



Chapter 1000	Medical Management
1000	Chapter Overview
1010	Medical Management Administrative Requirements

1000 CHAPTER OVERVIEW

EFFECTIVE DATE: May 13, 2016

Monitoring

The Division monitors AHCCCS acute services, for the Division's members, with the following processes:

- A. Contracts with acute health plan
- B. Operational Reviews with each Division contracted health plan
- C. Quarterly compliance meetings with each Division contracted health plan
- D. Annual Medical Management (MM) plans that include narratives, evaluations, completed work plans from the previous year and new work plans for the current year
- E. Quarterly AHCCCS deliverables (includes EPSDT reports) oversight for Division members
- F. Division contracted health plan quarterly Utilization Management (UM) reports
- G. Medical Management and Medical Director meetings with Division contracted health plans to discuss data analysis, interventions, and corrective action plans (CAPs)
- H. Provider manual and member handbook oversight
- I. Health Care Services Procedures.

The Chapter provides the necessary information for the Division to ensure compliance with Federal, State and Division requirements related to medical management activities.

Definitions

The Division's words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning. Refer to AHCCCS Policy for other applicable definitions.

- A. **Assess or Evaluate** means to study or examine methodically and in detail, typically for purposes of explanation and interpretation.

- B. **Authorization Request (Expedited)**, under 42 C.F.R. 438.210, means a request for which a provider indicates the Division determines that using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. The Division must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.
- C. **Authorization Request (Standard)**, under 42 C.F.R. 438.210, means a request for which a the Division must provide a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member's best interest.
- D. **Catastrophic Reinsurance** is a stop-loss mechanism to provide the Division with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, Medical Policy Manual and contract are met.
- E. **Concurrent Review** is the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. The Division reviewers assess the appropriate use of resources, Level of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.
- F. **Delegated Entity** is a qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Division.
- G. **Disease Management** is an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:
1. Identifying and proactively monitoring high-risk populations
 2. Assisting members and providers in adhering to identified evidence-based guidelines
 3. Promoting care coordination
 4. Increasing and monitoring member self-management
 5. Optimizing member safety.
- H. **Goal** means a desired result the Division envisions, plans, and commits to achieve within a proposed timeframe.
- I. **Grievance** means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of

care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member's rights. Grievances do not include "Action(s)" as defined in Arizona Administrative Code Title 9, Chapter 34 (9 A.A.C. 34).

- J. **Measurable** means a gauge to determine definitively whether a goal has been met or progress has been made.
- K. **Medical Management (MM)** means an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).
- L. **Methodology** means the planned process, steps, activities or actions taken by the Division to achieve a goal or objective or to progress toward a positive outcome.
- M. **Monitoring** means the process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results.
- N. **Retrospective Review** means the process of determining the medical necessity of a treatment/service post-delivery of care.
- O. **Utilization Management** applies to a Division process to evaluate and approve or deny health care services, procedures or settings based on medical necessity, appropriateness, efficacy and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review and case management.

1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 C.F.R. § 438.210(b)(3), A.R.S. 36-2907(B), A.A.C. R9-22-201 *et seq.*
(Article 2)

Medical Management Plan

The Division develops a written Medical Management (MM) Plan that describes the methodology to meet or exceed the standards and requirements of contract. The Division submits the MM Plan, and any subsequent modifications, to the Arizona Health Care Cost Containment System (AHCCCS) Medical Management (MM) for review and approval prior to implementation. At a minimum, the MM Plan describes, in detail, the MM program and how program activities assure appropriate management of medical care service delivery for enrolled members. MM Plan components include:

- A. A description of the Division's administrative structure for oversight of its MM program, including the role and responsibilities of:
 - 1. The governing or policy-making body
 - 2. The MM committee
 - 3. The Executive Management
 - 4. MM program staff.
- B. An organizational chart that delineates the reporting channels for MM activities and the relationship to the Medical Director and Executive Management
- C. Documentation that the governing or policy-making body has reviewed and approved the Plan
- D. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions
- E. The Division's specific MM goals and measurable objectives as required by AHCCCS Policy
- F. 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:
 - 1. MM Utilization Data Analysis and Data Management
 - 2. Concurrent Review
 - 3. Discharge Planning
 - 4. Prior Authorization
 - 5. Inter-Rater Reliability

6. Retrospective Review
 7. Clinical Practice Guidelines
 8. New Medical Technologies and New Uses of Existing Technologies
 9. Case Management/Care Coordination
 10. Disease/Chronic Care Management
 11. Drug Utilization Review
- G. The Division's method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AHCCCS Policy
- H. A description of how delegated activities are integrated into the overall MM program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS Policy
- I. Documentation of input into the medical coverage policies from the Division or providers and members
- J. A summary of the changes made to the Division's list of services requiring prior authorization and the rationale for those changes.

MM Work Plan

The Division develops a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the MM program requirements outlined in AHCCCS Policy. The work plan:

- A. Is submitted in an acceptable format or in the template provided by the MM Unit
- B. Supports the MM Plan goals and objectives
- C. Includes 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.

MM Evaluation

An annual narrative evaluation of the effectiveness of the previous year's MM strategies and activities is submitted to AHCCCS MM after being reviewed and approved by the Division governing or policy-making body; the evaluation includes:

- A. A summary of the MM activities performed throughout the year with:
 1. The title/name of each activity
 2. The desired goal and/or objective(s) related to each activity
 3. The staff positions involved in the activities
 4. Trends identified and the resulting actions implemented for improvement
 5. The rationale for actions taken or changes made
 6. A statement describing whether the goals/objectives were met.
- B. Review, evaluation and approval by the MM Committee of any changes to the MM Plan
- C. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and easily located.

Refer to AHCCCS Policy for reporting requirements and timelines.

MM Administrative Oversight

- A. The Division ensures ongoing communication and collaboration between the Division MM program and the other functional areas of the Division (e.g., quality management, member and provider services).
- B. The Division has an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if the MM Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that MM issues and topics are presented, discussed and acted upon.
 1. At a minimum, the membership includes:
 - a. The Medical Director or appointed designee as the chairperson of the MM Committee
 - b. The MM Manager
 - c. Representation from the functional areas within the Division
 - d. Representation of contracted or affiliated providers.

2. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan and has substantial involvement in the assessment and improvement of MM activities.
 3. The MM Committee ensures 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 MM Committee sign-in sheets with requirements noted).
 4. The frequency of MM Committee meetings is sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the MM Committee meets quarterly.
 5. MM Committee meeting minutes include the data reported to the MM Committee, and analysis and recommendations made by the MM Committee. Data, including utilization data, may be attached to the MM Committee meeting minutes as separate documents if the documents are noted in the MM Committee meeting minutes. Recommendations made by the MM Committee are discussed at subsequent MM Committee meetings. The MM Committee reviews the MM program objectives and policies annually and updates them as necessary to ensure:
 - a. The MM responsibilities are clearly documented for each MM function/activity
 - b. Division staff, administrative services sub-contractors and providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community
 - c. The providers are informed of information related to their performance (e.g., provider profiling data)
 - d. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS MM Unit.
- C. The MM Program is staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities.
1. Staff qualifications for education, experience and training are developed for each MM position.
 2. The grievance process is part of the new hire and annual staff training, including, but not limited to:
 - a. What constitutes a grievance
 - b. How to report a grievance
 - c. The role of the quality management staff in grievance resolution.
 3. A current organizational chart is maintained to show reporting channels and responsibilities for the MM program.

- D. The Division maintains records that document MM activities, and make the information available to AHCCCS MM 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 MM program such as inter-rater-reliability
 8. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.
- E. The Division has written policies and procedures pertaining to:
1. Information/data received from providers is accurate, timely, and complete.
 2. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented.
 3. All member and provider information protected by Federal and State law is kept confidential.
 4. Informing appropriate parties of the MM 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
 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.

- F. The Division has processes that ensure:
1. Per 42 C.F.R. 438.210(b)(3), Qualified health care professionals, with appropriate clinical expertise in treating the enrollee'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.
 - c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. 36-2907(B) and AHCCCS Administrative Code (A.A.C.) R9-22-201 *et seq.* (Article 2), as specified in section F.4.a (below) of this policy.
 2. Per 42 C.F.R. 438.406(a)(3), 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
 - c. Grievances and appeals involving clinical issues.
 3. 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).
 4. For purposes of this section:
 - a. 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: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor. Decision making includes determinations involving excluded or limited services under A.R.S. 36-2907 and A.A.C. R9-22-201 *et seq.* (Article 2).

- b. 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:
 - i. Arizona Long Term Care System (ALTCS) case management staff when the individual is a:
 - Registered Nurse,
 - Licensed Practical Nurse,
 - Degreed social worker, or
 - An individual with a bachelor's or master's degree in a related field.
 - ii. 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.
5. 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.
- G. The Division maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements include but are not limited to:
 1. Member demographics
 2. Provider characteristics
 3. Services provided to members
 4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.
- H. The Division oversees 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 evaluates the entity's ability to perform the delegated activities prior to executing a written agreement for delegation.

3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed.
- I. The Division ensures:
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.