

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

REVISION DATES: 07/29/2020, 05/13/2016

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 C.F.R. 438.210(b)(3), 42 C.F.R. 438.406(a)(2)(i), A.R.S. § 36-2907, A.R.S. § 36-2907(B), A.A.C. R9-22-201 et seq, 9 A.A.C. 34, ACOM Policy 438, AHCCCS Contractor Operations Manual (ACOM)

Purpose

This policy outlines the Medical Management administrative requirements.

Definitions

Plan, Do, Study Act (PDSA) Method - A four step model to test a change that is implemented. Going through the prescribed four steps utilizing one or more PDSA cycles guide the thinking process into breaking down the task into steps and then evaluating the outcome, improving on it, and testing again.

Medical Management Plan

- A. The Division of Developmental Disabilities (Division) shall develop a written Medical Management Plan that describes the methodology to meet or exceed the standards and requirements of contract.
- B. The Division shall submit the Medical Management Plan, and any subsequent modifications, to the AHCCCS Medical Management for review and approval prior to implementation.
- C. At a minimum, the Medical Management Plan shall describe, in detail, the Medical Management program and how program activities assure appropriate management of medical care service delivery for enrolled members. Medical Management Plan components shall include:
 1. A description of the Division's administrative structure for oversight of its Medical Management program, including the role and responsibilities of:
 - a. The governing or policy-making body,
 - b. The Medical Management Committee,
 - c. The Division Executive Management, and
 - d. Medical Management program staff.
 2. An organizational chart that delineates the reporting channels for Medical Management activities and the relationship to the Chief Medical Officer (unless delegated to an associate Medical Director) and Executive Management.
 3. Documentation that the governing or policy-making body has reviewed and approved the Medical Management Plan.

4. Documentation that appropriately qualified, trained, and experienced personnel are employed to effectively carry out Medical Management program functions.
5. The Division's specific Medical Management goals and measurable objectives as required by AHCCCS policy.
6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:
 - a. Medical Management Utilization Data Analysis and Data Management
 - b. Concurrent Review
 - c. Discharge Planning
 - d. Prior Authorization
 - e. Inter-Rater Reliability
 - f. Retrospective Review
 - g. Clinical Practice Guidelines
 - h. New Medical Technologies and New Uses of Existing Technologies
 - i. Case Management/Care Coordination
 - j. Disease/Chronic Care Management
 - k. Drug Utilization Review
7. The Division's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AHCCCS policy.
8. A description of how delegated activities are integrated into the overall Medical Management program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS policy.
9. Documentation of input into the medical coverage policies from the Division or providers and members.
10. A summary of the changes made to the Division's list of services requiring prior authorization and the rationale for those changes.

Medical Management Work Plan

The Division is responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the Medical Management program requirements outlined in AHCCCS policy. The work plan shall:

- A. Be submitted in an acceptable format or in the template provided by the Medical Management Unit.
- B. Supports the Medical Management Plan goals and objectives.
- C. Include goals that are quantifiable and reasonably attainable.
- D. Includes specific actions for improvement.
- E. Incorporates a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AHCCCS policy for details related to PDSA methodologies.

Medical Management Evaluation

- A. An annual narrative evaluation of the effectiveness of the previous year's Medical Management strategies and activities shall be submitted to AHCCCS Medical Management after being reviewed and approved by the Division's governing or policy-making body. The narrative summary of the previous year's work plan shall include but is not limited to:
 - 1. A summary of the Medical Management activities performed throughout the year with:
 - a. Title/name of each activity,
 - b. Desired goal and/or objective(s) related to each activity,
 - c. Staff positions involved in the activities,
 - d. Trends identified and the resulting actions implemented for improvement,
 - e. Rationale for actions taken or changes made, and
 - f. Statement describing whether the goals/objectives were met.
 - 2. Review, evaluation, and approval by the Medical Management Committee of any changes to the Medical Management Plan.
 - 3. Necessary follow-up with targeted timelines for revisions made to the Medical Management Plan.
- B. The Medical Management Plan and Medical Management Evaluation may be combined or written separately, as long as required components are addressed and easily located.
- C. Refer to AHCCCS policy for reporting requirements and timelines.

Medical Management Administrative Oversight

- A. The Division shall ensure ongoing communication and collaboration between the Division Medical Management program and the other functional areas of the Division (e.g., quality management, member, and provider services).
- B. The Division shall have an identifiable and structured Medical Management Committee that is responsible for Medical Management functions and responsibilities, or if the Medical Management Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that Medical Management issues and topics are presented, discussed and acted upon.
- C. At a minimum, the membership includes:
 - 1. The Chief Medical Officer or appointed designee as the chairperson of the Medical Management Committee,
 - 2. The Medical Management Manager,
 - 3. Representation from the functional areas within the Division, and
 - 4. Representation of contracted or affiliated providers.
- D. The Chief Medical Officer, unless delegated to an associate Medical Director, as chairperson for the Medical Management Committee, or his/her designee, is responsible for the implementation of the Medical Management Plan and has substantial involvement in the assessment and improvement of Medical Management activities.
- E. The Medical Management Committee shall ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or Medical Management Committee sign-in sheets with requirements noted).
- F. The frequency of Medical Management Committee meetings is sufficient to demonstrate that the Medical Management Committee monitors all findings and required actions. At a minimum, the Medical Management Committee meets quarterly.
- G. Medical Management Committee meeting minutes include the data reported to the Medical Management Committee, and analysis and recommendations made by the Medical Management Committee. Data, including utilization data, may be attached to the Medical Management Committee meeting minutes as separate documents if the documents are noted in the Medical Management Committee meeting minutes.

Recommendations made by the Medical Management Committee shall be discussed at subsequent Medical Management Committee meetings. The Medical Management Committee shall review the Medical Management program objectives and policies annually and updates them as necessary to ensure:

- 1. The Medical Management responsibilities are clearly documented for each Medical Management function/activity;

2. Division staff, administrative services sub-contractors (AdSS) and providers are informed of the most current Medical Management requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community;
 3. The providers are informed of information related to their performance (e.g., provider profiling data); and
 4. The Medical Management policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS Medical Management Unit.
- H. The Medical Management shall be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities.
- I. Staff qualifications for education, experience and training are developed for each Medical Management position.
- J. The grievance process shall be part of the new hire and annual staff training, including, but not limited to:
1. What constitutes a grievance,
 2. How to report a grievance, and
 3. The role of the Quality Management staff in grievance resolution.
- K. A current organizational chart is maintained to show reporting channels and responsibilities for the Medical Management program.
- L. The Division shall maintain records that document Medical Management activities and shall make the information available to AHCCCS Medical Management Unit upon request. The required documentation includes, but is not limited to:
1. Policies and procedures;
 2. Reports;
 3. Practice guidelines;
 4. Standards for authorization decisions;
 5. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization);
 6. Meeting minutes including analyses, conclusions, and actions required with completion dates;
 7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the Medical Management program such as inter-rater-reliability; and

8. Other information and data deemed appropriate to support changes made to the scope of the Medical Management Plan.
- M. The Division shall have written policies and procedures pertaining to:
1. Verification that information/data received from providers is accurate, timely, and complete;
 2. Review of reported data for accuracy, completeness, logic, and consistency, (review and evaluation processes shall be clearly documented);
 3. Security and confidentiality of all member and provider information protected by federal and state law;
 4. Informing appropriate parties of the Medical Management requirements and updates, utilization data reports, and profiling results;
 5. Identification of provider trends and subsequent necessary corrective action;
 6. Quarterly evaluations and trending of subcontracted health plan internal appeal overturn rates;
 7. Quarterly evaluations of the timeliness of service request decisions; and
 8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.
- N. The Division shall have processes that ensure:
1. Per 42 C.F.R. 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the member's condition or disease, render decisions to:
 - a. Deny an authorization request based on medical necessity;
 - b. Authorize a request in an amount, duration, or scope that is less than requested; and
 - c. Make a decision involving excluded or limited services under A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in section N4 (below) of this policy.
 2. Per 42 C.F.R. 438.406(a)(2)(i), qualified health care professionals, with appropriate clinical expertise in treating the members' condition or disease, and who have not been involved in any previous level of decision making, render decisions regarding:
 - a. Appeals involving denials based on medical necessity,
 - b. Grievances regarding denial of expedited resolution of an appeal, and

- c. Grievances and appeals involving clinical issues.
3. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and nonskilled services within their scope of practice:
 - a. Physician
 - b. Podiatrist
 - c. Optometrist
 - d. Chiropractor
 - e. Psychologist
 - f. Dentist
 - g. Physician assistant
 - h. Physical or occupational therapist
 - i. Speech-language pathologist
 - j. Audiologist
 - k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife)
 - l. Licensed social worker
 - m. Registered respiratory therapist
 - n. Licensed marriage and family therapist
 - o. Licensed professional counselor
4. Decision making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.
5. In addition to those providers listed above, the following health care professionals have the appropriate clinical expertise to render decisions for non-skilled Home and Community Based Service (HCBS) such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care:
 - a. Arizona Long Term Care System (ALTCS) case management staff when the individual is a:
 - i. Registered Nurse,
 - ii. Licensed Practical Nurse,

- iii. Degreed social worker, or
 - iv. An individual with a bachelor's or master's degree in a related field.
 - b. Support Coordination ALTCS case management staff with a minimum of two consecutive years of experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities, when the staff individual does not have a degree or a license.
 - 6. Consistent application of standards and clinical criteria and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action is developed and implemented for staff who fail to meet the inter-rater reliability standards of 90%.
 - 7. Prompt notifications to the requesting provider and the member or member's authorized representative or medical power of attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the AHCCCS Contractor Operations Manual (ACOM) and 9 A.A.C. 34.
- O. The Division shall maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its Medical Management program. Data elements shall include but are not limited to:
- 1. Member demographics;
 - 2. Provider characteristics;
 - 3. Services provided to members; and
 - 4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.
- P. The Division shall oversee and maintains accountability for all functions or responsibilities that are delegated to other entities. Documentation is kept that demonstrates:
- 1. A written agreement specifies the delegated activities and reporting responsibilities of the entity to the subcontracted health plan and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.
 - 2. The Division shall evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation per ACOM Policy 438.
 - 3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed annually.

Q. The Division shall ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.
2. Providers are not prohibited from advocating on behalf of members within the service provision process.