Arizona Department of Health Services
Division of Behavioral Health Services

2012 Annual Medical Management/Utilization Management Plan
(AHCCCS Contract Year October 1, 2011 – September 30, 2012)

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Bureau of Quality Management Operations
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Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide administration, regulation, and monitoring of all facets of the State public behavioral health system. ADHS/DBHS contracts with community-based organizations known as Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TBHAs) to administer behavioral health services throughout the State. ADHS/DBHS Contractors function in a fashion similar to a health plans and are responsible for the development of service networks for adult and child behavioral health recipients.

The state is divided into six geographical service areas (GSAs) served by four Contractors:

- **Cenpatico Behavioral Health of Arizona** (CBHAZ) serves three GSAs (GSAs 2, 3 and 4) covering Pinal, Gila, Yuma, La Paz, Graham, Greenlee, Santa Cruz and Cochise Counties.
- **Community Partnership of Southern Arizona** (CPSA) serves one GSA (GSA5) covering Pima County.
- **Northern Arizona Behavioral Health Authority** (NARBHA) serves one GSA (GSA 1) covering Mohave, Coconino, Apache, Navajo, and Yavapai Counties.
- **Magellan of Arizona** (Magellan) of Arizona serves one GSA (GSA 6) covering Maricopa County.

ADHS/DBHS has Intergovernmental Agreements (IGAs) with three of Arizona’s American Indian Tribes to deliver behavioral health services to persons living on the reservations:

- **Gila River Indian Community**
- **Pascua Yaqui Tribe**
- **White Mountain Apache Tribe of Arizona**
The ADHS/DBHS Medical/Utilization Management (MM/UM) program is designed to assure systemic, appropriate utilization of services to achieve desired outcomes by establishing utilization management requirements, monitoring utilization data, and promoting the use of nationally recognized best practices through practice guidelines and approved use of new technologies. All ADHS/DBHS MM/UM program requirements are either directly reflected in the contracts with ADHS/DBHS Contractors, or are in policies that are incorporated into the contracts by reference. ADHS/DBHS Contractors must implement and adhere to ADHS/DBHS’ requirements and must describe these practices in the Contractors’ annual MM/UM Plans. Oversight of Contractors adherence to these practices is accomplished through the review of Contractor monthly and quarterly submissions of utilization data, ADHS/DBHS data validation exercises and the Annual Administrative Review process.

Vision
ADHS/DBHS maintains a vision for the delivery of behavioral health services that provides the basis for all MM/UM activities. The ADHS/DBHS vision states:

_All Arizona residents touched by the public behavioral health delivery system are easily able to access high quality prevention, support, rehabilitation and treatment services that have resiliency and recovery principles at their core, which assist them in achieving their unique goals for a desired quality of life in their homes and communities._

To support the ADHS/DBHS vision, the goals of the ADHS/DBHS Medical/Utilization Management Program are to:

- Monitor utilization of behavioral health services.
- Provide oversight of delegated functions.
- Provide oversight of Contractor medical/utilization management processes.
- Provide authorization services for TBHA Contractors.
- Coordinate the Pre-Admission Screening and Resident Reviews (PASRR) for individuals in need of placement in skilled nursing facilities.
- Implement nationally recognized best practices in the area of care coordination.
- Validate utilization data.
- Ensure that Notice of Action requirements are adhered to.

Activities defined to support MM/UM processes and program goals are delineated in the 2012 ADHS/DBHS MM/UM Work Plan (Attachment C). These activities serve to direct the ADHS/DBHS MM/UM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequency of activities and target dates for activities completion. ADHS/DBHS MM/UM activities include Contractor, stakeholder and recipient input and serve to further the vision of ADHS/DBHS.

The ADHS/DBHS MM/UM Plan includes activities designed to meet federal and AHCCCS requirements and all data driven, focused performance improvement activities conducted by ADHS/DBHS Contractors. ADHS/DBHS provides oversight and technical
assistance to every Contractor to ensure compliance with all performance standards and contractual requirements.

I. Medical/Utilization Management Administrative Oversight

(AMPM Chapter 1000, Policy 1010, Contract ¶ 21)

ADHS/DBHS implements its MM/UM plan both internally and through its contracts with T/RBHAs. For example:

- Tribal Prior Authorizations, Concurrent and Retrospective Reviews are conducted by ADHS/DBHS Medical Management Staff in accordance with AHCCCS requirements
- Review and Analyze utilization data provided by RBHAs on monthly and quarterly basis, which includes
  - Readmits and Length of Stay (LOS)
  - Court Ordered Treatment
  - SMI Eligibility Determination
  - Authorizations which is a part of the Monthly Enrollee Grievance Report submitted to AHCCCS
- ADHS/DBHS Conducts monthly MM/UM Committee meetings where all components of the MM/UM Plan/Program are discussed, evaluated, and approved.
- MM/UM Committee reports directly to the Leadership team for recommendations and approval
- ADHS/DBHS implement two subcommittees:
  - Pharmacy and Therapeutic Committee where drug and medication utilization and related issues are presented and discussed
  - T/RBHA MM/UM Coordinators meetings serves as a venue for its Contractor MM/UM program oversight and as a means for ongoing technical assistance.
- ADHS/DBHS conducts onsite data validation visits on a biannual basis
- ADHS/DBHS Conducts Annual Administrative Reviews of its contractors
- ADHS/DBHS reviews and approves new Technologies and new use of existing technologies

Additionally, ADHS/DBHS delegates the following MM/UM functions to its Contractors:

- RBHAs Prior Authorization, Concurrent Review, and Retrospective Review, Inter-rater reliability
- Care Coordination/Case Management
- Provider and Recipient over and under utilization monitoring and action
- Pharmacy utilization review at provider and recipient level

ADHS/DBHS provides oversight and has ultimate accountability for all functions delegated to its Contractors (Please review Section III-Delegated Activities)
Structural Framework and Communications
The ADHS/DBHS Office of Medical Management/Utilization Management (MM/UM) operates within the Bureau of Quality Management Operations (BQMO). The BQMO works collaboratively with all functional areas of ADHS/DBHS to evaluate service utilization throughout Arizona. MM/UM administrative oversight and communication activities are conducted via ADHS/DBHS committees and data sharing. ADHS/DBHS committees are utilized as a forum for decision making, performance monitoring, development and guidance of performance improvement activities, and as a means for incorporating stakeholder and member feedback into MM/UM activities.

ADHS/DBHS Leadership Team
The ADHS/DBHS Leadership Team (SET) acts as the governing, policy making body for ADHS/DBHS, providing strategic direction and ultimate authority for the scope of BQMO activities. The Leadership Team ensures ongoing communication between BQMO and other functional areas in the division of behavioral health service for service alignment. The Leadership Team acts as the final approval authority for all activities related to the ADHS/DBHS system of care.

Membership: ADHS/DBHS Leadership Team

- Laura Nelson, MD, Deputy Director
- Steven Dingle, MD, Chief Medical Officer
- Sara Salek, MD, Deputy Chief Medical Officer
- Robert Sorce, Assistant Director
- Ann Froio, Assistant Director
- Cynthia Lane, Branch Chief, Finance
- Margery Ault, Branch Chief, Consumer Rights
- Claudia Sloan, Special Project Administrator

Meeting Frequency: Weekly

MEDICAL MANAGEMENT COMMITTEE STRUCTURE
MM/UM Committee
The ADHS/DBHS MM/UM Committee operates under the direction of ADHS/DBHS’ Leadership Team. The Chief Medical Officer chairs the committee; is responsible for the implementation of the MM/UM Plan; and has substantial involvement in the assessment and improvement of MM/UM activities. Committee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings.

The MM/UM Committee analyzes MM/UM reports to identify potential opportunities to improve availability, access, and delivery of behavioral health services. This Committee is responsible for developing solutions to issues identified in MM/UM reports. MM/UM program objectives, policies, and procedures are reviewed (at a minimum) annually and modified or updated as needed. The MM/UM Committee addresses and makes recommendations to the ADHS/DBHS Leadership Team concerning the following utilization functions:

- Monitoring of over and under-utilization of care services at both the provider and recipient level;
- Validating utilization data provided by its Contractors to ensure accuracy;
- Assessment of the utilization management program and develop/adopt utilization criteria;
- Development and adoption of clinical practice guidelines that are based on scientific evidence. These guidelines are reviewed and updated at least annually;
- Monitoring Contractors’ coordination of care;
- Review of the application of new technologies, as well as new uses of existing technologies; and,
- Monitor and support Contractors’ UM activities including utilization practice patterns, Notices of Actions, policies and procedures to ensure contract compliance.

The annual MM/UM Plan and the annual MM/UM Evaluation as well as recommendations for MM/UM activities are reviewed and approved by this Committee prior to presentation to the ADHS/DBHS Leadership Team.

Membership:
MM/UM Committee Membership (Voting Members)
- Steven Dingle, MD, Chief Medical Officer (Chair)
- Alexandra O’Hannon, Office Chief, Medical Management (Co-Chair)
- Sara Salek, MD, Deputy Chief Medical Officer
- Ashraf Lasee, Branch Chief, BQMO
- Laura Nelson, MD, Deputy Director and Chief Medical Officer
- Cynthia Lane, Division Financial Officer
- Margery Ault, Branch Chief, Consumer Rights
- Melissa Thomas, Acting Branch Chief, Program Operations
- Ann Froio, Assistant Director

Meeting Frequency: Monthly
Pharmacy and Therapeutics Committee
The Pharmacy and Therapeutics (P and T) Committee provides guidance to ADHS/DBHS Contractors regarding formulary decisions; safe and effective prescribing; reviews of new technologies or requests for new use of existing technologies; and monitoring of psychiatric medications.

All Subcommittee members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The subcommittee chair reports on utilization of psychiatric medication and formulary recommendations at the MM/UM Committee.

Membership:

Pharmacy and Therapeutics Committee Membership
- Steven Dingle, MD, Chief Medical Officer (Chair)
- Alexandra O’Hannon, Office Chief, Medical Management (Co-Chair)
- Sara Salek, MD, Deputy Chief Medical Officer
- Margaret McLaughlin Acting Branch Chief, Contract Compliance
- Cynthia Lane, Division Financial Officer
- Suzanne McClelland, Arizona State Hospital Pharmacist
- Shannon Shiver, Utilization Specialist
- Earlene Allen, Health Program Manager
- Karla Schaff, Utilization Specialist

Meeting Frequency: Quarterly, or as needed

MM/UM Coordinators Meeting
The ADHS/DBHS Contractor MM/UM Coordinators Meeting serves as a venue for ADHS/DBHS Contractor MM/UM program oversight and as a means for ongoing technical assistance to ADHS/DBHS Contractors. MM/UM Coordinator Meeting summaries are provided to the ADHS/DBHS MM/UM Committee at least quarterly.

MM/UM Coordinators Meeting Membership:
- Alexandra O’Hannon, Office Chief, Medical Management (Chair)
- Ashraf Lasee, Branch Chief of Quality Management Operations
- Steven Dingle, MD, Chief Medical Officer
- Contractor MM/UM Representatives
- MM/UM Staff

Meeting Frequency: Quarterly, or as needed

MM/UM Program Staff
The ADHS/DBHS Office of MM/UM is staffed with individuals who have the knowledge, training and experience to perform the MM/UM functions and responsibilities in a timely and knowledgeable manner as required by ADHS/DBHS’
contract with AHCCCS. The Office of MM/UM consists of nine (9) positions: a Chief Medical Officer, a Medical Management Office Chief, two (2) Prior Authorizations Coordinators, one (1) Pre-Admission, Screening and Resident Review (PASRR) Coordinator, one (1) Utilization Specialist, two (2) Monitoring Specialist (one Monitoring Specialist position is currently vacant), and one (1) Administrative Assistant. As depicted in the flow chart below, the Office of MM/UM within the BQMO is overseen by the Branch Chief of the Office of Consumer Rights. Responsibilities are outlined as table below.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Steven Dingle, MD</td>
<td>The Chief Medical Officer will:</td>
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<tr>
<td>Chief Medical Officer</td>
<td>• Chair MM/UM Committee Meeting</td>
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<td>• Provide Consultation on all clinical aspects of the program (Denial, NOA etc)</td>
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<td>• Work with RBHAs Chief Medical Officers on issues related to drug utilization,</td>
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<td>new medical technologies, practice protocols etc</td>
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<td>• Member of the ADHS/DBHS Leadership Team</td>
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<td>Margery Ault, JD</td>
<td>• Supervises the Branch Chief for BQMO</td>
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<tr>
<td>Branch Chief of the</td>
<td>• Provides administrative, executive-level leadership, guidance and support for</td>
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<td>Consumer Rights</td>
<td>BQMO</td>
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<td>Ashraf Lasee, MBBS, MPH, Dr.</td>
<td>• The Branch Chief for the Bureau of Quality Management</td>
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<tr>
<td>PH</td>
<td>Operation is responsible to ensure ongoing communication and collaboration</td>
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<td>Branch Chief of the</td>
<td>between Executive Leadership, BQMO, and other functional areas of the Division</td>
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<td>Bureau of Quality</td>
<td>of Behavioral Health Services.</td>
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<td>Management Operations</td>
<td>• Provides administrative support and technical assistance to three Offices in</td>
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<td>the Bureau: Office of MM/UM, Office of Performance Improvement and the Office</td>
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<td>of Information Management.</td>
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<td>• Leadership role to communicate program related issues and needs with AHCCCS and</td>
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<td>ADHS/DBHS Leadership Team</td>
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<td>Alexandra O’Hannon MSW,</td>
<td>MM/UM Office Chief provides oversight of:</td>
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<tr>
<td>CPHQ</td>
<td>• All components of the PASRR process</td>
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<tr>
<td>Medical Management Office</td>
<td>• All components of the Tribal Prior Authorization Process</td>
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<td>Chief</td>
<td>• Oversight and facilitation of the Administrative Review Process</td>
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<td></td>
<td>• The MM/UM component of the Operational and Financial Review process</td>
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<td></td>
<td>• Six (6) staff</td>
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<td></td>
<td>• Oversight and facilitation of data validation activities</td>
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<td></td>
<td>• Writes policies and procedures for both internal and external use</td>
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<td>• Designs databases to effectively track service utilization</td>
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<tr>
<td>Staff</td>
<td>Responsibilities</td>
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| Shannon Shiver MA Utilization Specialist | • Provides transition oversight for recipients in the Arizona State Hospital  
• Acts as the Health Plan Liaison  
• Conducts data analysis and data validation  
• Provides RBHA UM/MM Program oversight  
• Tracks and monitors children placed in out of state placements  
• Conducts Administrative Reviews of the RBHAs  
• Evaluates and monitors Contractors’ corrective action plans  
• Participates in various committees  
• Conducts Research Activities  
• Participates in the AHCCCS Operation and Financial Review process  
• Provides technical assistance to internal and external customers  
• Represents ADHS/DBHS in various capacities |
| Karla Schaff MPH Utilization Specialist | • Provides RBHA UM/MM Program oversight  
• Conducts data analysis and data validation  
• Conducts Administrative Reviews of the RBHAs  
• Participates in various committees  
• Conducts Research Activities  
• Participates in the AHCCCS Operation and Financial Review process  
• Provides technical assistance to internal and external customers  
• Provides oversight of the RBHAs’ MCE studies  
• Represents ADHS/DBHS in various capacities |
| Vacant Position- RN Monitoring and Oversight (Position advertized) | The following will be the responsibility of the newly hired staff:  
• Gather, plan, organize and evaluate information from multiple data sources  
• Conduct case file reviews and audits,  
• Conduct Administrative Reviews  
• Conduct research  
• Conduct data validation  
• Evaluate clinical decision-making specific to Notices of |

- Reviews documentation specific to children placed in out of state placements  
- Provides technical assistance to internal and external customers  
- Participant in the MM/UM, QM, Children’s QM, and Pharmacy and Therapeutics Committee  
- Monitors Contractors’ utilization practices  
- Monitors Contractors’ compliance with the ADHS/DBHS contract, AMPM, and the Federal Regulations
<table>
<thead>
<tr>
<th>Staff</th>
<th>Responsibilities</th>
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<tr>
<td><strong>Vacant Position-LBHP</strong></td>
<td>The following will be the responsibility of the newly hired staff</td>
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<tr>
<td><strong>Monitoring and Oversight</strong></td>
<td>• Gather, plan, organize and evaluate information from multiple data sources</td>
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<tr>
<td><em>(Position advertized)</em></td>
<td>• Conduct case file reviews and audits,</td>
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<td>• Conduct Administrative Reviews</td>
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<td>• Conduct research</td>
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<td>• Conduct data validation</td>
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<td>• Evaluate clinical decision-making specific to Notices of Actions</td>
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<td>• Participate in the Peer Review Process</td>
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<td>• Synthesize data</td>
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<td>• Produce Reports used for decision-making</td>
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<td><strong>Tilmon Broadway BS</strong></td>
<td>• Collects, reviews, and authorizes RTC, L2 Group Home, and Hospital services for Tribal recipients</td>
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<td><strong>PA Coordinator</strong></td>
<td>• Conducts retrospective reviews</td>
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<td>• Participates in Inter-rater reliability testing</td>
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<td>• Manages various internal databases</td>
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<td>• Runs reports for the BQMO</td>
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<td>• Participates in the MM/UM Committee</td>
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<td>• Participates in meetings with internal and external stakeholders</td>
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<tr>
<td><strong>Alice Plaxco</strong></td>
<td>• Manages the Pre-Admissions Screening and Resident Review process for Arizona’s non- DDD residents</td>
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<td><strong>PASRR Coordinator</strong></td>
<td>• Provides reports to AHCCCS</td>
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<td>• Participates in the Operational and Financial Review</td>
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<td>• Coordinates with the ADHS/DBHS Chief Medical Officer and Medical Director</td>
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<tr>
<td><strong>Linda Cram BSW</strong></td>
<td>• Collects, reviews, and authorizes RTC, L2 Group Home, and Hospital services for Tribal recipients</td>
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<td><strong>PA Coordinator</strong></td>
<td>• Conducts retrospective reviews</td>
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<td></td>
<td>• Participates in Inter-rater reliability testing</td>
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<td>• Runs reports for the BQMO and the tribes</td>
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<tr>
<td></td>
<td>• Participates in the MM/UM Committee</td>
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<td></td>
<td>• Participates in meetings with internal and external</td>
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<td>• In the absence of Ms. Plaxco, acts as the backup PASRR Coordinator.</td>
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<tr>
<td><strong>Julia Spooner</strong></td>
<td>• Administratively supports the Office of Medical Management</td>
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<tr>
<td><strong>Administrative Assistant</strong></td>
<td>• Takes minutes for meetings</td>
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<td></td>
<td>• Manages internal and external communications</td>
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</tbody>
</table>
II. Monitoring and Evaluation of Service Delivery

(AMPM Chapter 1000, Policy 1020, Policy 1020, ADHS/DBHS Contract ¶ 21)

The ADHS/DBHS MM/UM Plan identifies all monitoring and evaluation activities conducted by the ADHS/DBHS Office of MM/UM, including the monitoring and oversight of Contractor MM/UM activities. New initiatives and performance improvement activities are implemented via analysis of data and evaluation of systems performance. Initiatives are evidenced based and inclusive of feedback from behavioral health recipients and stakeholders.

Annual Evaluation

As part of it’s MM/UM program, ADHS/DBHS conducts biannual evaluations of the MM/UM Work Plan within the MM/UM Committee. The biannual evaluations assist in identifying trends and assessing where additional focus may be warranted. These evaluations are also used to determine the scope of the coming year’s activities and in the development of MM/UM processes and performance measures. The evaluation identifies:
• Goals and tasks completion status
• Data trends
• Changes to the scope of the work plan
• Goals and tasks timelines
• Corrective actions

**Data Integrity**

Accurate and reliable data is imperative for the success of the ADHS/DBHS MM/UM program. Per Provider Manual Section 7.5, Enrollment, Disenrollment and Other Data Submissions, Contractors must maintain a health information system which includes data elements such as member demographics, service utilization, provider characteristics, enrollment, outcomes measures and diagnoses for use in ADHS/DBHS and Contractor MM/UM activities. Demographic data submitted to the ADHS/DBHS Client Information System (CIS) must pass a series of validation measures and logic safeguards prior to acceptance. Each validation measure or edit is designed to operate in a specific manner to ensure accuracy, completeness and logic. ADHS/DBHS provides direction related to systems edits and business rules to its Contractors through the Demographic and Outcome Data Set Users Guide (DUG).

The Office of Program Support publishes the Program Support Procedures Manual, which outlines provisions for daily, weekly, and monthly claims and encounters processing. This manual includes operations details and a description of the interface between Contractors, ADHS/DBHS, and AHCCCS along with a description of monitoring processes undertaken by ADHS/DBHS. Monitoring includes data validation in conjunction with fraud and abuse reviews. Training and technical assistance is provided to Contractors as needed. In addition to ensure accuracy and completeness of service utilization data, ADHS/DBHS requires Contractors to conduct validation studies as outlined in ADHS/DBHS Provider Manual, Section 8.1 Encounter Validation Studies.

The BQMO Specifications Manual includes details on the ADHS/DBHS methodologies for calculating, reporting, and analyzing all performance indicators. When submitting data to ADHS/DBHS, Contractors are required to utilize standardized data collection tools. The standardization of reporting ensures critical data elements are provided consistently across Contractors for improved analysis on a statewide level. ADHS/DBHS mandates that no Contractor exceed an allowable error rate of 5 percent in any data submission for more than two quarters. Any Contractor exceeding the allowable error rate on MM/UM data submissions are subject to corrective actions, sanctions, and other contractual remedies.

For Tribal utilization data (which is mainly authorization data), ADHS/DBHS utilizes an Access database to monitor and track authorization patterns every other month. This information is shared with Tribal Regional Authorities so they are aware of the status of prior authorization, concurrent and retrospective reviews and to ensure that the times are met in making medical necessity determination. However, ADHS/DBHS has not used Tribal utilization (authorization) data to detect utilization patterns in terms of over and under utilization of services. TRBHAs are not required to submit flat files for utilization
Data (COT, SMI Eligibility determination, LOS and Readmissions) like the RBHAs are, therefore, ADHS/DBHS is not able to conduct utilization analysis for this population.

Data Validation:
The Office of MM/UM conducts data validation activities on the following Contractor data submissions:
- Prior Authorization
- Length of Stay/Readmissions
- SMI Determination,
- Court Ordered Treatment

Data validation activities occur twice per year and support the integrity of data reported to ADHS/DBHS. Negative trends identified over multiple reporting periods for any one Contractor may result in an ad hoc focused review conducted at the Division’s discretion, and/or Corrective Action or Sanction.

ADHS/DBHS Annual Administrative Review
ADHS/DBHS conducts comprehensive administrative review of its contractors (RBHAs and TBHAs) to evaluate the performance of Contractors’ MM/UM Program/Plan, and the ADHS/DBHS delegated functions. Results are shared with Contractors and actions are taken based on performance.

Confidentiality
Contractors must adhere to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules when working with recipient data or engaging in discussions regarding recipient specific information. ADHS/DBHS Provider Manual, Section 4.1, Disclosure of Behavioral Health Information and ADHS/DBHS Policy and Procedure Manual, Section CO 1.4 Confidentiality provide additional guidance on requirements for use and disclosure of behavioral health recipient information.

Under and Over Utilization
Contractors must evaluate the over and under utilization of services from an individual member and systemic perspective in order to identify members who require additional assistance and opportunities to address the quality of care provided and/or capacity enhancement. ADHS/DBHS monitors its Contractors’ processes for adhering to the Over and Under Utilization policy and identifying under and over utilization of services through the collection of several data points in standardized quarterly MM/UM reports. The MM/UM Committee is charged with reviewing these reports for systemic trends; implementing/approving improvement actions when necessary and assessing actions for effectiveness. ADHS/DBHS collects Contractor Levels 1-4 Readmission Rate and Length of Stay data; prior authorizations/notices of action logs; Court Ordered Treatment (COT) and Seriously Mentally Ill (SMI) eligibility determination rates for use in systems evaluation. ADHS/DBHS monitors Contractors’ compliance with this requirement through assessment and approval of the Contractor MM/UM Plans and via the Annual Administrative Review.
Pharmacy Utilization Review
ADHS/DBHS monitors utilization of psychotropic medication through the standardized Quarterly Pharmacy Utilization Report. Pharmacy utilization trends are reviewed and analyzed on a quarterly basis and then are presented to the P and T Committee to discuss patterns of utilization. Performance improvement activities are implemented as necessary and monitored by the committee. ADHS/DBHS monitors its Contractors pharmacy utilization practices, including the use of new technologies or new use for existing technologies, through quarterly data submissions, the Annual Administrative Review, and through the Contractors processes for prior authorization of non-formulary drug requests.

Evaluation of New Technologies and New Uses of Existing Technologies
There are few new technologies or new uses for existing technology in the mental health field; still, the P and T Committee also serves as a formal venue to discuss psychiatric procedures, new medications and treatment modalities, consideration of new uses for existing technology, and medication utilization. Should a Contractor want to administer a new medication or use an existing technology for a newly identified purpose, the Contractor must first submit a report to ADHS/DBHS explaining the Contractor’s rationale for making such a request. The report must include (at a minimum) a literature based, in-depth analysis of the medication/technology requested, a cost analysis, and a benefit analysis. Once submitted to the Medical Director, the request is brought to the P and T Committee for consideration. The P and T Committee is scheduled to meet on a quarterly basis; however, should a request for a new technology or new use of an existing technology occur, the P and T Committee is prepared to meet on an ad hoc basis to ensure that Contractors and Recipients receive a response in a timely manner. New technologies are implemented via additions to the ADHS/DBHS Provider Manual, Section 3.16 Medication Formulary. Medical policies are created when necessary and follow a detailed process that includes distribution for public comment and approval by AHCCCS prior to implementation.

Tribal Prior Authorization, Concurrent Review and Retrospective Review
Tribal Authorizations (Prior Auth, Concurrent Review, Retrospective Reviews) are conducted by the ADHS/DBHS prior authorization specialists. Two full time staff are dedicated for completing the TBHA’s prior authorizations, concurrent review, and retrospective review functions for Level I (Hospitalization and RTC) and Level II group homes. Staff uses medical necessity coverage criteria based on nationally recognized, evidence based practices approved by the ADHS/DBHS Medical Directors in consultation with T/RBHA Medical Directors. Requests to authorize services for Tribal Recipients are communicated to ADHS/DBHS telephonically, electronically, and/or via fax Monday thru Friday from 8:00 am to 5:00 pm. ADHS/DBHS provides e-mail notification to the TBHA case managers once the requested service has been authorized. The criteria used to determine medical necessity for ADHS/DBHS Tribal Recipients is the same criteria used by the RBHAs. The admission and ongoing stay criteria for Acute Hospitalizations, Level I Residential Treatment Centers, and Level II Behavioral Health Group Homes are as follows:
Admission to Psychiatric Acute Hospital or Sub-Acute Facility Authorization

Criteria

A person must meet ALL criteria in Sections A., C., and D., and at least ONE of the criteria in Section B. for admission to a psychiatric acute hospital or sub-acute facility.

A. DIAGNOSIS

A specific diagnosis is not a condition for admission to an inpatient setting; however a specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

B. BEHAVIOR AND FUNCTIONING

1. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
   a. Current suicidal ideation, behavior or intent,
   b. Current homicidal or significant assaultive ideation, behavior or intent, or
   c. Immediate physiologic jeopardy.

2. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation;

3. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or

4. Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral health decompensation.

C. INTENSITY OF SERVICE

This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person’s need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service.

D. EXPECTED RESPONSE

1. The client's behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting.
2. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

**Level I Inpatient Treatment Continued Authorization Criteria**
A person must meet ALL criteria in Sections A and E, at least ONE of the criteria in each of Sections B, C and must meet Section D for continued stay in a psychiatric acute hospital or sub acute facility.

**A. DIAGNOSIS**
A specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.

**B. BEHAVIOR AND FUNCTIONING**
1. Emergence or continued evidence of symptoms which reflect imminent risk of danger to self or others as a result of a behavioral health condition, as evidenced by:
   a. Current suicidal ideation, behavior or intent, or
   b. Current homicidal or significant assaultive ideation, behavior or intent, or
   c. Ongoing physiologic jeopardy; or

2. Continued disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation; or

3. Significant regression of the person’s condition is anticipated without continuity of this type of service.

**C. INTENSITY OF SERVICE**
There is documented evidence that the person requires at least one of the following:

1. Continued planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. This may be as a result of a change in diagnosis, treatment failure, or newly-discovered aspect of the person’s case necessitating a significant change in the treatment plan; or

2. Close, continuous, 24 hour skilled medical/nursing supervision of the person’s behaviors, which are due to a behavioral health condition, in order to prevent injury to the person or others; or

3. Pharmacotherapy which requires continuous, skilled medical/nursing supervision for safe, effective use; or

4. Skilled nursing observation and care in the management of disturbances of mood, thought or behavior which cannot be provided by non-medical personnel; or

5. Repeated use of physical restraint; or
6. Psychiatric acute hospital or sub-acute facility services may be continued if the person no longer requires the type of service provided in a psychiatric acute hospital or sub acute facility but there is not an available lower intensity of services suitable to the behavioral health needs of the person or the person cannot return to the person’s residence because of a risk to harm self or others.

D. EXPECTED RESPONSE
There is documented evidence that:
1. Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; or

2. There has been a re-evaluation and subsequent change in the treatment plan.
   AND

3. There is still an expectation that continued treatment in this type of service can reasonably be expected to improve or stabilize the patient’s condition so that this type of service will no longer be needed. OR

4. There is no less restrictive type of service available to safely meet the person’s behavioral health needs.

E. DISCHARGE PLAN
There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment.

Residential Treatment Center Authorization Criteria

A. PURPOSE
Level One psychiatric residential treatment facility (RTC) services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when outpatient services (ambulatory care) in the community do not meet their treatment needs and they require services at a psychiatric residential treatment facility under the direction of a psychiatrist. These services are designed for children and adolescents who have significant deficits in social, behavioral, psychiatric, and psychological functioning and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24 hour nursing presence, effective program and treatment availability, and continuous supervision provided by professional behavioral health staff.

Admissions to a RTC are not emergent or urgent and are always prior service will no longer be needed. OR authorized. As per ADHS/DBHS Policy Manual Section 3.14 Securing Services and Prior Authorization, “prior authorization seeks to ensure that persons are treated in the most appropriate, most cost effective, and least restrictive setting, with sufficient intensity of service, treatment and supervision to safely and adequately treat the person’s behavioral health condition.” Such admissions are only appropriate where outpatient care has failed or where service will no longer be needed.
OR the child’s/adolescent’s psychiatric treatment needs are so severe they can only be met by the degree of specialized professional treatment available in a RTC. Active treatment focuses on specific targeted goals identified by the Child and Family Team, and are designed to enable the child/adolescent to be discharged from the psychiatric residential treatment facility at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for admission to a RTC.

Determination of the need for services is based on the federal regulations in 42 CFR:

**§ 441.152 Certification of need for services.**

A team specified in § 441.154 must certify that—

(a) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
(b) Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(c) The services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

**§ 441.154 Active treatment.**

Inpatient psychiatric services must involve ‘‘active treatment’’, which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 that is—

(a) Developed and implemented no later than 14 days after admission; and
(b) Designed to achieve the recipient’s discharge from inpatient status at the earliest possible time.

B. BEHAVIOR AND FUNCTIONING REQUIRED FOR ADMISSION

1. Symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature, are consistent with a DSM IV-TR diagnosis (within the range of 290 through 316.99), and require residential 24-hour psychiatric treatment under the direction of a psychiatrist.
   a) Psychiatric conditions best described as 314.xx (Attention Deficit/Hyperactivity Disorder) and 312.8 (Conduct Disorder), without another DSM IV-TR co-morbid diagnosis, are not properly treated at a psychiatric residential treatment facility as per Mental Health: A Report of the Surgeon General and therefore should be closely reviewed for appropriateness of treatment in this level of care.

2. In addition, all of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:
   a) Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the child/adolescent;
   b) The child/adolescent does not require a level of medical or professional
supervision that surpasses that which is available at a Level I Residential Treatment Center. For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital;

c) The admission is **not** used primarily, and in a clinically inappropriate manner, as:

i) an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior; or

ii) the equivalent of safe housing, permanency placement, or iii) an alternative to parents’/guardian’s or other agency’s capacity to provide for the child or adolescent; or iv) an intervention when other less restrictive alternatives are available and not being utilized.

C. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT
Active treatment with the services available at this level of care can reasonably be expected to improve the child/adolescent’s psychiatric condition in order to achieve discharge from the psychiatric residential treatment facility at the earliest possible time and facilitate his/her return to outpatient care and/or family living.

D. DISCHARGE PLAN
There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness

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**Residential Treatment Center Continued Authorization Criteria**

A. PURPOSE
Level One psychiatric residential treatment facility (RTC) services provide treatment for children and adolescents who demonstrate severe and persistent psychiatric disorders, when outpatient services (ambulatory care) in the community do not meet their treatment needs and they require services under the direction of a psychiatrist at a psychiatric residential treatment facility. These services are designed for children and adolescents who have significant deficits in social, behavioral, psychiatric, and psychological functioning and who require active treatment in a controlled environment with a high degree of psychiatric oversight, 24 hour nursing presence, effective program and treatment availability and continuous supervision provided by professional behavioral health staff. Continued stays in a RTC are not emergent or urgent and are always prior authorized. As per ADHS/DBHS Policy Manual Section 3.14 Securing Services and Prior Authorization, “prior authorization seeks to ensure that persons are treated in the most appropriate, most cost effective, and least restrictive setting, with sufficient intensity of service, treatment and supervision to safely and adequately treat the person’s behavioral health condition.” Such admissions are only appropriate where outpatient care has failed or where
the child’s/adolescent’s psychiatric treatment needs are so intense that they can only be met by the degree of specialized professional treatment available in a RTC. Active treatment focuses on specific targeted goals identified by the Child and Family Team, and are designed to enable the child/adolescent to be discharged from the psychiatric residential treatment facility at the earliest possible time. A lack of available outpatient services is not in and of itself the sole criterion for continued stay at a RTC. If a child/adolescent receiving services no longer requires this level of care, but services suitable to meet his/her behavioral health needs are not available or he/she cannot return to his/her previous residence because of a risk of harm to self or others, services may continue to be authorized with an, active attempt to secure a suitable discharge placement or residence.

Determination of the need for services is based on the federal regulations in 42 CFR: § 441.152 Certification of need for services.

(a) A team specified in § 441.154 must certify that—
(1) Ambulatory care resources available in the community do not meet the treatment needs of the recipient;
(2) Proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician; and
(3) The services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

§ 441.154 Active treatment.
Inpatient psychiatric services must involve “active treatment”, which means implementation of a professionally developed and supervised individual plan of care, described in § 441.155 that is—
(a) Developed and implemented no later than 14 days after admission; and
(b) Designed to achieve the recipient’s discharge from inpatient status at the earliest possible time.

B. BEHAVIOR AND FUNCTIONING REQUIRED FOR CONTINUED STAY:
1. The symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature, are consistent with a DSM IVTR diagnosis (within the range of 290 through 316.99), and continue to require residential 24-hour psychiatric treatment under the direction of a psychiatrist.
   a) Psychiatric conditions best described as 314.xx (Attention-Deficit/Hyperactivity Disorder) and 312.8 (Conduct Disorder) are not properly treated at a psychiatric residential treatment facility as per Mental Health: A Report of the Surgeon General and therefore should be closely reviewed for appropriateness of treatment in this level of care.

2. In addition, all of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:
   a) Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the
child/adolescent;
b) The child/adolescent does not require a level of medical or professional behavioral health supervision that surpasses that which is available at a Level I Residential Treatment Center. For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital;
c) The continued stay is not used primarily and in a clinically inappropriate manner as:
   i) an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior;
   ii) the equivalent of child protection, safe housing, permanency placement, or
   iii) an alternative to parents'/guardian’s or other agency’s capacity to provide for child or adolescent; or
   iv) an intervention when other outpatient care is available and not being utilized.

C. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT
The child/adolescent is receiving services which are improving his/her psychiatric condition in order to achieve discharge from residential status at the earliest possible time and facilitate his/her return to outpatient care and/or family living. The professionally developed and supervised individual service plan has been changed (revised) if necessary to respond to any identified lack of progress.

D. DISCHARGE PLAN
There is a written plan for discharge with specific discharge criteria and recommendations for aftercare treatment that includes involvement of the Child and Family Team and complies with current standards for medically necessary covered behavioral health services, cost effectiveness, and least restrictive environment and is in conformance with 42 CFR.

**Level II Group Home Authorization Criteria for Children Under the Age of 21**

**Background**
The Arizona Vision and 12 Practice Principles clearly articulate as a core value that services be provided in the most appropriate, integrated setting responsive to the child’s needs. At the same time, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) recognizes that there are children/youth whose needs, in spite of intensive community-based service provision, can only be adequately and safely addressed through the use of targeted, short-term out of home treatment intervention. When community-based services are not effective in maintaining the child in his/her home setting, or safety concerns become critical, the use of out of home treatment services can provide essential behavioral health interventions to stabilize the situation.
**Service Expectations:**
For services requiring prior authorization, if the prior authorization is denied the T/RBHA must assist the CFT with recommendations of alternative services that are congruent with the child’s/family’s needs.

Service Plans must include goals and objectives that prepare the child and family for the child’s return to home or to a less restrictive community setting, as quickly as possible.

Every child receiving treatment services in an out of home setting must be served through a Child and Family Team, and the Residential Service Provider and CFT Service Plans must be in alignment.

Family involvement and partnership, including the provider’s attempts to engage the family, must be clearly documented in the clinical record.

Residential service provider staff must be trained and supervised to ensure treatment interventions and service plans are being implemented effectively. All staff directly involved with the child’s care must receive regularly scheduled clinical supervision, as well as event-driven supervision when necessary, to ensure the provision of sound clinical treatment.

Residential service providers must work collaboratively with the CFT to identify and address the changing needs of the child and family. Treatment interventions and services are modified as needed.

All behavioral health staff who provide out of home treatment services must complete required training per *ADHS/DBHS Provider Manual Section 9.1, Training Requirements* and OBHL guidelines.

For both planned and unplanned admissions, concurrent review must occur within three business days of the recipient’s admission and services must not be authorized for more than three business days per review. ADHS/DBHS conducts retrospective review on 100% of inpatient stays for which ADHS/DBHS was not notified of the Tribal Recipient’s admission. For such cases, ADHS/DBHS reviews documentation gathered from the facility, discusses the cases with facility staff, and then makes a decision regarding whether the stay was medically necessary. When reviewing a case retrospectively, ADHS/DBHS and its Contractors are required to apply the same criteria used to make the initial and continued stay decisions. Retrospective reviews must occur within twenty-eight (28) business days from the receipt of notification.

All ADHS/DBHS staff that completes prior authorization, concurrent review, and retrospective review participates in inter-rater reliability exercises to ensure consistency in decision making. Inter-rater reliability testing is conducted biannually to monitor consistency across staff, with additional training provided to reviewers do not appropriately apply authorization criteria. The results of inter-rater reliability testing are
presented in the MM/UM Committee. Both staff that presently completes authorizations are also responsible for concurrent and retrospective reviews.

RBHAs Prior Authorization, Concurrent Review and Retrospective Review

ADHS/DBHS delegates Prior Authorization, Concurrent Review and Retrospective Review to its RBHAs/Contractors. Contractors must comply with AHCCCS Medical Policy Manual and the requirements and criteria (same as above) documented in ADHS/DBHS Provider Manual Section 3.14, Securing Services and Prior Authorization, Policy 3.0, Concurrent Review, and Policy 2.9, Retrospective Review. All three policies specify the type of staff that is permitted to conduct prior authorization, concurrent review, and retrospective review. The policies also require Contractors to have systems in place that incorporate:

A) The use of criteria when making medical necessity determinations;
B) Policies and procedures that address the medical necessity of ongoing hospital stays;
C) Policies and procedures that incorporate approval and denial of services;
D) Policies and procedures that address review of medical necessary hospitalizations (planned hospitalizations)
E) Length of stay criteria;
F) Discharge criteria that is inclusive of the recipient’s needs at the time of discharge;
G) Evaluation of the quality of services provided;
H) Whether the services provided met the Recipient’s needs;
I) Which clinical documents must be obtained and reviewed;
J) The time requirements for conducting prior authorizations, concurrent review, and retrospective review
K) Facility and recipient based utilization patterns and analysis; and
L) Concurrent review staff’s role in managing a recipient who has another primary payer. At a minimum, the staff must participate in the discharge planning process.

Staff requirements for staff conducting prior authorization, concurrent review, and retrospective review are specific. At a minimum:

A) Staff must be qualified behavioral health professionals, RN/BSH, nurse practitioners, physician assistants, and/or physicians to execute the authorization functions.
B) Staff must be adequate in number to ensure timely reviews.
C) Staff participating in medical necessity determinations must be tested to ensure consistency in the application of standardized criteria.
D) In the event that a staff does not follow the established criteria and/or timelines, the Contractor must have a system in place to provide additional education/training and monitoring of the staff to remedy the discrepancy in a manner which ensures the integrity of the criteria is maintained.

The Office of MM/UM reviews all Medical Management specific policies and criteria at least annually through the Policy Committee and presents any changes made to the policies to the MM/UM Committee for approval prior to implementation.
As required by AHCCCS contract with ADHS/DBHS, the Division sends a monthly Grievance System Report to AHCCCS that is inclusive of the number of prior authorizations and denials for all levels of care. The monthly MM/UM report is reported in the MM/UM Committee to identify areas of needed improvement across the system. In addition, ADHS/DBHS evaluates its Contractors’ compliance with prior authorization and concurrent review requirements via chart reviews during the Annual Administrative Review. If areas in need of improvement are identified, Contractors are required to submit a plan for improvement using the QM Corrective Action Plan (CAP) Template which is approved by ADHS/DBHS and monitored through completion.

ADHS/DBHS assesses Notices of Action (NOAs) to ensure compliance with NOA requirements and to ensure that decisions are meeting clinical decision making expectations. Although reviewed monthly, NOA data is presented to the MM/UM Committee on a quarterly basis for feedback and recommendations.

During the Annual Administrative Review, ADHS/DBHS will review its Contractor’s Inter-rater reliability testing results for staff involved in authorization decision making. As per ADHS/DBHS policy, all new staff should complete IRR testing within 90-days of hire (including RBHAs’ Medical Directors), and testing must be repeated annually thereafter. A minimum performance score of 90 percent is acceptable for meeting this requirement. ADHS/DBHS will also monitor to ensure that staff who do not achieve the minimum performance score receive IRR training and are re-evaluated for meeting the requirement.

Contractors are required to submit a quarterly Showing Report, per ADHS/DBHS Policy and Procedures, Section QM 2.2, Showing Report, attesting to their compliance with 42 CFR 456.650 regarding certification of need for inpatient hospitalizations. ADHS/DBHS reviews this information for completeness and accuracy and forwards the Showing Report to AHCCCS.

Adoption and Dissemination of Policies and Procedures (including Revisions to existing Policies)
ADHS/DBHS maintains an inclusive approach when developing new policies and procedures, as well as reviewing and revising existing policies. The ADHS/DBHS Policy Department presents all newly proposed policies to the Policy Committee, and tracks all existing policies to ensure that they are reviewed at least annually. The Policy Committee consists of representation from all areas within ADHS/DBHS, providers, recipients, and other stakeholders who have vested interest. After the policy committee’s review, each policy is sent out for public comment and comments are reviewed by the appropriate functional area within ADHS/DBHS, as presented in the flow chart below. All MM/UM policies are reviewed by the MM/UM Committee for final approval.
CREATION OF NEW POLICY PROCESS

Policy Analyst works with the “expert” area to draft the policy and final review.

Policy Analyst organizes a workgroup that consists of representatives from each functional area within ADHS/DBHS to write the new policy.

Once the policy has been written, the Policy Analyst presents policy to Policy Committee for feedback (Policy Committee is composed of representatives from each functional area within ADHS/DBHS, family member representatives and peer representatives).

Policy Analyst incorporates feedback from Policy Committee and sends policy out for a two week public comment period (public comment list includes internal staff, T/RBHAs, AHCCCS, other state agencies, advocacy organizations, legal counsel, peer representatives, behavioral health recipients).

Policy Analyst sends final draft of policy to other Policy Analysts and Bureau Chief for quality check and final review. Bureau Chief submits policy to Deputy Director and Chief Medical Officer, if medical policy, for approval (and signature for Policy & Procedure Manual sections). Once approved, Policy Analyst sends policy to T/RBHAs 30 days before policy effective date (policies will be effective either the 1st or 15th of the month) and posts it to the ADHS/DBHS website.

ANNUAL REVIEW/REVISION PROCESS

Policy Analyst incorporates suggested revisions from stakeholders and any new requirements identified for the policy.

Policy Analyst presents policy to Policy Committee for feedback (Policy Committee is composed of representatives from each functional area within ADHS/DBHS, family member representatives and peer representatives).

Policy Analyst incorporates feedback from Policy Committee and sends policy out for a two week public comment period (public comment list includes internal staff, T/RBHAs, AHCCCS, other state agencies, advocacy organizations, legal counsel, peer representatives, behavioral health recipients).

Policy Analyst sends final draft of policy to other Policy Analysts and Bureau Chief for quality check and final review. Bureau Chief submits policy to Deputy Director and Chief Medical Officer, if medical policy, for approval (and signature for Policy & Procedure Manual sections). Once approved, Policy Analyst sends policy to T/RBHAs 30 days before policy effective date (policies will be effective either the 1st or 15th of the month).

Policy Analyst posts the policy online on effective date and issues Revision Notice to all stakeholders. If policy is a Provider Manual section, Policy Analyst also checks T/RBHA websites to ensure posting of new policy on effective date.
Adoption and Dissemination of Evidence-based Practice Protocols

Behavioral Health does not have Practice Guidelines like Acute Care; however, ADHS/DBHS ensures that clinical guidance documents and policies include nationally accepted evidence-based practice approaches, and are developed and disseminated for use by Contractors in providing care. ADHS/DBHS works with its Contractors’ Medical Directors to develop practice protocols and stakeholder feedback is obtained prior to implementation; and to ensure that these protocols direct practice across the state, educate behavioral health recipients and providers, and enhance service delivery. Practice Protocols are incorporated by reference into applicable sections of the ADHS/DBHS Provider Manual. Clinical Practice Protocols and National Practice Guidelines are available on the ADHS/DBHS website. The following diagram reflects the process for adopting new Practice Protocols and conducting annual reviews of existing Practice Protocols. ADHS/DBHS organizes the documents in the categories:

- Clinical Practice Protocols with Required Elements;
- Clinical Practice Protocols without Required Elements; and
- National Clinical Practice Guidelines.

ADOPTION OF A NEW PRACTICE GUIDELINE

ADHS/DBHS Medical Director or RBHA Medical Director discovers a new Practice Guideline that is based on valid and reliable clinical evidence.

Medical Director researches the practice guideline and evaluates its applicability to the Behavioral Health population, recipient need, and systemic impact. Medical Director brings this information to the T/RBHA Medical Directors monthly meeting for discussion and recommendation.

If the Medical Directors make the decision to proceed with the practice guideline, the ADHS/DBHS Medical Director brings the guideline to the DBHS MM/UM Committee for discussion and decision.

For new practice guidelines approved through the DBHS UM committee, T/RBHAs will be notified of this decision and the guideline will be posted on ADHS/DBHS website.

T/RBHAs to disseminate the newly adopted practice guideline to all affected providers and if appropriate, to recipients and potential recipients.
Care Coordination

Care Coordination is delegated to the T/RBHAs. Contractors must follow policies and procedures related to the provision of care coordination services, per the following ADHS/DBHS Provider Manual sections:

- **Section 3.8, Outreach, Engagement, Re-engagement, and Closure**;
- **Section 3.9, General and Informed Consent to Treatment**;
- **Section 3.17, Transitions of Persons**;
- **Section 3.19, Special Populations**;
- **Section 4.3, Coordination of Care with AHCCCS Health Plans and Primary Care Providers**;
- **Section 4.4, Coordination of Care with Other Governmental Entities**;
- **Section 5.1, Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons**;
- **Section 5.2, Member Complaints**;
- **Section 5.4, Special Assistance for Persons Determined to have a Serious Mental Illness**; and
- **Section 5.5, Notice and Appeal requirements (SMI and Non-SMI/Non-Title XIX/XXI)**.
Although ADHS/DBHS does not directly provide Care Coordination, Care Coordination monitoring occurs through a variety of mechanisms including but not limited to the following:

- The analysis of the AHCCCS/ADHS/DBHS Coordination of Care performance measure;
- Submission of Transition Logs;
- Through the Quality of Care Concern (QOC) process; and,
- Data Validation Activities.

ADHS/DBHS requires its Contractors to include the position of Health Plan Coordinator in its staffing structure. This position coordinates and tracks the sharing of information on referrals and communication between the AHCCCS Acute Health Plans and the ADHS/DBHS Contractors.

ADHS/DBHS requires its Contractors to identify behavioral health recipients in need of intensive monitoring and support. Contractors must provide or arrange for intensive monitoring of individuals identified as at risk for higher levels of care, frequent crises, or recipients under court order. The Quality Improvement Office reports coordination of care outcomes to the MM/UM Committee.

### III. Delegated Activities

(AMPM Chapter 1000, Policy 1020(C), Contract ¶ 41)

ADHS/DBHS delegates the following MM/UM functions to its Contractors as delineated in the ADHS/DBHS/RBHA contracts:

- A comprehensive MM/UM program that includes all the required components within the ADHS/DBHS MM/UM Plan; the AHCCCS AMPM Chapter 1000, and the ADHS/DBHS/RBHA Contracts;
- Prior Authorization, Concurrent Review, and Retrospective Review, Inter-rater reliability
- Over and Under Utilization Monitoring
- Pharmacy Utilization Review
- Care Coordination/Case Management

ADHS/DBHS provides oversight and has ultimate accountability for all functions delegated to its Contractors. Contractor monthly, quarterly and ad hoc reports, ADHS/DBHS focused reviews, data validation exercises and the Annual Administrative Review serve as the mechanisms by which ADHS/DBHS monitors delegated functions. Furthermore, the Contractors must complete the following for any activities they delegate to their providers:

- Evaluate the entity’s ability to perform the delegated activities prior to delegation;
- Execute a written agreement that specifies the delegated activities and reporting responsibilities of the entity that incorporates revocation of the delegation or other remedies for inadequate performance;
- Monitor the performance and quality of services provided on an ongoing basis, including an annual formal review;
• Evaluate qualification of Medical Management staff that performs delegated activities.

IV. Reporting Requirements
(AMPM Chapter 1000, Policy 1020(C))

ADHS/DBHS reports all AHCCCS deliverables per the AHCCCS/ADHS/DBHS contract schedule. ADHS/DBHS requires all Contractors to report MM/UM data at least quarterly.

ADHS/DBHS MM/UM Reporting to AHCCCS
• Annual MM/UM Plan, Work Plan and Evaluation
• Quarterly Showing Report

Contractor MM/UM Reporting to ADHS/DBHS
• Annual Contractor MM/UM Plan, Work Plan and Evaluation
• Annual Contractor Medical Care Evaluation Studies
• Biannual Recipient and Provider Over and Under Utilization Reports
• Quarterly Showing Report
• Quarterly MM/UM Report
• Quarterly SMI Eligibility Data
• Quarterly Court Ordered Treatment Data
• Quarterly Pharmacy Utilization Logs
• Monthly Prior Authorization Data
• Monthly Transition Logs
• Monthly Length of Stay/Readmissions Data

ADHS/DBHS ensures all deliverables are submitted to AHCCCS in a timely manner and are complete and error free. ADHS/DBHS Contractors must submit timely, logical and error free reports to ADHS/DBHS for the compilation of statewide reports to AHCCCS. ADHS/DBHS MM/UM reports are reviewed by the ADHS/DBHS Leadership Team for approval before submission to AHCCCS.

V. Conclusion
The ADHS/DBHS Office of Medical Management/Utilization Management is committed to not only reviewing practices related to resource utilization, but also to taking action to modify inappropriate, inefficient or ineffective utilization. Many of ADHS/DBHS’ Medical Management/Utilization Management’s goals and functions are reliant on coordination with Contractors and other functional areas within the agency including but not limited to: Quality Management, Network Management, Bureau for Consumer Rights, Finance, the Data Department and various committees. The Office of Medical Management/Utilization Management recognizes their participation in success of this Medical Management/Utilization Management Plan and program.
Attachments

A. 2011 Medical Management/Utilization Management Work Plan Evaluation *(Not resubmitted per AHCCCS request)*
B. 2012 Medical Management/Utilization Management Plan
C. 2012 Medical Management/Utilization Management Work Plan
D. UM Plan Checklist
E. Resume-Office Chief Office of Medical Management: Alexandra O’Hannon
F. MM/UM Plan- Committee Approval
G. MM/UM Plan- Chief Medical Officer
H. MM/UM Plan- Leadership Team Approval