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Behavioral Health Services Vision

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.

Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide coordination, planning, administration, regulation, and monitoring of all facets of Arizona’s public behavioral health system. ADHS/DBHS contracts with community based organizations, known as Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to administer behavioral health services throughout the state, referred to as Contractors or T/RBHAs. T/RBHAs function in a fashion similar to a health maintenance organization and are responsible for the development of service networks for behavioral health members.

Regional Behavioral Health Authorities
Arizona is divided into six geographical service areas (GSAs) served by four RBHAs:
1. **Cenpatico Behavioral Health of Arizona (CBHAZ)** Serves GSAs 2, 3 and 4. Covers Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz, and Yuma Counties.


**Tribal Regional Behavioral Health Authorities**

ADHS/DBHS has Intergovernmental Agreements (IGAs) with four of Arizona’s American Indian Tribes, known as TRBHAs. The TRBHAs deliver behavioral health services to American Indians living on the reservations:

1. **Gila River Indian Community**
2. **Navajo Nation**
3. **Pascua Yaqui Tribe**
4. **White Mountain Apache Tribe of Arizona**

**Medical Management/Utilization Program**

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 clinical 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 and documents 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 TRBHAs’ adherence to these practices is accomplished through the review of Contractor submissions of utilization data, grievance system data, MM/UM data validation exercises, and the Annual Administrative Review process.

To support the ADHS/DBHS vision, the goals of the MM/UM Program are to:

- Ensure timely and accurate submission of utilization data
- Monitor over- and underutilization data
- Provide oversight of RBHA’s authorization for services
- Provide training and technical assistance for TRBHAs’ service authorization processes
- Provide oversight of RBHAs’ concurrent and retrospective reviews
- Ensure consistency in authorizations through Inter-rater Reliability (IRR) testing
- Ensure Notice of Action (NOA) requirements are adhered to
- Ensure that practice guidelines remain applicable, represent the best practice standards, and reflect current medical standards
- Ensure new technologies and new uses of existing technologies are reviewed, discussed, and adopted, as appropriate
- Ensure care coordination activities are clinically appropriate in meeting members’ needs
- Coordinate the Pre-Admission Screening and Resident Reviews (PASRR) for individuals in need of placement in skilled nursing facilities.
Activities defined to support the MM/UM Program’s processes and program goals are delineated in the 2013 MM/UM Work Plan. These activities serve to direct the MM/UM Program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequency of activities, and target dates for activities completion. MM/UM Program activities include input from T/RBHAs, stakeholders, and members and serve to further the vision of ADHS/DBHS.

The MM/UM Program includes activities designed to meet federal and AHCCCS requirements, as well as facilitate data-driven, focused performance improvement activities conducted by the T/RBHAs. The MM/UM Program provides oversight and technical assistance to all T/RBHAs to ensure compliance with all utilization management performance standards and contractual requirements.

Medical/Utilization Management Administrative Oversight

ADHS/DBHS implements it’s MM/UM Program both internally and through its contracts with T/RBHAs. For example:

- Utilization data provided by RBHAs is reviewed and analyzed. The type of utilization data includes:
  - Readmits and Length of Stay (LOS)
  - Court Ordered Treatment (COT)
  - Seriously Mentally Ill (SMI) Eligibility Determination
  - Prior authorizations (PA)
  - Pharmacy Utilization
  - Over- and underutilization Reports

- ADHS/DBHS conducts bi-monthly MM/UM Committee meetings where all components of the MM/UM Program are discussed, evaluated, and approved.

- MM/UM Committee reports directly to the Leadership Team for recommendations and approval

- ADHS/DBHS MM/UM has two subcommittees:
  - Pharmacy and Therapeutic (P&T) Subcommittee, where drug and medication utilization data and related issues are presented and discussed
  - T/RBHA MM/UM Coordinators Subcommittee serves as a venue for oversight of the behavioral health Contractors’ MM/UM Programs and serves as a venue for ongoing technical assistance

- ADHS/DBHS conducts onsite data validation visits
- ADHS/DBHS conducts Annual Administrative Reviews of its Contractors
- ADHS/DBHS reviews and approves clinical practice guidelines, new technologies, and new uses of existing technologies

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

- RBHAs’ PA, concurrent review, retrospective review, and inter-rater reliability (IRR)
- Care coordination and case management
- Provider and member over- and underutilization monitoring and actions
- Pharmacy utilization review at provider and member level
ADHS/DBHS provides oversight and has ultimate accountability for all functions delegated to its Contractors. (See Delegated Activities)

Structural Framework and Communications
The ADHS/DBHS MM/UM Program 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 forums for decision making, performance monitoring, program development, guidance of performance improvement activities, and as a means for incorporating stakeholder and member feedback into MM/UM activities.

ADHS/DBHS Administrative Leadership Team
The ADHS/DBHS Administrative Leadership Team functions as the governing, policy making body for ADHS/DBHS, and provides strategic direction and ultimate oversight responsibility over BQMO planning and activities. The Administrative Leadership Team meetings include and utilize the technical expertise from specific functional areas as needed for information and decision making. The Administrative Leadership Team meets every other week.

Voting Membership:
- Cory Nelson, Acting Deputy Director
- Steven Dingle, MD, Chief Medical Officer
- Robert Sorce, Assistant Director
- Pat Benchik, Assistant Director
- Margery Ault, Branch Chief, Consumer Rights
- Cynthia Layne, Chief Financial Officer
- Claudia Sloan, Division Chief of Communications

MM/UM Committee
The ADHS/DBHS MM/UM Committee operates under the direction of the Administrative Leadership Team. The Chief Medical Officer chairs the Committee, is responsible to provide guidance for the implementation of the MM/UM Program, 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 and signed at all meetings.

The MM/UM Committee analyzes MM/UM reports to identify 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 least annually and are modified or updated as needed. The MM/UM Committee addresses and makes recommendations to the Administrative Leadership Team regarding the following functions:
- Monitoring over- and underutilization of care services at both the provider and member level
- Validating utilization data provided by Contractors to ensure accuracy
• Assessment of the utilization management program and development/subscription of utilization criteria
• Development, adoption and annual review of clinical practice guidelines that are evidence-based
• Monitoring Contractors’ coordination of care
• Review of the application of new technologies, as well as new uses of existing technologies
• Monitoring and supporting Contractors’ UM activities, including utilization practice patterns, NOAs, and policies and procedures to ensure contract compliance

The annual MM/UM Program Description, MM/UM Work Plan, and 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.

Voting Membership:
• Steven Dingle, MD, Chief Medical Officer (Chair)
• Nadia Graves, Office Chief, Medical Management (Co-Chair)
• Cory Nelson, Acting Deputy Director
• Ashraf Lasee, Branch Chief, BQMO
• Pat Benchik, Assistant Director
• Cynthia Layne, Chief Financial Officer
• Margery Ault, Branch Chief, Consumer Rights
• Melissa Thomas, Branch Chief, Program Operations
• Michael Sheldon, Bureau Chief, Business Information Systems
• Margaret McLaughlin, Branch Chief, Compliance
• Kathy Bashor, Chief, Office of Individual and Family Affairs
• Don Erickson, Bureau Chief, Systems of Care

The membership of the MM/UM Committee comprise of voting members. The MM/UM Committee meets every other month.

Medical Management Committee Structure
Pharmacy and Therapeutics Subcommittee
The Pharmacy and Therapeutics (P&T) Subcommittee provides guidance to ADHS/DBHS Contractors regarding formulary decisions, safe and effective prescribing practices, reviews of new technologies or requests for new use of existing technologies, and monitoring of psychiatric medications and T/RBHA pharmacy utilization reports.

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

Voting Membership:
- Steven Dingle, MD, Chief Medical Officer (Chair)
- Nadia Graves, Office Chief, Medical Management (Co-Chair)
- Margaret McLaughlin Branch Chief, Contract Compliance
- Cynthia Layne, Chief Financial Officer
- Gianna Sullivan, Arizona State Hospital Pharmacist
- Tiffany Williams, Utilization Specialist
- Karla Schaff, Utilization Specialist

The P&T Subcommittee meets at least quarterly.

ADHS/DBHS is currently discussing a new approach for the P&T Subcommittee which may involve the T/RBHA Medical Directors as required attendees of the Subcommittee.

T/RBHA Medical/Utilization Management Coordinators Subcommittee
The ADHS/DBHS T/RHBA MM/UM Coordinators Subcommittee 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 Subcommittee summaries are provided to the MM/UM Committee at least quarterly.

Membership:
- Nadia Graves, Office Chief, Medical Management (Chair)
- Contractor MM/UM Representatives
- ADHS/DBHS MM/UM Staff

The MM/UM Coordinators Subcommittee meets at least quarterly.

Medical/Utilization Management 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 Authorization Coordinators, one (1) Pre-Admission, Screening and Resident Review (PASRR) Coordinator, two (2) Utilization Specialists, two (2) Monitoring Specialists,
and one (1) Administrative Assistant. Both monitoring specialist positions are currently vacant. As depicted in the flow chart below, the Office of MM/UM Program, within the BQMO, is overseen by the Branch Chief of the Office of Consumer Rights. Responsibilities are outlined within the table below.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>Steven Dingle, MD</td>
<td>• Chairs MM/UM Committee Meeting&lt;br&gt;• Provides consultation on all clinical aspects of the program&lt;br&gt;• Works with T/RBHAs’ Chief Medical Officers on issues related to drug utilization, new medical technologies, and practice protocols&lt;br&gt;• Member of the ADHS/DBHS Administrative Leadership Team</td>
</tr>
<tr>
<td>Margery Ault, JD</td>
<td>• Supervises the Branch Chief for BQMO&lt;br&gt;• Provides administrative, executive-level leadership, guidance and support for BQMO&lt;br&gt;• Member of ADHS/DBHS Administrative Leadership Team</td>
</tr>
<tr>
<td>Ashraf Lasee, MBBS, MPH, Dr. PH</td>
<td>• Ensures ongoing communication and collaboration between executive leadership, BQMO, and other functional areas of ADHS/DBHS.&lt;br&gt;• Provides administrative support and technical assistance to four Offices in the Bureau: Office of MM/UM, Office of Performance Improvement (OPI), the Office of Quality of Care (OQOC), and the Office of Information Management (OIM).&lt;br&gt;• Leadership role to communicate program related issues and needs with ADHS/DBHS Administrative Leadership Team and AHCCCS.</td>
</tr>
<tr>
<td>Nadia Graves, RN, BSN</td>
<td>• Provides oversight and facilitation of:&lt;br&gt;  o All components of the PASRR process&lt;br&gt;  o All components of the TRBHA PA Process&lt;br&gt;  o Annual Administrative Review process&lt;br&gt;  o MM/UM component of the AHCCCS Operational and Financial Review (OFR) process&lt;br&gt;  o Eight (8) staff&lt;br&gt;  o Data validation activities&lt;br&gt;• Writes policies and procedures for internal and external use&lt;br&gt;• Designs databases to track service utilization&lt;br&gt;• Reviews documentation specific to children placed in out-of-state placements&lt;br&gt;• Provides technical assistance to internal and external customers&lt;br&gt;• Participant in the MM/UM, QM, Children’s QM, and P&amp;T committees and subcommittees&lt;br&gt;• Monitors Contractors’ utilization practices&lt;br&gt;• Monitors Contractors’ compliance with the ADHS/DBHS contract, AHCCCS Medical Policy Manual (AMPM), and Code of Federal Regulations (CFR)&lt;br&gt;• Provides transition oversight for members in the Arizona State Hospital (AzSH)</td>
</tr>
<tr>
<td>Staff</td>
<td>Responsibilities</td>
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| Tiffany Williams, RN                      | • Acts as the health plan liaison  
• Evaluates RBHA adherence to AHCCCS NOA Guidelines                                                                                                                                                    |
| Utilization Specialist                    |                                                                                                                                                                                                              |
| Karla Schaff, MPH                         | • Provides RBHA MM/UM Program oversight  
• Conducts data analysis and data validation  
• Participates in Administrative Reviews of the Contractors  
• Participates in various committees  
• Participates in the MM/UM component of the AHCCCS OFR process  
• Provides technical assistance to internal and external customers  
• Represents ADHS/DBHS in various capacities  
• Provides oversight of the RBHAs’ MCE studies  
• Represents ADHS/DBHS in various capacities                                                                                                         |
| Utilization Specialist                    |                                                                                                                                                                                                              |
| Vacant Position                           | • Provides MM/UM Program oversight to RBHAs  
• Collects, reviews, and authorizes RTC, Level II Group Home, and hospital services for tribal members  
• Conducts data validations, file reviews, and audits  
• Participates in Administrative Reviews of the Contractors  
• Provides technical assistance to internal and external customers                                                                                   |
| Utility Auditor                           |                                                                                                                                                                                                              |
| Vacant Position                           | • Gathers, plans, organizes and evaluates information from multiple data sources  
• Conducts case file reviews and audits,  
• Conducts Annual Administrative Reviews  
• Conducts research  
• Conducts data validation  
• Evaluates RBHA adherence to AHCCCS NOA Guidelines  
• Participates in the peer review process  
• Synthesizes data  
• Produces reports used for decision-making                                                                                                           |
| Monitoring and Oversight                  |                                                                                                                                                                                                              |
| Tilmon Broadway, BS                       | • Collects, reviews, and authorizes RTC, Level II Group Home, and hospital services for tribal members  
• Conducts retrospective reviews  
• Manages various internal databases  
• Runs reports for the BQMO                                                                                                                             |
<p>| PA Coordinator                            |                                                                                                                                                                                                              |</p>
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<tr>
<th>Staff</th>
<th>Responsibilities</th>
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| Alice Plaxco, *PASRR Coordinator* | - Designs databases to track service utilization  
- Participates in the MM/UM Committee  
- Participates in meetings with internal and external stakeholders |
| Linda Cram, BSW, *PA Coordinator* | - Manages the PASRR process for Arizona’s non-DDD residents  
- Provides reports to AHCCCS  
- Participates in the MM/UM Component of the AHCCCS OFR process  
- Coordinates with the ADHS/DBHS Chief Medical Officer |
| Julia Spooner, *Administrative Assistant* | - Collects, reviews, and authorizes RTC, Level II Group Home, and hospital services for Tribal members  
- Conducts retrospective reviews  
- Runs reports for the BQMO and the tribes  
- Participates in the MM/UM Committee  
- Participates in meetings with internal and external stakeholders  
- Acts as the backup PASRR Coordinator. |

**Organization Structure**

**Office Of Medical Management**

- Margery Ault, Branch Chief of Consumer Rights
- Steven Dingle, MD, Chief Medical Officer
- Ashraf Lasee, Branch Chief of BQMO
- Nadia Graves, Medical Management Office Chief
- Julia Spooner, Administrative Assistant
- Karla Schaff, Utilization Specialist
- Tiffany Williams, Utilization Specialist
- Vacant, UM Auditor
- Vacant, Monitoring Staff
- Linda Cram, Prior Authorizations
- Alice Plaxco, PASRR Coordinator
- Tilmon Broadway, Prior Authorizations
Monitoring and Evaluation of Service Delivery

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 activities are implemented via the analysis and discussion of data submitted by the Contractors.

Annual Evaluation
As part of its MM/UM Program, OMM presents utilization management activities to the MM/UM Committee. This process assists in identifying trends and assessing areas where additional focus may be warranted. Recommendation, feedback, and lessons learned are used to determine the scope of the coming year’s activities and assists in the development of MM/UM processes and performance measures. The evaluation of work plan activities identifies:

- Goals and tasks’ completion status
- Data trends
- Changes to the scope of the work plan
- Goals and tasks’ timelines
- Corrective actions

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

Quarterly, RBHAs submit flat files (data files) for authorizations, pharmacy utilization, SMI eligibility determination, LOS/Re-admission, and COT data. Flat files are data file submissions submitted by the RBHAs with aggregate data that is processed and formatted in an Excel document to allow for data analysis to occur. The data submissions provide ADHS/DBHS with important utilization information that is vital to the Division. Due to the importance of the submitted information, it is imperative that OMM ensures the information is accurate and validated. The data submissions are analyzed by the BQMO-Office of Information Management (OIM) and the Agencies’ Bureau of Business Information System (BIS) to ensure timely submission and accurate data. Data submissions exceeding an error rate over 5% are returned to the RBHA for resubmission. If patterns of inaccuracy are established for two consecutive quarters, the RBHA will be placed on a CAP.

Although they are submitted quarterly, ADHS/DBHS MM/UM Staff conduct data validation activities bi-annually on the submitted flat files to ensure the accuracy of data used for by MM/UM for various reports. During the bi-annual review, the RBHAs submit a random selection of at least 35 charts for PA, COT, SMI eligibility, and LOS/Re-admissions selected by ADHS/DBHS MM staff. PA charts are reviewed to validate the accuracy of decisions, timeliness, accuracy of type of request, and verification of authorizations. COT charts are
reviewed to validate the member was on COT, the type of COT, and if the member received a face-to-face assessment 30 days prior to expiration of COT. SMI eligibility files are reviewed to validate determination timeliness, reason for denial, and signed denials by a Medical Director. LOS/re-admission files are reviewed to validate the LOS was accurate, re-admission occurred within the reporting period, and the level of care was accurate. All RBHAs must achieve a minimum score of 90% for each selection of charts, or they will be placed on a CAP. All CAPs are monitored until the RBHA achieves a validation score of at least 90%.

Data Utilization
Utilization data is analyzed by MM/UM Specialists and presented to the MM/UM Committee quarterly for further recommendations. The information is presented in chart and graph format to allow for a comparison of quarters and to identify any trends that must be addressed. Additionally, utilization data may be used to create various reports and spreadsheets as needed, based on Department need. Utilization data may be used to facilitate various work groups, internal discussions, external reports, and more. For example, although it is not reported to the MM/UM Committee, Level II and Level III LOS data may be pulled and analyzed per RBHA for the previous eight quarters as a result of a work group’s request.

PA data is presented as statewide averages and by GSA. PA categories presented are broken down into standard authorization requests completed timely, timely completion of authorizations requiring extensions, expedited authorization requests completed timely, expedited authorization requiring extensions, and expedited authorizations changed to standard requests. RBHAs failing to meet the goal of 98% may be provided technical assistance or be placed on a CAP until compliance is attained.

In addition to PA data mentioned above, NOA data is presented to show the RBHA compliance scores for NOAs for the previous quarter. RBHAs failing to meet minimum performance scores of 90% may be provided technical assistance or be placed on a CAP until compliance is attained.

LOS data is presented separately for adults for all Level I admissions, for children for all Level I admissions, and for children for all RTC placements, as a statewide aggregate and is broken down for further analysis at the RBHA level. Because of the difference in admissions between RBHAs that may affect the average LOS, the number of discharges per RBHA is also presented to the MM/UM Committee. Outliers may be discussed in the MM/UM Committee and followed-up by the Office Chief of MM/UM.

Readmission rates are presented separately for adults for all Level I admissions, for children for all Level I admissions, and for children for all RTC placements, as a statewide aggregate and is broken down for further analysis by GSA. Because of the difference in admissions between RBHAs that may affect the average LOS, the number of discharges per RBHA is also presented to the MM/UM Committee. Outliers may be discussed in the MM/UM Committee and followed-up by the Office Chief of MM/UM.

SMI determination data is presented in a variety of formats for in-depth analysis and discussion. Statewide SMI determination results per quarter is presented to show the number and percent determined SMI, the number and percent determined non-SMI due to diagnosis, and the number
and percent determined non-SMI due to functional impairment as statewide aggregate data. Further analysis shows the data by GSA per quarter and shows the number determined SMI, the number determined non-SMI due to diagnosis, and the number determined non-SMI due to functional impairment. Statewide SMI determinations results by fund source is also presented to ensure no variances are occurring due to funding. This information is shown for the previous eight quarters and shows the number of TXIX/TXXI determined SMI, percent determined SMI, denials, and percent denied and compares this information to Non-Title recipients with the same categories. Outliers may be discussed in the MM/UM Committee and followed-up by the Office Chief of MM/UM.

COT data is presented is a variety of formats for in-depth analysis and discussion. Persons with active COT is presented for the previous eight quarters as statewide aggregate data, as well as by GSA. Quarterly non-compliant COT is presented for the previous eight quarters by GSA. Outliers may be discussed in the MM/UM Committee and followed-up by the Office Chief of MM/UM.

Pharmacy data is presented using the completed pharmacy template submitted by the RBHAs on a quarterly basis. The completed pharmacy template is distributed prior to the MM/UM Committee and prior to the P&T Subcommittee to all the committee members to allow for an in-depth analysis and discussion at the Committees. Any questions regarding the data may be presented during the Committees, in addition to data presented at the Committees. Pharmacy data presented at the Committees includes the count of medication encounters per utilization adult per month for the previous five quarters broken down by GSA and a statewide average. Additionally, the same analysis is presented per utilizing child per month for the previous five quarters. The cost of medication encounters per utilizing adult per month for the previous five quarters is presented by GSA and as a statewide average. Additionally, the same analysis is presented per utilizing child per month for the previous five quarters. Over- and underutilization trends of medications is presented to the committee for further discussion and follow-up by the Office Chief of MM/UM or the Medical Director.

**ADHS/DBHS Annual Administrative Review**
ADHS/DBHS conducts Annual Administrative Reviews of its Contractors to evaluate the performance of Contractors’ MM/UM Programs and the ADHS/DBHS delegated functions. During the Annual Administrative Review, ADHS/DBHS MM/UM staff review Contractors’ policies and procedures, as well as verifies data submissions by performing chart reviews, to ensure all delegated functions are being performed as required. Results are shared with Contractors and actions are taken based on performance, including, but not limited to CAPs and technical assistance. The results of the Annual Administrative Review are presented to the MM/UM Committee for feedback and discussion.

**Confidentiality**
Contractors must adhere to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules when working with member data or when engaging in discussions regarding member 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 member information.

Over- and Underutilization Report
Contractors must evaluate the over- and underutilization of services from member and systemic perspectives to identify members who require additional assistance and to provide opportunities to address the quality of care provided and/or capacity enhancement. RBHAs submit Over- and Underutilization Reports to ADHS/DBHS bi-annually. ADHS/DBHS reviews these reports and monitors RBHAs’ processes for adhering to the over- and underutilization requirements and identifying over- and underutilization of services as explained in the ADHS/DBHS Specification Manual. By monitoring over- and underutilization, identifying outliers, and evaluating trends, quality improvement activities may be developed and implemented. ADHS/DBHS also monitors Contractors’ compliance with this requirement through the assessment and approval of the Contractor MM/UM Plans and via the Annual Administrative Review. The MM/UM Committee is charged with reviewing these reports for systemic trends, implementing and approving improvement actions when necessary, and assessing actions for effectiveness.

The current reporting template and monitoring protocols for the Over- and Underutilization Report is currently being reviewed and revised by the MM/UM Program to improve the quality of information provided, as well as to ensure the data provided is meaningful, useful, and provides individual and provider specific data. During the template development, the MM/UM Program staff will perform necessary research activities related to over- and underutilization reporting and discuss the outcomes of the research activities for ideas on how to improve the reporting. Once a new template and process for monitoring is complete, they will be presented to the MM/UM Committee for discussion, recommendations, and approval. MM/UM will collaborate with the OIM to incorporate the suggested changes into the BQMO Specifications Manual. The changes will be communicated to the RBHAs at least 30 days prior to implementation.

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 are presented to the P&T Subcommittee to discuss patterns of utilization (See Data Utilization Section). Performance improvement activities are implemented as necessary and monitored by the Subcommittee. 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 PA of non-formulary drug requests.

The current reporting template and monitoring protocols for the Pharmacy Utilization Report is currently being reviewed and revised by the MM/UM Program to improve the quality of information provided, as well as to ensure the data provided is meaningful, useful, and provides individual and provider specific data. During the template development, the MM/UM Program staff will perform necessary research activities related to pharmacy utilization reporting and discuss the outcomes of the research activities for ideas on how to improve the reporting. Once a new template and process for monitoring is complete, they will be presented to the MM/UM
Committee and P&T Subcommittee for discussion, recommendations, and approval. MM/UM will collaborate with the OIM to incorporate the suggested changes into the BQMO Specifications Manual. The changes will be communicated to the RBHAs at least 30 days prior to implementation.

**Evaluation of New Technologies and New Uses of Existing Technologies**
The P&T Subcommittee 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. At a minimum, the report must include 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&T Subcommittee for consideration. The P&T Subcommittee 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&T Subcommittee is prepared to meet on an ad hoc basis to ensure Contractors and members 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 (see Adoption, Revision, and Dissemination of Policies below). Once incorporated into policies, new technologies and new uses of existing technologies are reviewed during the annual policy review.

**TRBHA Prior Authorization, Concurrent Review, and Retrospective Review**
ADHS/DBHS PA Specialists act as intermediaries between the providers and AHCCCS Claims Department by conducting documentation reviews to ensure the documentation is accurate and complete. For the purpose of this program, these reviews are considered prior authorization, concurrent review, and retrospective review for TRBHAs. Once the PA Specialists determine the documentation is accurate and complete, they provide authorization numbers so the providers can submit the completed claims to the AHCCCS Claims Department. Authorization for services does not guarantee payment of services. Once an authorization number is given to the provider of services, it is up to the provider to submit the claim and authorization number to AHCCCS Claims Department for payment approval or denial.

These two full-time staff are dedicated for completing the TRBHAs’ authorization review functions for Level I hospitalizations, Level I residential treatment centers (RTCs), and Level II behavioral health group homes. Requests to authorize services for tribal members are communicated to ADHS/DBHS electronically, and/or via fax Monday thru Friday from 8:00 am to 5:00 pm. ADHS/DBHS provides e-mail notification to the TRBHA case managers once the initial requested service has been authorized. ADHS/DBHS provides e-mail notification directly to the providers once continued stays and retrospective stays have been authorized.

Authorization for services, concurrent review, and retrospective review are processed upon receipt. Prior authorization decisions for non-emergency admissions to Level I facilities and Level II facilities for persons under the age of 21 are made within 24 hours of receiving the
completed request, or if the request is received on a weekend or State holiday, the decision is made on the next business day. An authorization cannot be provided without all the required documentation. Timeframes for prior authorizations, concurrent review, and retrospective review are monitored continuously by the MM/UM Office Chief and are reviewed in percentage form on a quarterly basis. Staff who do not meet the AHCCCS guidelines for timeliness at least 95% of the time will receive corrective actions or technical assistance and training.

In the event the documentation is incorrect or incomplete, the PA Specialist places the already received documentation in a secure, confidential electronic folder until the accurate and complete documentation is received. Monthly, the PA Specialists run a report entitled the “Hold Report” to determine the number of authorizations pending documentation. The Hold Report is run for each TRBHA and then sent to the delegated person of correspondence at the TRBHA level. This Hold Report is monitored by the PA Specialists for the number of persons on the Hold Report, as well as for the length of time on the Hold Report.

The PA Specialists review the prior authorization and concurrent review criteria for acute hospitalizations, Level I RTCs, and Level II behavioral health group homes to include:

- A required Axis I diagnosis within the range of 290-316.99,
- Documented behavior and functioning which cannot be reversed in a less restrictive setting,
- Documented evidence that the person requires the intensity of service requested, and
- Documented evidence that the expected response can be reasonably met in the requested environment.

Emergency admissions to Level I facilities do not require prior authorization prior to admission. ADHS/DBHS PA Specialists conduct reviews on 100% of emergency inpatient stays for admission requests received from the TRBHA’s for which ADHS/DBHS was not notified of the tribal member’s admission. For such cases, ADHS/DBHS reviews the initial documentation along with the Certification of Need (CON) documentation gathered from the facility. The PA Specialists review the documentation to ensure there is:

- A required Axis I diagnosis within the range of 290-316.99,
- Documented behavior and functioning which cannot be reversed in a less restrictive setting,
- Documented evidence that the person requires the intensity of service requested, and
- Documented evidence that the expected response can be reasonably met in the requested environment.

The PA Specialists also verify dates of service, type of service requested, and checks that all information is accurate. In the case information is not accurate, the staff e-mail the providers and TRBHA Case Managers requesting the correct, accurate documentation. When all documentation received is accurate and complete, the PA Specialist enters the data into the internal DBHS Prior Authorization Database, as well as the AHCCCS PMMIS System where an authorization number is given for the dates of service. The provider and TRBHA Case Manager are notified of the authorization number upon this time.
Concurrent review is required every 7 days for hospitalizations after the initial 72 hour authorization. Level I RTC stays are reviewed every 30 days after the initial 30 day authorization. Therapeutic group homes stays are reviewed every 60 days after the initial 60 day authorization. For concurrent review, the facility must send the Recertification of Need (RON) request along with updated progress notes to the PA staff handling the member’s service authorizations. The PA Specialists follow the same process identified above before giving an authorization number to the provider.

Because ADHS/DBHS PA Specialists do not make authorization determinations which may lead to denials in service, they do not participate in IRR testing.

**RBHA Prior Authorization, Concurrent Review and Retrospective Review**

ADHS/DBHS delegates PA, concurrent review and retrospective review to its RBHAs. RBHAs must comply with AHCCCS AMPM and the requirements and criteria 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. The policies also require RBHAs to have systems in place that incorporate:

- The use of criteria when making medical necessity determinations;
- Policies and procedures that address the medical necessity of ongoing hospital stays;
- Policies and procedures that incorporate approval and denial of services;
- Policies and procedures that address review of medical necessary hospitalizations (planned hospitalizations);
- Policies and procedures that address emergency admissions that do not require prior authorization
- Length-of-stay criteria;
- Discharge criteria inclusive of the member’s needs at the time of discharge;
- Whether the services provided met the member’s needs;
- Which clinical documents must be obtained and reviewed;
- Time requirements for conducting prior authorizations, concurrent review, and retrospective review;
- Facility and member based utilization patterns and analysis; and
- Concurrent review staff’s role in managing a member who has another primary payer. At a minimum, the staff must participate in the discharge planning process.

Decisions to prior authorize inpatient admission must be made:

- Within one hour of the request for psychiatric acute hospital or sub-acute facility;
- Within 24 hours of the request for a residential treatment center for persons under the age of 21; and
- Within the RBHA-specific timeframes approved by ADHS/DBHS MM/UM.

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

- Staff must be a qualified behavioral health professional, RN/BSN, nurse practitioner, physician assistant, and/or physician to execute the authorization functions.
- Staff must be adequate in number to ensure timely reviews.
• Staff participating in medical necessity determinations must be tested to ensure consistency in the application of standardized criteria.

• 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.

Quarterly, the RBHAs are reviewed to ensure validity of authorization submission data. A random sample of 35 charts per RBHA are selected by ADHS/DBHS MM staff to review and validate. The validation checklist includes accuracy of decisions, timeliness, accuracy of type of request, and verification of authorizations. Scores are computed and any RBHA who does not achieve a minimum score of 90% will be placed on a CAP. CAPs are monitored until the RBHA achieves a score of at least 90% on future validation tests for authorizations.

Annually, the RBHAs are monitored for concurrent and retrospective reviews as part of the Annual Administrative Review. A random sample of 35 charts per RBHA are selected by ADHS/DBHS MM staff to review. The RBHAs’ charts and policies are reviewed to ensure qualified staff are making medical necessity decisions by confirming documents are signed by licensed behavioral health professionals, use standardized medical necessity criteria based on nationally recognized criteria, and use evidence-based practices when making medical necessity determinations. Policies and procedures for concurrent and retrospective reviews must incorporate inter-rater reliability practices. Inter-rater reliability is discussed below.

As required by the AHCCCS contract with ADHS/DBHS, the Division sends a monthly Grievance System Report to AHCCCS that is inclusive of the number of PAs and denials for all levels of care. This report is generated from the monthly flat file authorization data submitted by the RBHAs on a monthly basis. The monthly MM/UM report is reported in the MM/UM Committee to identify areas of needed improvement across the system. In addition, MM/UM staff evaluate Contractors’ compliance with PA 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. Failure to improve after CAPs may lead to further actions or sanctions.

**Notices of Action**
ADHS/DBHS assesses NOAs to ensure compliance with NOA requirements. Quarterly, NOA data is received from the Office of Appeals and Grievance for MM/UM clinical staff to review. Clinical MM/UM staff will review NOAs using the AHCCCS Notice of Action Audit Checklist. Any RBHA who fails to achieve a minimum performance score of 90% will be provided technical assistance and may be placed on a CAP, if necessary. NOA data is presented to the MM/UM Committee on a quarterly basis for feedback and recommendations.

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

ADHS/DBHS will monitor the T/RBHAs compliance with this requirement through the submission of QM 3.1.1 as a contract deliverable and during the Administrative Review process by requiring documentation of trainings and staff test results. The results of inter-rater reliability testing are presented in the MM/UM Committee.

T/RBHA staff must receive an inter-rater reliability test score of at least 90% in order to make medical necessity determinations. T/RBHA inter-rater reliability testing and training results will be reported to the T/RBHA’s Medical Management Committee. Corrective action plans (CAPs) must be initiated for those individuals who do not achieve a score of at least 90%. Monitoring of testing, training, timeliness, and/or any staff that scores less than 90% will occur until such time that the desired outcomes are achieved.

All variances between reviewers will be trended and evaluated at least annually and monitored by ADHS/DBHS on an ongoing basis.

**Discharge Planning**
ADHS/DBHS MM/UM is currently in the process of developing a program for the monitoring and oversight of discharge planning. Currently, the prior authorization, concurrent review, and retrospective review requirements include a discharge plan for the member prior to authorization. Once developed, the process for monitoring and oversight of RBHA discharge planning will be presented to the MM Committee for approval.

ADHS/DBHS MM/UM receives a monthly Discharge Pending List from the Arizona State Hospital (AzSH). This Discharge Pending List identifies recipients who are ready to be discharged from AzSH, along with an anticipated discharge window. Additional information for each recipient includes a summary of placement needs, such as housing needs and treatment needs; barriers to discharge at the hospital and RBHA level; and plans to address barriers from the hospital and RBHA levels. The Discharge Pending List is reviewed to ensure recipients are being discharged from AzSH within the anticipated timeframes and to ensure coordination is occurring with the respective RBHAs. If a recipient is not discharged within the anticipated discharge window and the Discharge Pending List does not identify active involvement at the RBHA level, the RBHA may be contacted for additional information and to address any additional barriers to transition.

**Adoption, Revision and Dissemination of Medical 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 they are reviewed at least annually. The Policy Committee consists of representation from all areas within ADHS/DBHS, providers, members, 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 areas 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

1. **Policy Analyst** works with the "expert" area to draft the policy and final review.
2. **Policy Analyst** organizes a workgroup that consists of representatives from each functional area within ADHS/DBHS to write the new policy.
3. Once the policy has been written, the **Policy Analyst** presents policy to Policy Committee for feedback.
4. **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 members).
5. **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 a medical policy, for approval. Once approved, **Policy Analyst** sends policy to T/RBHAs 30 days before policy effective date and posts it to the ADHS/DBHS website.

### Annual Review/Revision of a Policy Process

1. **Policy Analyst** presents policy to Policy Committee for feedback.
2. **Policy Analyst** incorporates revisions from stakeholders and any new requirements identified for the policy.
3. **Policy Analyst** presents policy to 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 members).
4. **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 a medical policy, for approval. Once approved, **Policy Analyst** sends policy to T/RBHAs 30 days before policy effective date.
5. **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 Clinical Practice Guidelines

In FY 2012, ADHS/DBHS Chief Medical Officer streamlined the process of review, approval and dissemination of nationally recognized Clinical Practice Guidelines (CPG). The following documents are classified as the Clinical Practice Guidelines.

American Psychiatric Association Practice Guidelines (APAPG)
- Acute Stress Disorder and Post Traumatic Stress Disorder
- Alzheimer's Disease and Other Dementias
- Bipolar Disorder
- Borderline Personality Disorder
- Delirium
- Eating Disorders
- HIV/AIDS
- Major Depressive Disorder
- Obsessive Compulsive Disorder
- Panic Disorder
- Psychiatric Evaluation of Adults
- Schizophrenia
- Substance Use Disorders
- Suicidal Behaviors

ADHS/DBHS Children's Practice Guidelines
- Medication Guidelines for Children: Birth to Five Years of Age

National Practice Guidelines American Academy of Child and Adolescent Psychology (AACAP) Practice Parameters
- Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care
- Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents
- Practice Parameter for the Use of Atypical Antipsychotic Medication in Children and Adolescents
- Practice Parameter on the Psychiatric Assessment and Management of Physically Ill Children and Adolescents

The ADHS/DBHS Office of Chief Medical Officer (OCMO) will annually evaluate the Clinical Practice Guidelines through the T/RBHAs Medical Director meeting, P&T Subcommittee and subsequently through the MM/UM Committee to determine if the guidelines remain applicable and represent the best practice standards and reflect current medical standards.
Protocol For The Adoption Of A New Clinical 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, member need, and systemic impact. Medical Director brings this information to the TRBHA 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 P&T Subcommittee followed by the MM/UM Committee for discussion and decision.

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

TRBHAs to disseminate the newly adopted practice guideline to all affected providers and if appropriate, to members and potential members.

Annual Review Of Existing Clinical Practice Guidelines

ADHS/DBHS Medical Director brings the Practice Guideline to the TRBHA Medical Directors’ Meeting to determine whether the guideline remains applicable and represents the best practice and medical standards.

The ADHS/DBHS Medical Director brings the TRBHA Medical Directors feedback to the DBHS P&T Subcommittee and MM/UM Committee for discussion and decision as to whether or not the Practice Guideline should remain in effect.

The MM/UM Committee’s decision is documented in the MM/UM Committee meeting minutes and the website is either updated to reflect the most current version of the Practice Guideline or the Guideline is removed.

TRBHAs are notified of any changes to the DBHS adopted practice guidelines and disseminate this information to all affected providers and if appropriate, to members and potential members.

Care Coordination
Care Coordination is delegated to the TRBHAs. 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 3.11, 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**
- **Section 5.5, Notice and Appeal requirements (SMI and Non-SMI/Non-Title XIX/XXI)**

Care coordination monitoring for the RBHAs occurs through a variety of mechanisms including, but not limited to:
• The analysis of the AHCCCS/ADHS/DBHS Coordination of Care Performance Measure
• Submission of Transition Logs
• Submission of Acute Health Plan and Provider Contact (AHPPC) Logs
• Maintaining, authorizing and monitoring the out of state placement data and requests, 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.

Monthly, RBHAs submit a transition log to the MM/UM Office Chief for review. The transition log is reviewed for members transitioning to a new RBHA and for members transitioning from a behavioral health medical practitioner to a primary care physician for treatment of ADHD, depression, or anxiety. Timeliness of transition and appropriateness of transition are monitored in the transition logs. When issues are identified, the RBHAs will be given technical assistance. During the Annual Administrative Review, further monitoring of RBHAs policies and procedures and transition logs are reviewed to ensure compliance with ADHS/DBHS policies.

Monthly, RBHAs submit an Acute Health Plan Provider Contact (AHPPC) log to the MM/UM Office Chief for review. The AHPPC log is reviewed for members transitioning to a new RBHA and for members transitioning from a behavioral health medical practitioner to a primary care physician for treatment of ADHD, depression, or anxiety. Timeliness of transition and appropriateness of transition are monitored in the transition logs. When issues are identified, the RBHAs will be given technical assistance. During the Annual Administrative Review, further monitoring of RBHAs policies and procedures and transition logs are reviewed to ensure compliance with ADHS/DBHS policies.

The Office of Performance Improvement (OPI) monitors the RBHAs’ performance on the care coordination (COC) performance measure on quarterly basis. A random sample of behavioral health members from the client information systems data with an open episode of care is selected and sent to RBHAs each quarter; RBHAs evaluate care coordination by confirming that requests for the information by the health plan or primary care physician are responded to within 10 days. RBHAs who care coordination scores fall below the minimum performance standard (MPS) of 85% are placed on a CAP.

Quarterly, coordination of care activities are presented to the MM/UM Committee from the OPI for analysis and discussion. Data presented includes the percentage of adult records in which ongoing communication and coordination of care with the health plan/primary care physician (PCP) was documented as a statewide average and by GSA for the previous eight quarters. Additionally, the same data is presented for children for the previous eight quarters. Outliers may be discussed in the MM/UM Committee and followed-up by the appropriate party.

ADHS/DBHS requires its Contractors to identify behavioral health members 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 members under court
order. The Quality Improvement Office reports coordination of care outcomes to the MM/UM Committee.

**Delegated Activities**

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, Chapter 1000 of the AHCCCS AMPM, and the ADHS-DBHS/RBHA contracts;
- Prior authorization, concurrent review, retrospective review, and inter-rater reliability
- Over- and underutilization monitoring
- Pharmacy utilization review
- Care coordination and 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; and
- Evaluate qualification of MM staff that perform delegated activities.

**Reporting Requirements**

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
- Bi-annual Member and Provider Over and Underutilization Reports
- Bi-annual Authorization Inter-rater Reliability 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 Administrative Leadership Team for approval before submission to AHCCCS.

**Conclusion**

The ADHS/DBHS Office of MM/UM 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 MM/UM’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 MM/UM recognizes their participation in success of this MM/UM Program and Plan.
Attachments

B. 2013 Medical Management/Utilization Management Plan Revisions
C. 2013 Medical Management/Utilization Management Work Plan Revisions