Prior Authorization (PA)" means a process by which the AdSS authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this policy and as specified in A.A.C. R9-201, and any applicable contract provisions. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

14. "Provider Preventable Condition (PPC)" is a condition that meets the definition of a health care acquired condition or another provider preventable condition as defined by the State of Arizona.

15. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental

disability who is a client or an applicant for whom no guardian has been appointed. A.R.S. § 36-551.

16. "Retrospective Review" means the process of determining the medical necessity of a treatment/service post-delivery of care.

17. "Service Plan (SP)" means a complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

18. "Special Health Care Needs (SHCN)" means 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.

19. "Subcontracted health plan" means an organization with which the Division has contracted or delegated some of its management/administrative functions or responsibilities.

20. Support Coordination" means 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.

21. "Telehealth" means healthcare services delivered via asynchronous , remote patient monitoring, teledentistry, or telemedicine (interactive audio and video).

POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

1. The Division's Health Care Services (HCS) shall provide oversight and identifies trends, best practices and opportunities for improvement in utilization management through the following:
   a. HCS shall meet with the AdSS' Medical Management (MM) staff on a quarterly basis to review utilization data, trends, performance, and implementation of action plans.
   b. HCS shall review and approve annual AdSS' Medical

Management Program Plan, Work Plan and Evaluation to ensure goals, service quality and outcomes reflect member needs and Division goals.

2. The Division shall work in collaboration with AHCCCS Division of Fee for Service Management (DFSM) to monitor health outcomes of members enrolled in the Tribal Health Program (THP).

3. The Medical Management (MM) Committee shall review utilization data and findings to make recommendations to improve performance and achieve better outcomes. The MM Committee responsibilities include:

   a. The review of validated data provided by the Utilization Management (UM) subcommittee and any other relevant data;

   b. The review of tracking and trending utilization data on an on-going basis to:

      i. Identify under-utilization and/or over-utilization of services;

      ii. Identify opportunities for early intervention,

iii. Mitigate adverse outcomes;

iv. Identify opportunities for improvement and best practices;

v. Review of performance data related to integrated care, such as support coordination activities, access to services, and actions undertaken to resolve barriers to care; and

vi. Review of the utilization data, performance and opportunities for improvement with the AdSS at least quarterly.

4. The UM Subcommittee shall provide a quarterly tracking and trending report, including data provided by the AdSS, to the MM Committee.

5. The UM Subcommittee shall meet at least 10 times per year.

B. CONCURRENT REVIEW

1. The Division shall provide oversight of concurrent review services conducted by the AdSS. The Division shall monitor and review, at least annually, the AdSS' hospital and institutional stays to

ensure that treatment and lengths of stay meet member needs and are provided in accordance with clinical standards of care.

2. The Division shall provide oversight of the AdSS who are required to implement the following:
   a. Pre-certification prior to a planned hospital or institutional admission based on medical necessity and appropriateness of proposed care. After hospital or institutional admission occurs authorization of the continued stay is based on medical necessity established during the concurrent review process.
   b. Clinical documentation includes relevant medical information to be reviewed when making hospital length of stay decisions. Information may include: symptoms, diagnostic test results, diagnoses, and required services. The clinical review shall include the information used for determining the length of stay.
   c. The admission review and subsequent concurrent reviews shall occur within the timeframes and frequency set forth below:

i. Admission reviews shall be conducted within one working day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) as specified in 42 CFR 456.125;

ii. If the hospital or institution does not provide clinical information with the notification of admission, the AdSS shall request the member's medical records pertinent to the admission within one business day;

iii. Continued stay authorizations for hospital and institutional stays shall specify a date by which the next medical review shall be done based on the member's clinical information and criteria guidelines.

3. The Division shall notify providers of the option to request a peer-to-peer discussion with the appropriate AdSS or the AHCCCS DFSM Medical Director when additional information is requested or when the admission or continued stay is denied.

4. HCS shall ensure the concurrent review process is clearly documented and includes the following elements:

a. Medical necessity of admission, level of care and appropriateness of the service setting, criteria used for decision determination;
b. Quality of care, services and setting meeting the member needs;
c. Projected length of stay, based on approved clinical criteria;
d. Continued stay authorization with identification of next review date;
e. Denials or reduction in level of service;
f. Requests for peer-to-peer review and disposition of the request;
g. Proactive discharge planning starting on the day of admission and ongoing throughout the hospital/institutional stay to ensure continuity of care and linkage to required treatment services and supports at discharge;
h. Identification of utilization patterns, such as readmissions, extended length of stays.

5. The Division's support coordinator shall participate proactively in discharge planning for its members admitted to inpatient settings from the day of admission.

6. Support coordination shall manage discharge planning to ensure a safe discharge back to the community and facilitate active engagement from the health plans, health care and behavioral healthcare providers, allied treatment providers, supports and services to meet the comprehensive needs of the member.

7. The support coordinator shall collaborate with AHCCCS DFSM, as appropriate for THP enrolled members.

8. HCS shall review the AdSS' notification of an Institution of Mental Disease (IMD) placement exceeding 15 days and report it to AHCCCS.

9. The AdSS' Medical Management Committee shall annually approve the medical criteria used for concurrent review, which shall be adopted from the national standards. Subsequently it shall be approved by the Division's MM Committee.

10. The Division shall ensure criteria for physical health and behavioral health coverage and medical necessity decisions are clearly documented and based on reasonable medical evidence or the consensus of relevant health care professionals.
11. The Division shall review the AdSS submission of the quarterly Inpatient Hospital Showings Report and sends it to AHCCCS after ensuring the report is signed by the AdSS' Chief Medical Officer attesting that:
    a. A physician has certified to the necessity of inpatient hospital services,
    b. The services were periodically reviewed and evaluated by a physician,
    c. Each admission was reviewed or screened under a utilization review program, and
    d. All hospitalizations of members were reviewed and certified by medical utilization staff.
12. The Division shall collaborate with AHCCCS DFSM to review the Inpatient Hospital Showings Report for Division members enrolled in THP.

C. DISCHARGE PLANNING

1. The Division shall ensure the discharge planning process for members receiving inpatient services has proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member to arrange necessary services and resources for appropriate and timely discharge from a facility.

2. The support coordinator shall proactively engage with the interdisciplinary planning team which includes the hospital/institutional staff, the AdSS UM staff, HCS nurses, health care and behavioral healthcare providers, allied treatment providers, supports and services in discharge planning to meet the comprehensive needs of the member.

3. The Division support coordinator shall engage within the interdisciplinary planning team to support discharge planning from the day of admission and during the inpatient stay and after discharge to ensure all the necessary treatment, services and supports are available to sustain recovery, health, wellness, and well-being upon discharge to the community.

a. If the discharge cannot be affected because of the lack of a resource including return to home or community-based setting, the support coordinator shall identify the needed resource to support discharge from the hospital or institutional setting or resolve member issues and service concerns timely at the lowest level through the identification of care coordination strategies, resources, and clinical consultation.

b. If a covered behavioral health service required after discharge is temporarily unavailable for individuals in an inpatient or residential facility who are discharge-ready, the member may remain in that setting until the service is available. The support coordinator shall work with the Behavioral Health Complex Care Specialist, as needed and/or seek assistance to elevate the issue for resolution of the barrier in accordance with established procedures.

4. The support coordinator shall ensure care management, intensive outpatient services, provider support coordination,

and/or peer service are available to the member while waiting for the appropriate covered physical or behavioral health services.

a. The HCS shall compile a census report identifying the number of members who remain in discharge pending status due to the lack of community resources for review by the MM Committee including the barrier, type of resources needed, date of projected discharge and date of discharge.

5. The Division shall ensure discharge planning is performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continues through post-discharge to ensure a timely, effective, safe, and appropriate discharge.
6. Division staff participating in discharge planning shall ensure the member/responsible person, 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 with resources, referrals, and possible interventions to meet the member's assessed and anticipated needs after discharge.

7. The Division shall ensure discharge planning, coordination, and management of care includes, but is not limited to:

a. Follow-up appointment with the PCP and/or specialist within seven business days;

b. Coordination and communication by the Division 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 entities/contractors, and FFS providers 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;

k. Referral to appropriate community resources;

l. Referral to Disease Management or Care Management (if needed);

m. A post-discharge follow-up call is made by the District nurse to the member/responsible person within three business days of discharge to confirm the member's well-being and progress of the discharge plan;

n. Additional follow-up actions as needed based on the member's needs;

o. Proactive discharge planning when the Division is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

1. The Division's support coordinator and Health Care Services staff shall work in conjunction with the Division's Network Administrator to provide needed support to homeless clinics to identify available providers and assist in obtaining PA to ensure timely delivery of services that are included in the member plan of care.

2. The Division shall not require PA for tribal members utilizing Indian Health Services (IHS)/638 Tribal providers and facilities. Non-IHS/638 providers or facilities rendering covered services shall obtain PA. PA is not a guarantee of payment as specified in A.A.C. R9-22-101.

3. The AdSS Medical Management committee shall determine PA criteria and is approved by the Division's Medical Management committee.

4. The Division shall provide oversight of the PA process conducted by the AdSS, including adherence to benefit coverage and timeliness of PA requests.

5. The Division shall provide oversight to ensure that all PA

activities are performed in accordance with AdSS Medical Manual Policy 1020 including, but not limited to:

a. The AdSS shall clearly document its criteria for decisions on coverage and medical necessity for both physical and behavioral health services and be based on reasonable medical evidence or a consensus of relevant health care professionals.

b. The AdSS shall utilize Arizona licensed 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 AdSS' medical criteria or make coverage decisions.

c. The AdSS shall implement a system that allows providers to submit PA requests via telephone, fax, and/or electronically through email.

d. Any AdSS network provider who requests authorization for a service shall be notified of the option to request a peer-to-peer discussion with the AdSS Medical Director

when additional information is requested by the Division or when a PA request is denied.

e. The AdSS shall coordinate the discussion with the requesting provider when appropriate.

f. The AdSS shall identify and communicate to providers and members/Responsible Person the services that require and do not require PA and the relevant medical criteria required for authorization decisions.

g. The AdSS shall respond to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Chapter Overview of this Policy Manual, Division Operations Manual policy 414, 42 CFR 457.1230(d), and 42 CFR 438.210(b).

h. The AdSS shall respond as expeditiously as the member's condition requires but no later than 72 hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i). The expedited authorization request shall meet federal standards, because a delay in processing could seriously jeopardize the member's life,

health, or ability to attain, maintain or regain maximum function. If the PA request does not meet the criteria for an expedited request, the requesting provider will be notified and given the opportunity to provide additional clinical information to support the expedited request status. However, if the additional clinical information does not support an expedited request, the PA request will be processed as a standard request within the specified timelines.

h. The AdSS shall communicate information to members/Responsible Person and providers in multiple ways including but not limited to newsletters, the AdSS' websites, the Member Handbooks, and provider manuals.

i. Medical criteria shall be available to members/Responsible Person upon request.

j. The AdSS shall consistently apply medical criteria through inter-rater reliability.

k. The AdSS shall authorize services in a sufficient amount,

duration, and scope to achieve the purpose for which the services are furnished.

l. The AdSS MM Committee and the Division MM Committee shall review and approve any changes to medical criteria and shall be communicated to providers at least 30 business days prior to implementation of the change.

6. The Division shall require PA for the following Medical and Behavioral Health Services:

a. Behavioral Health Residential Facility;

b. Non-emergency Acute Inpatient Admissions;

c. Level I Behavioral Health Inpatient Facility and RTC Admissions;

d. Elective Hospitalizations;

e. Elective Surgeries;

f. Medical Equipment;

g. Medical Supplies;

h. Home Health;

i. Home and Community Based Services;

j. Hospice;

k. Skilled Nursing Facility;

l. Therapies - Rehabilitative/Habilitative;

m. Medical and/or behavioral health services;

n. Nursing facility;

o. Emergency alert system services;

p. Rehabilitative/Habilitative Physical/Occupational Therapy for members twenty-one (21) years of age and older;

q. Behavior Analysis Services;

r. Augmentative and Alternative Communication (AAC) services, supplies, and accessories;

s. Non-Emergency Transportation;

t. Select Medications.

7. The Division shall not require PA for these services:

a. Services performed during a Retroactive Eligibility Period;

b. When Medicare or other commercial insurance coverage is primary;

c. Emergency Medical Hospitalization < 72 hours;

d. Emergency Admission to Behavioral Health Level 1 Inpatient facility, however, notification of the admission to the health plan shall occur within 72 hours;

e. Some Diagnostic procedures, e.g., EKG, MRI, CT Scans, X rays, Labs; check the member's health plan's prior authorization requirements;

f. Dental Care - emergency and non-emergency, check the member's health plan's PA requirements;

g. Eyeglasses for members < 21 years old;

h. Family Planning Services;

i. Physician and/or Specialty Consultations and Office Visits;

j. Behavioral Analysis Assessment;

k. Prenatal Care;

l. Emergency Transportation;

m. Non-Emergency Transportation of less than 100 miles;

n. Emergency room visit.

E. INTER-RATER RELIABILITY

1. The Division shall provide oversight of inter-rater reliability (IRR) done by the AdSS to ensure the consistent application of review criteria in making medical necessity decisions which require PA, concurrent review, and retrospective review. Each AdSS plan is monitored to ensure the following:
    a. Adoption of policy and procedures for conducting inter-rater reliability;
    b. All staff, including medical directors, making medical necessity decisions in PA, concurrent review and retrospective review shall have IRR testing as part of the orientation process and at least annually thereafter;
    c. A process for corrective action shall be developed and implemented for all staff who do not meet the minimum passing compliance standard of 90%.
2. The Division shall conduct IRR testing for the following HCS functions:
    a. Skilled Nursing Services,
    b. Second Level Medical Review.
3. At least annually, the IRR testing results from the AdSS plans,

the District Support Coordination and the Division medical directors are presented to the Medical Management Committee for review and approval.

F. RETROSPECTIVE REVIEW

1. The Division shall oversee the retrospective review of medical necessity of a treatment or service post-delivery of care done by the AdSS plans.

2. The AdSS plans shall be monitored for the following:

   a. Policy and procedure that reflect:

      i. The identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,

      ii. Which services require retrospective review,

      iii. Timeframe(s) established by the AdSS plans for completion of the retrospective review.

3. The Division shall ensure criteria for making medical necessity decisions is clearly documented and based on reasonable

medical evidence or a consensus of relevant health care professionals.

4. The Division shall ensure there is a process for consistent application of review criteria.

5. Guidelines for Provider-Preventable Conditions (PPC), other Provider-Preventable Conditions (OPPC), Health Care Acquired Conditions (HCAC) include:

   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 an error by a hospital or medical professional, the AdSS

shall conduct a Quality of Care (QOC) investigation and report it in accordance with AdSS Medical Manual Policy 960.

G. CLINICAL PRACTICE GUIDELINES

1. The Division shall collaborate with the AdSS to ensure the clinical practice guidelines (CPGs) developed by the AdSS meet the individualized needs of the Division members.

2. The AdSS shall develop, adopt and disseminate CPGs for physical and behavioral health services, in accordance with 42 CFR 457.1233(c) and 42 CFR 438.236 that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field;
   b. Have considered the individualized needs of the Division's members;
   c. Are adopted in consultation with contracted health care professionals and National Practice Guidelines or 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;

d. Are disseminated by the AdSS to all their affected providers and, upon request, to members/Responsible Person and potential members;

e. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply.

3. The AdSS MM Committee shall 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 every two years.

4. The Division shall review the AdSS' approved CPGs and 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. The Division shall collaborate with the AdSS to ensure new medical technologies and new uses of existing technologies to meet the individualized needs of the Division members. The AdSS shall be monitored for the following:

   a. Implementation written procedures for evaluating new technologies and new uses of existing technology that include an evaluation of benefits for physical and behavioral healthcare services, pharmaceuticals, and devices;

   b. The procedures shall include both a mechanism for MM 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 expedited request shall be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request.

3. The AdSS shall include coverage decisions by Medicare

intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions in its evaluation.

4. The AdSS 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.

5. The AdSS shall have a process for documenting the coverage determinations and rationale in the MM Committee meeting minutes.

I. DIVISION OVERSIGHT RESPONSIBILITIES

1. The Division MM Committee shall monitor utilization management activities.

2. The MM Committee shall review relevant metrics and reports, and meet quarterly to discuss performance, outliers, and opportunities for improvement for HCS UM activities and AdSS UM activities.

3. HCS shall address the need for improvement of UM activities conducted by the AdSS through quarterly meetings with the AdSS and through the UM Subcommittee as well as the Division's Operational Review.

J. SUPPLEMENTAL INFORMATION

1. The Division is responsible for the oversight of the AdSS' administration of utilization management activities for all services provided to members of the Division.
2. AHCCCS DFSM is responsible for the administration of utilization management functions for acute physical and behavioral health services for Division members enrolled in the Tribal Health Program.
3. The intent of the discharge planning process is to improve the management of inpatient admissions and the coordination of post discharge services, reduce unnecessary hospital and institutional stays, ensure discharge needs are met, and decrease readmissions.

Signature of Chief Medical Officer: Anthony Dekker (Jan 20, 2023 08:46 MST)
Anthony Dekker, D.O.