

# CHAPTER 1000

## MEDICAL MANAGEMENT (MM)

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**CHAPTER 1000**

**MEDICAL MANAGEMENT (MM)**

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**1000**            **CHAPTER OVERVIEW**

REVISION DATES:    07/01/16, 10/01/15, 02/01/15, 07/01/12, 04/01/12, 01/01/11, 10/01/08,  
11/01/05

INITIAL  
EFFECTIVE DATE:    10/01/1994

The standards and requirements included in this Chapter are applicable to AHCCCS Acute Care and Arizona Long Term Care Systems (ALTCS) Contractors, the Department of Economic Security, Division of Developmental Disabilities (DES/DDD), the Comprehensive Medical and Dental Program (CMDP), the Regional Behavioral Health Authorities (RBHAs), and Children’s Rehabilitative Services (CRS). If requirements of this Chapter conflict with specific contract language, the contract will take precedence. For purposes of this Chapter, the above listed organizations and agencies will be referred to as “Contractors”.

At least annually, the Medical Management (MM) Unit will conduct reviews of each Contractor’s compliance with the requirements of this Chapter. The MM Unit is located within the Division of Health Care Management (DHCM).

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

**Definitions**

The words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning. Refer to Chapter 900 of this manual for other applicable definitions.

1. **Assess or Evaluate** means to study or examine methodically and in detail, typically for purposes of explanation and interpretation.
2. **Authorization Request (Expedited)**, under 42 C.F.R. 438.210, means a request for which a provider indicates or a Contractor 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 Contractor 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 Contractor justifies a need for additional information and the delay is in the member’s best interest.



3. **Authorization Request (Standard)**, under 42 C.F.R. 438.210, means a request for which a Contractor 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 Contractor justifies a need for additional information and the delay is in the member's best interest.
4. **Care Management** is a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.
5. **Case Management** is 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.
6. **Catastrophic Reinsurance** is a stop-loss mechanism to provide Contractors 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, AHCCCS Medical Policy Manual (AMPM) and contract is met.
7. **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. Contractor 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.
8. **Delegated Entity** is a qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Contractor.
9. **Disease Management** is an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:
  - a. Identifying and proactively monitoring high-risk populations
  - b. Assisting members and providers in adhering to identified evidence-based guidelines
  - c. Promoting care coordination
  - d. Increasing and monitoring member self-management, and
  - e. Optimizing member safety



10. **Goal** means a desired result the Contractor envisions, plans, and commits to achieve within a proposed timeframe.
11. **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).
12. **Measurable** means a gauge to determine definitively whether or not a goal has been met or progress has been made.
13. **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).
14. **Methodology** means the planned process, steps, activities or actions taken by a Contractor to achieve a goal or objective or to progress toward a positive outcome.
15. **Monitoring** means the process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results.
16. **Retrospective Review** means the process of determining the medical necessity of a treatment/service post delivery of care.
17. **Utilization Management** applies to a Contractor's 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.

Refer to:

- Chapter 500 of this Manual for additional information regarding care coordination requirements,
- Chapter 800 of this Manual for Fee-For Service (FFS) quality and utilization management, and



- Chapter 900 of this Manual for member rights and responsibilities, medical records and communication of clinical information and additional related definitions.

**REFERENCES**

- AMPM Chapter 500
- AMPM Chapter 800
- AMPM Chapter 900
- AHCCCS Contracts
- 9 A.A.C. 22, Article 5
- 9 A.A.C. 22, Article 12
- 9 A.A.C. 28, Article 5
- 9 A.A.C. 28, Article 11
- 9 A.A.C. 31, Article 5
- 9 A.A.C. 31, Article 12
- 9 A.A.C. 34 42 C.F.R. 438.200 *et seq*
- A.R.S. § 36-2903
- A.R.S. § 36-2917
- 42 C.F.R. Part 456, Subparts A through J
- 45 C.F.R. Part 164



**1010 MEDICAL MANAGEMENT (MM) ADMINISTRATIVE REQUIREMENTS**

REVISION DATES: 10/01/15, 02/01/15, 12/18/14, 07/01/12, 04/01/12, 01/01/11, 10/01/10,  
10/01/08, 11/01/05

INITIAL

EFFECTIVE DATE: 10/01/1994

**A. MM PLAN**

Contractors must develop a written MM Plan that describes the Contractors' methodology to meet or exceed the standards and requirements of contract and this Chapter. Contractors must submit the MM Plan, and any subsequent modifications, to AHCCCS Medical Management (MM) for review and approval prior to implementation. Please refer to Appendix C for the MM Plan Checklist and to Appendix G for the MM Work Plan Guide and Template. At a minimum, the MM Plan must describe, in detail, the Contractors' MM program and how program activities will assure appropriate management of medical care service delivery for enrolled members. MM Plan components must include:

1. A description of the Contractors' administrative structure for oversight of its MM program as required by Policy 1010, Section C of this Chapter, including the role and responsibilities of:
  - a. The governing or policy-making body
  - b. The MM committee
  - c. The Contractor Executive Management,
  - d. MM program staff
2. An organizational chart that delineates the reporting channels for MM activities and the relationship to the Contractor Medical Director and Executive Management.
3. Documentation that the governing or policy-making body has reviewed and approved the Plan.
4. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions and meet Contractor qualifications required by Policy 1010, Section C.



5. The Contractor's specific MM goals and measurable objectives as required by Policy 1020 of this Chapter.
  
6. Documentation of how each of the following processes are implemented and monitored to ensure quality and cost-effective care is provided to enrollees in compliance with State and Federal regulations:
  - a. MM Utilization Data Analysis and Data Management
  - b. Concurrent Review
  - c. Discharge Planning
  - d. Prior Authorization (PA)
  - 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 Contractor's method(s) for monitoring and evaluating their service delivery system and provider network that demonstrates compliance with Policy 1020.
  
8. 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 Policy 1010 C.
  
9. Documentation of input into the medical coverage policies from contracted or affiliated providers and members.
  
10. A summary of the changes made to the Contractor's list of services requiring prior authorization and the rationale for those changes.



## B. MM WORK PLAN

The Contractor is responsible for developing a work plan that identifies the Contractor's goals; methodology for improvement; and monitoring efforts related to the MM program requirements outlined in Policy 1020. Refer to Appendix G for the MM Work Plan Guide and Template.

The Contractor's work plan shall:

1. Be submitted in an acceptable format or in the template provided by the MM Unit,
2. Support the Contractor's MM Plan goals and objectives,
3. Include goals that are quantifiable and reasonably attainable,
4. Include specific actions for improvement, and
5. Incorporate a plan, do, study, act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AMPM Policy 970 for details related to PDSA methodologies.

## C. MM EVALUATION

An annual narrative evaluation of the effectiveness of the previous year's MM strategies and activities must be submitted to MM after being reviewed and approved by the Contractor's governing or policy-making body. The narrative summary of the previous year's work plan must include but is not limited to:

1. A summary of the MM activities performed throughout the year with:
  - a. The title/name of each activity,
  - b. The desired goal and/or objective(s) related to each activity,
  - c. The Contractor staff positions involved in the activities,
  - d. Trends identified and the resulting actions implemented for improvement,
  - e. The rationale for actions taken or changes made, and
  - f. A statement describing whether or not the goals/objectives were met.
2. Review, evaluation and approval by the MM Committee of any changes to the MM Plan, and
3. 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 are easily located within the document(s) submitted. Refer to Appendix C, *MM Plan Checklist*.



Refer to Policy 1030 of this Chapter for reporting requirements and timelines.

**D. MM ADMINISTRATIVE OVERSIGHT**

1. The Contractor's MM program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the MM program. Contractors must ensure ongoing communication and collaboration between the MM program and the other functional areas of the organization (e.g., quality management, member and provider services and grievances).
2. The Contractors must have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if combined with the Quality Management Committee, the agenda items and minutes must reflect that MM issues and topics are presented, discussed and acted upon.
  - a. At a minimum, the membership must include:
    - i. The Medical Director or appointed designee as the chairperson of the committee
    - ii. The MM Manager
    - iii. Representation from the functional areas within the organization, and
    - iv. Representation of contracted or affiliated providers.
  - b. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan, and must have substantial involvement in the assessment and improvement of MM activities.
  - c. The MM Committee must 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 MM Committee sign-in sheets with requirements noted).
  - d. The frequency of Committee meetings must be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the Committee must meet on a quarterly basis.
  - e. Committee meeting minutes must include the data that are reported to the Committee as well as, analysis and recommendations made by the Committee. Data, including utilization data, may be attached to the Committee meeting minutes as separate documents as long as the documents are noted in the Committee meeting minutes. Recommendations made by the Committee must be discussed at subsequent Committee Meetings. The MM Committee must review the MM program objectives and policies annually and update them as necessary to ensure:
    - i. The MM responsibilities are clearly documented for each MM function/activity,
    - ii. The Contractor staff 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,



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- iii. The providers are informed of information related to their performance (i.e., provider profiling data), and
  - iv. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS MM Unit.
3. The MM Program must be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter.
- a. Staff qualifications for education, experience and training must be developed for each MM position.
  - b. The grievance process must be part of the new hire and annual staff training including, but not limited to:
    - i. What constitutes a grievance,
    - ii. How to report a grievance, and
    - iii. The role of the Contractor's quality management staff in grievance resolution.
  - c. A current organizational chart must be maintained to show reporting channels and responsibilities for the MM program.
4. The Contractors must maintain records that document MM activities, and make the information available to AHCCCS MM Unit upon request. The required documentation must include, but is not limited to:
- a. Policies and procedures,
  - b. Reports,
  - c. Practice guidelines,
  - d. Standards for authorization decisions,
  - e. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization),
  - f. Meeting minutes including analyses, conclusions, and actions required with completion dates,
  - g. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the MM program such as inter-rater-reliability, and
  - h. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.
5. The Contractors must have written policies and procedures pertaining to:
- a. Information/data received from providers is accurate, timely, and complete.
  - b. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented.
  - c. All member and provider information protected by Federal and State law is kept confidential.
  - d. The Contractor shall inform providers and appropriate staff of the following:
    - i. MM requirements and updates,
    - ii. Utilization data reports, and
    - iii. Profiling results.
  - e. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services.



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- f. Quarterly evaluations and trending of Contractor internal appeal overturn rates.
  - g. Quarterly evaluations of the timeliness of service request decisions.
  - h. 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.
6. Contractors must have in place processes which ensure:
- a. Under 42 C.F.R. 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee's condition or disease, will render decisions to:
    - i. Deny an authorization request based on medical necessity,
    - ii. Authorize a request in an amount, duration, or scope that is less than requested, or
    - iii. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. 36-2907(B) and AHCCCS Administrative Code R9-22-201 et seq (Article 2), as specified in section 6.d.(1) of this policy.
  - b. Under 42 C.F.R. 438.406(a)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee's condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:
    - i. Appeals involving denials based on medical necessity,
    - ii. Grievances regarding denial of expedited resolution of an appeal, or
    - iii. Grievances and appeals involving clinical issues.
  - c. There is prompt notification 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 must include information as specified in the AHCCCS Contractor Operations Manual (ACOM), Policy 414 and Arizona Administrative Code 9 A.A.C. 34.
  - d. For purposes of Section 1010 (C) (6):
    - i. The following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established 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 AHCCCS Administrative Code R9-22-201 et seq (Article 2).
    - ii. In addition to those providers listed in 1010 (C) (6) (d) (1), the following health care professionals have the appropriate clinical expertise to render



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- 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 bachelors or masters degree in a related field.
  - (b) ALTCS case management staff with a minimum of two consecutive years of experience in long term care when the individual does not have a degree or a license.
- e. Ensure consistent application of contractor 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 must be developed and implemented for staff who fail to meet the inter-rater reliability standards.
7. All Contractors must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements must include but are not limited to:
- a. Member demographics,
  - b. Provider characteristics,
  - c. Services provided to members, and
  - d. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.
8. Contractors must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for AHCCCS review, and the documentation must demonstrate and confirm that the following requirements have been met for all delegated functions:
- a. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity to the Contractor and must also include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.
  - b. Contractors must evaluate the entity's ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement must be submitted with the contractor review checklist (refer to the AHCCCS Contractor Operations Manual).
  - c. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed by the Contractors annually, at a minimum.
  - d. The following documentation must be submitted to AHCCCS:



**MEDICAL MANAGEMENT (MM) ADMINISTRATIVE REQUIREMENTS**

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- i. Annual evaluation reports to be included in the MM Plan, and
  - ii. Notification of the issuance of corrective action plans, documentation related to sanctions, notices of non-performance, and deficiencies and notices to cure within 30 days of issuance. The actual documents must be kept on file and available for AHCCCS review.
9. Contractors must ensure that:
- a. 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, and
  - b. Providers are not prohibited from advocating on behalf of members within the service provision process.



## 1020 MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

REVISION DATES: 07/01/16, 10/01/15, 03/01/15, 02/01/15, 04/01/12, 03/01/11, 01/01/11,  
10/01/08, 11/01/05

REVIEW DATE: 10/01/13

INITIAL  
EFFECTIVE DATE: 10/01/1994

### A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

Contractors must have in effect mechanisms to detect both underutilization and over utilization of services (42 CFR 438.240(b)(3)). Contractors must develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the 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 both over and underutilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in MM Committee minutes.

### B. CONCURRENT REVIEW

Contractors must have policies, procedures, processes and criteria in place that govern the utilization of services in institutional settings. Contractors will have procedures for review of medical necessity prior to a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

1. Policies and procedures for the concurrent review process must:
  - a. 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.
  - b. Specify timeframes and frequency for conducting concurrent review and decisions:
    - i. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed.



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- ii. Admission reviews must be conducted within one business day after notification is provided to the Contractor by the hospital or institution (this does not apply to precertifications) (42 C.F.R.456.125).
  - c. Provide a process for review that includes but is not limited to:
    - i. Necessity of admission and appropriateness of the service setting,
    - ii. Quality of care,
    - iii. Length of stay,
    - iv. Whether services meet the member needs,
    - v. Discharge needs, and
    - vi. Utilization pattern analysis.
  - d. Establish a method for the Contractor's participation in the proactive discharge planning of all members in institutional settings.
- 2. 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.
  - a. Medical criteria must be approved by the Contractor's MM Committee. Criteria must be adopted from national standards. When providing concurrent review, the Contractor must compare the member's medical information against medical necessity criteria that describes the condition or service.
  - b. Initial institutional stays are based on the Contractor's adopted criteria, the member's specific condition, and the projected discharge date.
  - c. 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 Contractor ensures that each continued stay review date is recorded in the member's record.
  - d. The Children's Rehabilitative Service (CRS) Contractor's 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 Fully Integrated CRS members and CRS Partially Integrated Acute.
  - e. The CRS Contractor's concurrent review staff must notify the American Indian Health Plan (AIHP), CMDP, or DDD Contractor's concurrent review staff when they become aware that a CRS Partially Integrated Behavioral Health or CRS only member is admitted to the hospital.
  - f. Conversely, the AIHP, CMDP, or DDD Contractor's concurrent review staff must notify the CRS Contractor's concurrent review staff when they become aware that a CRS Partially Integrated Behavioral Health or CRS only member is admitted to the hospital.
  - g. Coordination will include proactive discharge planning between all potential payment and care sources upon completion of the CRS related service.



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**C. DISCHARGE PLANNING**

Contractors must have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into acute care facilities. The intent of the discharge planning policy and procedure is to increase the management of inpatient admissions, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. Discharge planning must include, but not be limited to, an individual post discharge assessment performed by a qualified healthcare professional prior to discharge. The discharge needs assessment must be initiated on the initial concurrent review. Proactive discharge planning must include:

1. Follow-up appointment with the PCP and/or specialist within 7 – 10 days,
2. Prescription medications,
3. DME,
4. Therapies (AHCCCS limits outpatient physical therapy visits for members 21 years of age and older. See [Chapter 300, Policy 310](#)),
5. Referral to appropriate community resources,
6. Referral to Contractor's Disease Management or Case Management (if needed), and
7. A follow-up call to the member to confirm the member's well-being and that post discharge services have been provided.

The Contractor must conduct proactive discharge planning when the Contractor is not the primary payer.

**D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION**

Contractors must have 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 Contractor's medical criteria or make medical decisions.

Refer to Chapter 1600, Policy 1630, for qualifications of staff members who may authorize long term care home and community based services that are not considered skilled.

Refer to Chapter 300, Policy 310 for additional information regarding emergency services.



MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

Contractors must develop and implement a system that includes policies and procedures, coverage criteria and processes for approval of covered services.

1. Policies and procedures for approval of specified services must:
  - a. Identify and communicate to providers 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, Contractor website, and/or member handbook. Methods of communication with providers include newsletters, Contractor website, and/or provider manual. Changes in the coverage criteria must be communicated to members and providers 30 days prior to implementation of the change.
  - b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers through the provider manual and Contractor website. Criteria must be available to members upon request.
  - c. Authorize services in a sufficient amount, duration or scope to achieve the purpose for which the services are furnished.
  - d. Ensure consistent application of review criteria
  - e. Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in Policy 1000, Definitions, and 42 C.F.R. 438.210.
  - f. Provide for consultation with the requesting provider when appropriate.
  - g. 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.
2. Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.
  - a. Contractors may not arbitrarily deny or reduce the amount, duration or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member.
  - b. Contractors may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome, and
  - c. Contractors must have in place criteria to make decisions on coverage when the Contractor receives a request for service involving Medicare or other third party payers. The fact that the Contractor is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes established by "1e" in this section. Refer to Policy 201, "*Medicare Cost Sharing for Members in Medicare Fee-For-Service (FFS)*", and Policy 202, "*Medicare Cost Sharing for Members in Medicare*



MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

*Health Maintenance Organization (HMO)*” in the AHCCCS Contractor Operations Manual (ACOM) for additional information regarding payment and cost sharing responsibilities. This manual is available from the AHCCCS Web site at [www.azahcccs.gov](http://www.azahcccs.gov).

3. Contractors must include the following in their wheelchair service request analysis and delivery tracking reporting and analysis:
  - a. Timeliness of prior authorization and average time frame from approval to delivery.
  - b. Timeliness of wheelchair repairs and average time frame from approval to completion.
  - c. Ongoing evaluation of wheelchair denials against clinical criteria.

**E. INTER-RATER RELIABILITY**

The Contractor 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 Contractor’s minimum test scores.

**F. RETROSPECTIVE REVIEW**

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

1. Policies and procedures:
  - a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,
  - b. Describe services requiring retrospective review, and
  - c. Specify time frame(s) for completion of the review.
2. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
3. A process for consistent application of review criteria.
4. 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:



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MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

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**Health Care-Acquired Condition (HCAC)** – means 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.

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

1. Surgery on the wrong member,
2. Wrong surgery on a member and
3. Wrong site surgery.

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 Contractor must conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

**G. CLINICAL PRACTICE GUIDELINES**

1. Contractors must develop or adopt and disseminate practice guidelines that:
  - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field,
  - b. Have considered the needs of the Contractor's members,
  - c. Are adopted in consultation with contracting health care professionals and National Practice Standards, or
  - d. Are developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. 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.
  - e. Are disseminated by the Contractor to all affected providers and, upon the request, to members and potential members, and



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MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

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- f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 C.F.R. 438.236).
2. Contractors 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.
3. Contractors will document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

**H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES**

1. Contractors 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.
2. Contractors must include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.
3. Contractors 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.
4. Contractors must establish:
  - a. 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.
  - b. 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.
  - c. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.



## I. CARE COORDINATION /CASE MANAGEMENT

Contractors must establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the Contractor. 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.

**NOTE:** Arizona Long Term Care System (ALTCs) Contractors must also refer to the additional ALTCs Case Management Standards in [Chapter 1600](#).

1. Contractors must establish policies and procedures that reflect integration of services to ensure continuity of care by:
  - a. 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.
  - b. Specifying under what circumstance services are coordinated by the Contractor, including the methods for coordination and specific documentation of these processes.
  - c. Coordinating covered services with community and social services that are generally available through contracting or non-contracting providers, in the Contractor service area.
  - d. Establishing timely and confidential communication of clinical information among providers, as specified in Chapter 900, Policy 940. This includes the coordination of member care between the PCP, Contractor, 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 Contractor or TRBHA providers when the PCP becomes aware of the Contractor or TRBHA provider's involvement in care.
  - e. Ensuring that Contractor and TRBHA providers are providing pertinent diagnoses and changes in condition to the PCP in a timely manner. Contractors must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:
    - i. "Urgent" – Requests for intervention, information, or response within 24 hours.
    - ii. "Routine" – Requests for intervention, information or response within 10 days.
  - f. 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:
    - i. Expectations described in "d" of this section and
    - ii. Monitoring the member's condition to ensure timely return to the PCP's care for ongoing treatment, when appropriate, following stabilization by a





**MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS**

and address member needs in a timely manner. The Case Manager must continuously document interventions and changes in the plan of care.

5. The Case Management individualized care plan for either Acute Care or ALTCS members will focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The case manager must also assist the member in identifying appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the Contractor.
6. Contractors must provide oversight and monitoring of case management that is subcontracted or inclusive in a providers' contractual agreement. The case management role must comply with all AHCCCS requirements.
7. In addition to care coordination as specified in their contract with AHCCCS, the Contractor 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 Contractor's criteria for case management, as well as, members who contact governmental entities for assistance, including AHCCCS.
8. Upon discharge from the Arizona State Hospital (AzSH), the Contractor must supply all insulin dependent diabetic members with the same brand and model blood glucose monitoring device and supplies with which the member demonstrated competency while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the Contractor must arrange ongoing medically necessary nursing services in a timely manner.

9. The Contractor must identify and track members who utilize Emergency Department (ED) services inappropriately 4 or more times within a 6 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.

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

- a. Outreach phone calls/visits
- b. Educational Letters



**MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS**

- c. Behavioral Health referrals
- d. High Need/High Cost Program referrals
- e. Disease Management referrals
- f. Exclusive Pharmacy referrals

The Contractor shall submit the bi-annual Emergency Department (ED) Diversion Report to AHCCCS as specified in Attachment F Chart of Deliverables of the Contract. The report must identify the number of times the Contractor intervenes with members.

**J. DISEASE/CHRONIC CARE MANAGEMENT**

Contractors 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.

1. The Contractor's MM Committee must focus on selected disease conditions based on utilization of services, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.
2. The Disease Management Program must include, but is not limited to:
  - a. Members at risk or already experiencing poor health outcomes due to their disease burden
  - b. Interventions with specific programs that are founded on evidence based guidelines
  - c. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members' ability to self- manage their disease and measurable outcomes
  - d. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care, and
  - e. Components for providers include, but are not limited to:
    - i. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program
    - ii. Involvement in the implementation of the program
    - iii. Methodology for monitoring provider compliance with the guidelines, and
    - iv. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

**K. DRUG UTILIZATION REVIEW**

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



MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

status and quality of care.

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

1. 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.
2. Contractors must manage a DUR program that includes, but is not limited to:
  - a. Prospective review process for:
    - i. All drugs prior to 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.
    - ii. All non-formulary drug requests.
  - b. Concurrent drug therapy of selected members to assure positive health outcomes.
  - c. 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.
  - d. 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.
  - e. Provision for education of prescribers and Contractor 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.



**1030 REPORTING REQUIREMENTS**

REVISION DATES: 10/01/15, 07/01/15, 03/01/15, 02/01/15, 04/01/12, 01/01/11, 10/01/08,  
11/01/05

INITIAL  
EFFECTIVE DATE: 10/01/1994

Contractors must submit the following data reports as indicated:

REPORT	DUE DATE	REPORTS DIRECTED TO:
QUARTERLY INPATIENT HOSPITAL SHOWING LETTER (REFER TO #2 BELOW)	15 days after the end of each quarter	DHCM/MM
HIGH NEED/HIGH COST SUMMARY	Twice annually January 15 July 15	DHCM/MM
EMERGENCY DEPARTMENT DIVERSION SUMMARY	Twice Annually October 15 <sup>th</sup> April 15 <sup>th</sup>	DHCM/MM
MEDICAL MANAGEMENT PLAN, EVALUATION AND WORK PLAN	Annually December 15	DHCM/MM
HUMAN IMMUNODEFICIENCY VIRUS (HIV) SPECIALTY PROVIDER LIST	Annually with the MM Plan December 15	DHCM/MM
QUARTERLY TRANSPLANT LOG	15 days after the end of each quarter	DHCM/MM



NON-TRANSPLANT CATASTROPHIC REINSURANCE	Annually, October 30, when newly enrolled to the plan, or when newly diagnosed	DHCM/MM
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1. The purpose of the Contractor Quarterly Showing Report for Inpatient Hospital Services is to certify 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 enrolled with AHCCCS Contractor were reviewed and certified by their medical utilization staff.
2. If an extension of time is needed to complete a report, the Contractor may submit a request in writing to AHCCCS Medical Management.

**APPENDIX C**, Contractors must submit the Medical Management (MM) Plan Checklist with the annual Medical Management Plan. The MM Plan Checklist must contain page numbers that indicate where the specific requirements can be found in the MM Plan narrative. The MM Plan Checklist must be included in order for the Annual Plan to be accepted.

**APPENDIX G**, The MM Work Plan Guide and Template, are included and may be used in writing the work plan.



## **1040 OUTREACH, ENGAGEMENT, RE-ENGAGEMENT AND CLOSURE FOR BEHAVIORAL HEALTH**

INITIAL

EFFECTIVE DATE: 07/01/2016

### **A. OVERVIEW**

Contractors and TRBHAs shall develop and implement outreach, engagement, re-engagement and closure activities. Contractors shall develop and make available to providers its policies and procedures regarding outreach, engagement, re-engagement and closure, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Contractors and TRBHAs shall ensure the incorporation of the following critical activities regarding service delivery within Arizona's behavioral health system:

1. Establish expectations for the engagement of persons seeking or receiving behavioral health services,
2. Determine procedures to re-engage persons who have withdrawn from participation in the treatment process,
3. Describe conditions necessary to end re-engagement activities for a person in the behavioral health system, and
4. Establish expectations for serving persons who are attempting to re-enter the behavioral health system.

### **B. COMMUNITY OUTREACH**

1. Contractors shall provide and participate in community outreach activities to inform the public of the benefits and availability of behavioral health services and how to access them. Contractors shall disseminate information to the general public, other human service providers, including but not limited to county and state governments, school administrators, first responders, teachers, those providing services for military veterans, and other interested parties regarding the behavioral health services that are available to eligible persons.



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**OUTREACH, ENGAGEMENT, RE-ENGAGEMENT AND CLOSURE FOR BEHAVIORAL HEALTH**

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2. Outreach activities conducted by the Contractor may include, but are not limited to:
  - a. Participation in local health fairs or health promotion activities,
  - b. Involvement with local schools,
  - c. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events,
  - d. Development of outreach programs and activities for first responders (i.e. police, fire, EMT),
  - e. Regular contact with AHCCCS Contractor behavioral health coordinators and primary care providers,
  - f. Development of outreach programs to members experiencing homelessness,
  - g. Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved,
  - h. Publication and distribution of informational materials,
  - i. Liaison activities with local, county and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs,
  - j. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers,
  - k. Development and implementation of outreach programs to identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have Serious Mental Illness (SMI) within the Contractor's geographic service area, including persons who reside in jails, homeless shelters, county detention facilities or other settings,
  - l. Provision of information to behavioral health advocacy organizations, and
  - m. Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

**C. ENGAGEMENT**

1. Contractors and TRBHAs shall ensure active engagement by providers in the treatment planning process with the following:
  - a. The member and/or member's legal guardian,
  - b. The member's family/significant others, if applicable and amenable to the person,
  - c. Other agencies/providers as applicable, and
  - d. For persons with a SMI who are receiving Special Assistance (see AMPM Policy 320-R), the person (guardian, family member, advocate or other) designated to provide Special Assistance.

**D. RE-ENGAGEMENT**

1. Contractors and TRBHAs shall ensure re-engagement attempts are made with members who have withdrawn from participation in the treatment process prior to



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the successful completion of treatment, refused services or failed to appear for a scheduled service based on a clinical assessment of need. All attempts to re-engage members must be documented in the comprehensive clinical record. The behavioral health provider must attempt to re-engage the member by:

- a. Communicating in the member's preferred language,
  - b. Contacting the member or the member's legal guardian by telephone at times when the member may reasonably be expected to be available (e.g., after work or school),
  - c. When possible, contacting the member or the member's legal guardian face-to-face if telephone contact is insufficient to locate the person or determine acuity and risk,
  - d. Sending a letter to the current or most recent address requesting contact. If all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record, and
  - e. For persons determined to have a SMI who are receiving Special Assistance (see AMPM Policy 320-R), contacting the person designated to provide Special Assistance for his/her involvement in re-engagement efforts.
2. If the above activities are unsuccessful, Contractors and TRBHAs shall ensure further attempts are made to re-engage the following populations: persons determined to have a SMI, children, pregnant substance abusing women/ teenagers, and any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts shall include at a minimum: contacting the person or person's legal guardian face-to-face, and contacting natural supports for whom the member has given permission to the provider to contact. All attempts to re-engage these members must be clearly documented in the comprehensive clinical record.
  3. If face-to-face contact with the member is successful and the member appears to be a danger to self, danger to others, persistently and acutely disabled or gravely disabled, the provider must determine whether it is appropriate to engage the person to seek inpatient care voluntarily. If the member declines voluntary admission, the provider must initiate the pre-petition screening or petition for treatment process described in AMPM Policy 320-T.

**E. FOLLOW-UP AFTER SIGNIFICANT AND/OR CRITICAL EVENTS**

1. Contractors and TRBHAs shall ensure activities are documented in the clinical record and follow-up activities are conducted to maintain engagement within the following timeframes:



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- a. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization,
- b. Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than seven days, and
- c. Refusing prescribed psychotropic medications within timeframes based upon the person's clinical needs and individual history.

**REFERENCES**

- AHCCCS MCO Contracts, Section D
- RBHA Contracts, Scope of Service
- TRBHA IGAs
- AMPM Policy 320-R
- AMPM Policy 320-T
- Substance Abuse Prevention and Treatment Block Grant
- AHCCCS Demographic and Outcome Data Set User Guide
- 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems
- 12 Principles for Children's Health
  - A.A.C. R9-21-302
- A.R.S. Title 36, Chapter 5



## 1050 COORDINATION OF CARE WITH OTHER GOVERNMENT ENTITIES FOR BEHAVIORAL HEALTH SERVICES

INITIAL

EFFECTIVE DATE: 07/01/2016

### A. PURPOSE

AHCCCS requires Contractors to coordinate services and communicate with other government entities, including AHCCCS Contractors who are governmental entities, to ensure that members have proper access to care, optimal quality of service and coordination of care. This Policy outlines requirements for Contractors to establish and maintain collaborative relationships with these entities and to develop and implement policies and procedures in accordance with this Policy. Contractors shall coordinate member care with Division of Developmental Disabilities (DDD) by:

1. Inviting DDD staff to participate in the development of the behavioral health service plan and all subsequent planning meetings as representatives of the member's clinical team (see AMPM Policy 320-O),
2. Incorporating information and recommendations in the Individual or Family Support Plan (ISP) developed by DDD staff, when appropriate.
3. Ensuring that the goals of the ISP, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptoms and achieving optimal functioning, not merely the management and control of challenging behavior,
4. Actively participating in DDD team meetings, and
5. For members diagnosed with Pervasive Developmental Disorders and Developmental Disabilities, sharing all relevant information from the initial assessment and ISP with DDD to ensure coordination of services.

For DDD members with a co-occurring behavioral health condition or physical health condition who demonstrate inappropriate sexual behaviors and/or aggressive behaviors, a Community Collaborative Care Team (CCCT) may be developed. For additional information regarding the roles and responsibilities of the CCCT and coordination of care expectations, see AMPM Policy 570.

Contractors must develop and make available to providers policies and procedures that include information on DDD specific protocols or agreements.



COORDINATION OF CARE WITH OTHER GOVERNMENT ENTITIES

**B. COURTS AND CORRECTIONS**

Contractors shall collaborate and coordinate care and ensure that behavioral health providers collaborate and coordinate care for members with behavioral health needs and for members involved with:

1. Arizona Department of Corrections (ADOC),
2. Arizona Department of Juvenile Corrections (ADJC), or
3. Administrative Offices of the Court (AOC).

Contractors shall collaborate with courts and/or correctional agencies to coordinate member care by:

1. Working in collaboration with the appropriate staff involved with the member,
2. Inviting probation or parole representatives to participate in the development of the ISP and all subsequent planning meetings for the Adult Recovery Team (ART) with the member's approval,
3. Actively considering information and recommendations contained in probation or parole case plans when developing the ISP, and
4. Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member's release (see AMPM Policy 580).

**C. ARIZONA DEPARTMENT OF ECONOMIC SECURITY/REHABILITATION SERVICES ADMINISTRATION (ADES/RSA)**

Contractors shall coordinate member care with ADES/RSA by:

1. Working in collaboration with the vocational rehabilitation counselors or employment specialists in the development and monitoring of the member's employment goals,
2. Ensuring that all related vocational activities are documented in the comprehensive clinical record (see AMPM Policy 940),
3. Inviting ADES/RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services,



4. Participating and cooperating with ADES/RSA in the development and implementation of a Regional Vocational Service Plan inclusive of ADES/RSA services available to adolescents, and
5. Allocating space and other resources for vocational rehabilitation counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.

**REFERENCES**

- AMPM Chapter 300
- AMPM Chapter 500
- AMPM Chapter 900



## 1060 TRAINING REQUIREMENTS FOR RBHAs AND BEHAVIORAL HEALTH PROVIDERS

INITIAL

EFFECTIVE DATE: 07/01/2016

### A. PURPOSE

In order to effectively meet the requirements of the Arizona Health Care Cost Containment System (AHCCCS), the Regional Behavioral Health Authorities (RBHAs) must participate in development, implementation and support of trainings for behavioral health contractors and subcontractors to ensure appropriate training, education, technical assistance, and workforce development opportunities. Specifically to:

1. Promote a consistent practice philosophy, provide voice and empowerment to staff and members,
2. Ensure a qualified, knowledgeable and culturally competent workforce,
3. Provide timely information regarding initiatives and best practices, and
4. Ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the [Adult Service Delivery System-Nine Guiding Principles as outlined in Contract](#) and Arizona Vision-Twelve Principles for Children Service Delivery as outlined in AMPM Policy 430.

The purpose of this section is to provide information to behavioral health providers regarding the scope of required training topics, how training needs are identified for behavioral health providers and how behavioral health providers may request specific technical assistance from contracted RBHAs.

### B. REQUIRED TRAINING FOR BEHAVIORAL HEALTH PROVIDERS

1. The RBHA shall monitor and implement training activities and requirements outlined in this Policy. The RBHAs must annually evaluate the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.
2. The RBHA and its providers must ensure that training in the content areas specified in B.2.a Section 1, b. Section 2 and c. Section 3 of this policy is completed within 90 days of the staff person's hire date, as relevant to each staff person's job duties and responsibilities and annually as applicable (see Section D



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TRAINING REQUIREMENTS FOR RBHAs AND BEHAVIORAL HEALTH PROVIDERS

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of this policy for training requirements applicable to Home Care Training to Home Care Client (HCTC) providers and Section E of this policy for training requirements applicable to Community Service Agencies):

**a. Section One**

- i. Fraud and program abuse recognition and reporting requirements and protocols,
- ii. Managed care concepts, including information on the RBHA and the public behavioral health system,
- iii. Screening for eligibility, enrollment for covered behavioral health services (when eligible), and referral when indicated,
- iv. Overview of Arizona behavioral health system policies and procedures in the Arizona Vision and 12 Principles (AMPM Policy 430) in the children's system,
- v. Overview of Arizona's behavioral health system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems Adult Service Delivery System-Nine Guiding Principles, RBHA Contract, Exhibit-6 in the adult system,
- vi. Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA),
- vii. Cultural competency; including *Cultural Competency 101: Embracing Diversity* (AHCCCS curriculum) as provided by the AHCCCS DHCM, Workforce Development Administrator,
- viii. Interpretation and translation services,
- ix. AHCCCS Demographic Data Set, including required timeframes for data submission and valid values, and
- x. Identification and reporting of quality of care concerns and the quality of care concerns investigation process.

**b. Section Two**

- i. Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program etc.), including the Birth-to-Five Assessment depending upon population(s) served,
- ii. Use of effective interview and observational techniques that support engagement and are strengths-based, recovery-oriented, and culturally sensitive,
- iii. Application of diagnostic classification systems and methods depending upon population(s) served,
- iv. Best practices in the treatment and prevention of behavioral health disorders,
- v. Behavioral health service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices,
- vi. Covered behavioral health services (including information on how to assist persons in accessing all medically necessary covered behavioral



**TRAINING REQUIREMENTS FOR RBHAS AND BEHAVIORAL HEALTH PROVIDERS**

- health services regardless of a person's behavioral health category assignment or involvement with any one type of service provider),
- vii. Overview of Substance Abuse Block Grant (SABG): priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in ACOM Policy 417, AMPM Policy 320-T, and 45 CFR Part 96,
  - viii. Behavioral health providers should receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person's hire date (protocol training is only required if pertinent to populations served).
  - ix. Clinical training as it relates to specialty populations including but limited to conditions based on identified need,
  - x. Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of the Arizona Department of Child Safety (DCS) and
  - xi. Understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint, and responding to emergency situations in accordance with AMPM 960, Tracking and Trending of Member and Provider Issues.
- c. **Section Three**
- i. Behavioral health record documentation requirements (see AMPM Policy 940),
  - ii. Confidentiality/Health Information Portability and Accountability Act (HIPAA),
  - iii. Sharing of treatment/medical information,
  - iv. Coordination of service delivery for persons with complex needs (e.g. persons at risk of harm to self and others, court ordered to receive treatment),
  - v. Rights and responsibilities of eligible and enrolled members, including rights for persons determined to have Serious Mental Illness (SMI),
  - vi. Grievance and Appeal System including SMI grievances, and requests for investigations,
  - vii. Customer service,
  - viii. Coordination of care requirements with Primary Care Providers (PCPs) (see AMPM Chapter 500),
  - ix. Third party liability and coordination of benefits (see ACOM Policy 434 and ACOM Policy 201),
  - x. Other involved agencies and government entities (see AMPM Policy 1050),
  - xi. Claims/encounters submission process (see ACOM Policy 203),
  - xii. Advance Directives (see AMPM Policy 640),
  - xiii. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring



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- involvement of persons providing Special Assistance (see AMPM Policy 320-R),
- xiv. Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams, Dialectical Behavioral Therapy, Multi-Systemic Therapy, developmental disabilities, trauma, substance abuse, children age birth to five, and Behavioral Health Inpatient Facilities), and
  - xv. Member benefit options trainings: such as Medicare Modernization Act (MMA), DES/RSA and SABG.
3. Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health system [e.g., the Balanced Budget Act (BBA), MMA, the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)]. Additional trainings may be required, as determined by geographic service area identified needs.
4. RBHAs must develop and make available to providers any policies and procedures regarding additional training information.

### C. ANNUAL AND ONGOING TRAINING REQUIREMENTS

1. In addition to training required within the first 90 days of hire, all RBHA subcontracted providers are required to undergo and provide ongoing training for the following content areas:
- a. AHCCCS Demographic Data Set, including required timeframes for data submission, valid values and as changes occur,
  - b. Monthly trainings concerning procedures for submissions of encounters as determined by AHCCCS,
  - c. Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved populations,
  - d. Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process,
  - e. American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R),
  - f. Child and Adolescent Service Intensity Instrument (CASII),
  - g. Ticket to Work/Disability Benefits 101,
  - h. Peer, family member, peer-run, family-run and parent-support training and coaching,
  - i. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see AMPM 320-R), and



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- j. Workforce Development trainings specific to hiring, support, continuing education and professional development.
2. Specific situations may necessitate the need for additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health system (e.g., the BBA, MMA, ACA, and DRA). Additional trainings may be required, as determined by geographic service area identified needs.
3. RBHAs shall develop and make available to providers any policies and procedures regarding specific ongoing training requirements.

ADHS Public Health Licensing required training must be completed and documented in accordance with Public Health Licensing requirements (see applicable provisions of A.A.C. Title 9, Chapter 10. and the [ADHS Public Health Licensing website](#)).

**D. REQUIRED TRAINING SPECIFIC TO PROFESSIONAL FOSTER HOMES PROVIDING HCTC SERVICES**

**1. Children**

Medicaid reimbursable HCTC services for children are provided in professional foster homes licensed by the DES/Office of Licensing, Certification and Regulation which must comply with training requirements as listed in A.A.C. R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each contracted provider:

- a. CPR and First Aid Training and
- b. 18 hours of pre-service training utilizing the HCTC to Client Service Curriculum.

The provider delivering HCTC services must complete the above training prior to delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in A.A.C. R6-5-5850, Special Provisions for a Professional Foster Home.

**2. Adults**

Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by ADHS Public Health Licensing, and must comply with training requirements as listed in applicable sections of A.A.C. Title 9, Chapter 10:

- a. Protecting the person's rights,



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- b. Providing behavioral health services that the adult therapeutic foster home is authorized to provide and the provider delivering HCTC services is qualified to provide,
- c. Protecting and maintaining the confidentiality of clinical records,
- d. Recognizing and respecting cultural differences,
- e. Recognizing, preventing or responding to a situation in which a person:
  - i. May be a danger to self or a danger to others,
  - ii. Behaves in an aggressive or destructive manner,
  - iii. May be experiencing a crisis situation, or
  - iv. May be experiencing a medical emergency.
- f. Reading and implementing a person's treatment plan, and
- g. Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by A.A.C. Title 9, Chapter 10

**E. REQUIRED TRAINING SPECIFIC TO COMMUNITY SERVICE AGENCIES**

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs prior to providing services to members. For a complete description of all required training specific to CSAs, see AMPM Policy 961, *Peer, Family and CSA Training, Credentialing and Oversight Requirements*.

**F. TRAINING EXPECTATIONS FOR AHCCCS CLINICAL AND RECOVERY PRACTICE PROTOCOLS**

- 1. Under the direction of the AHCCCS Chief Medical Officer, the Department publishes national practice guidelines and clinical guidance documents to assist behavioral health providers. These documents, some with required elements, can be accessed at <https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html>
- 2. Behavioral health providers providing services to children and families involved with DCS will be required to attend "Unique Needs of Children Involved with DCS" training that is offered by each RBHA on a regular basis (See AHCCCS Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS).
- 3. Training on Child and Family Team (CFT) practice, depending on the population(s) served (See AHCCCS Practice Protocol Child and Family Team).



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4. Training curriculums may be tailored to specific professional levels (e.g. BHMP, BHT, BHPP) and or job functions (e.g. Coach, Family Support Partner, Supervisor) so long as curriculums are consistent with the CFT Practice Protocol. Curriculums and certification processes shall be submitted for approval to HCCCS as specified in RBHA Contract Exhibit-9, Deliverables.

**G. TRAINING REQUESTS**

The RBHA shall make available to providers any policies, procedures, and contact information that identify how providers can access additional training and/or technical assistance specific to the trainings required by this policy and/or other types of applicable training resources. .

**H. WORKFORCE DEVELOPMENT**

1. RBHAs must develop and make available to providers any additional policies and procedures regarding specific workforce development requirements.
2. **Training Expert** – The RBHA shall employ a training expert/contact as key personnel and point of contact to implement and oversee compliance with the training requirements, training plan, AMPM Policy 1060 committees.
3. **Training Development Plan** - The RBHA shall develop, implement and submit an Annual Training Plan that provides information and documentation of all trainings. The training plan and training curriculums will be submitted annually, 45 days after fiscal year end as specified in RBHA Contract Exhibit-9, Deliverables.
4. **Training Quarterly Updates** - The RBHA shall submit a Workforce Development Quarterly Update which includes information specific to initiatives and activities specific to training. Quarterly updates are to be submitted 30 days after quarter end as specified in RBHA Contract Exhibit-9, Deliverables.

**REFERENCES**

- AMPM Chapter 300
- AMPM Chapter 500
- AMPM Chapter 600
- AMPM Chapter 900
- AMPM Chapter 1000
- ACOM Policy 201
- ACOM Policy 203
- ACOM Policy 417
- ACOM Policy 434



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- RBHA Contract, Scope of Service
- RBHA Contract, Exhibit 9, Deliverables
- A.A.C. R6-5-5850
- A.A.C. Title 9, Chapter 10
- A.A.C. R9-21-101
- A.A.C. R9-21-301 through 314
- 45 CFR Part 96
- Adult Service Delivery System-Nine Guiding Principles
- AHCCCS/DHCAA Office of Individual and Family Affairs Web Page