100 MANAGEMENT OF DIVISION POLICIES AND PROCEDURES

REVISION DATE: 08/23/23

EFFECTIVE DATE: November 9, 2022

REFERENCES:A.R.S. 36-553, A.R.S. 41-3801

PURPOSE

To detail the expectations for the lifecycle of policy and procedures within the Department of Economic Security (DES) Division of Developmental Disabilities (Division).

DEFINITIONS

1. "Medical Policy" means any Division policy that maintains requirements for Medical Services or Medical Supplies.
2. "Medical Services" means medical care and treatment provided by a Primary Care Provider (PCP), attending physician, or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
3. "Medical Supplies" means health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an

individual medical disability, illness or injury as specified in 42 CFR 440.70.

POLICY

A. The Division's Policy Unit shall be responsible for the development, revision, coordination, tracking, and maintenance of all official Division policies and procedures unless otherwise directed by the Division's Assistant Director.

B. DEVELOPMENT AND REVISION OF POLICY AND PROCEDURE

1. The Division's Policy Unit shall establish procedures that detail how Division staff initiate the development and revision of Division policy and procedure.
2. The Division's Policy Unit shall ensure that all new or revised policies and procedures are initiated only if they meet at least one of the following criteria:
    a. Aid the Division in maintaining compliance with:
        i. Applicable laws;
        ii. Regulations;
        iii. Contractual obligations;
        iv. AHCCCS policy; or

v. Written directives from the Arizona Governor or DES Director.

b. Ensure current business needs are being met; or

c. Clarify the document for the intended user or the public.

3. The Division's Policy Unit shall only accept requests for development or revision of Division policies and procedures from the following:

a. The administrator or manager identified as the owner of the document.

b. A member of the Division's Executive Leadership Team.

c. A proxy for the administrator or manager identified as the owner of the document that has been agreed to by the administrator or manager and the Division Policy Administrator.

d. The Division Policy Manager.

e. A Division Policy Specialist.

4. The Division's Policy Unit shall engage all functional areas identified as impacted by a policy or procedure being developed

or revised to provide input and work as part of a team for the final draft of the policy or procedure.

5. The Division Policy Specialist shall ensure that all policies and procedures adhere to the structure prescribed in the Division's Policy/Procedure Development and Format Manual.

C. APPROVAL OF POLICY

1. The following Division staff shall approve a new or revised policy in the following order after reviewing and being in agreement with the content and structure of the document:
   a. The owner, or the owner's proxy as described in (B)(3)(c) of this policy.
   b. The Division Policy Manager.
   c. The Division Policy Administrator.
   d. The Division Policy Review Team (PRT).
2. The Division Policy Specialist assigned to the development or revision of a policy shall:
   a. Coordinate discussion for policy needs with the identified policy owner and subject matter experts;

b. Engage subject matter experts as needed to address requested changes and questions from any individuals in (1) of this section;

c. Ensure consensus is reached by all subject matter experts involved in drafting or revision of the policy that the document is satisfactory in content and structure.

d. Ensure any changes instigated by any individuals in (1) of this section are approved by all other individuals in (1) of this section.

e. Prepare and send the draft policy to the Division Policy Manager and Division Policy Administrator for review and approval.

f. Route the draft policy:

    a. Back to the policy owner and any applicable subject matter experts to:

        i. Address any additional questions or recommendations; then

ii. Send back to the Division Policy Manager and Division Policy Administrator for final approval; or

b. To the PRT for consideration for approval.

3. The PRT shall review proposed policies for approval, determining whether the policy is:

a. Rejected;

b. Approved with changes; minor recommended changes agreed upon with the policy owner; or

c. Approved.

D. APPROVAL OF PROCEDURE

The Division Policy Specialist shall follow all steps in (C) of this document for the approval of procedures except (C)(1)(d).

E. PUBLIC COMMENTS

1. The PRT shall determine whether approved policies:

a. Post the following week to the Division's website and are then in effect; or

b. Require public comment if the policy:

i. Is a new Division policy; or

ii. Has substantive changes that may impact the public.

2. The Division Policy Manager shall ensure that the following actions are taken for policies going out for public comment:
   a. The unaltered version of the policy approved by the PRT with changes tracked in the document is used for the public comment period.
   b. Send a copy of the document for early notice of public comment to the following entities thirty days prior to posting the policy for public comment:
      i. The Arizona Developmental Disabilities Advisory Council;
      ii. The Independent Oversight Committees; and
      iii. Arizona Tribal entities.
   c. Thirty days after (2)(b) of this section, the policy is posted for a thirty day public comment period with a clear method for the public to submit comments to DDD.
3. The assigned Policy Specialist shall, at the conclusion of (2)(c) of this section, compile any received public comments and review the public comments with the subject matter experts and the

owner of the policy to determine if the policy requires changes based on the comments.

4. The assigned Policy Specialist shall, if substantive changes are made to the policy as a result of public comment or for any other reason following PRT approval, instigate the approval process described in (C) of this document.
5. The assigned Policy Specialist shall, if no substantive changes are made to the policy as a result of public comment or for any other reason following the PRT approval, inform the Policy Manager that the policy is ready to be posted.
6. The Division Policy Manager shall ensure each Quality Management and Medical Policy is signed by the Division's Chief Medical Officer prior to sending the policy to be posted.

F. POLICY AND PROCEDURE REVIEW

1. The Division Policy Manager shall establish and implement a process to ensure that each policy and procedure managed by the Division Policy Unit are reviewed on an annual basis by the following individuals to ensure the policy meets the current standards of the Division in terms of both content and structure:

a. The owner of the policy or their agreed to proxy; and

b. The Division Policy Specialist.

2. The Division Policy Manager shall, if a policy is determined to need changes based on the review in (1) of this section, ensure that the requirements in (B) of this document for the revision of a policy are instigated.

G. SHARING AND USE OF POLICY AND PROCEDURE

1. The Division shall only treat Division policies and procedures as official Division documents after the policies and procedures have completed the steps for approval designated in this policy.
2. The Division shall not represent or provide policies or procedures that have not completed the steps for approval designated in this policy as proof of compliance with requirements of contracts, regulations, laws, or oversight entities.

H. HISTORICAL MAINTENANCE OF POLICY AND PROCEDURE

The Division Policy Manager shall instigate and ensure the maintenance of a system to archive, track, and make available for research purposes past versions of policy and procedure.

101 MARKETING

REVISION DATE: 3/13/2024

REVIEW DATE: 6/19/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 101

PURPOSE

This policy sets forth requirements and restrictions for the Division of Developmental Disabilities' (Division) participation in Marketing activities related to the AHCCCS program.

DEFINITIONS

1. "Arizona Health Care Cost Containment System" or "AHCCCS" means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
2. "Administrative Services Subcontract/Subcontrator" or "AdSS" means An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims,

b. Pharmacy Benefit Manager (PMB),

c. Dental Benefit Manager,

d. Credentialing, including those for only primary source verification (i.e., Credential Verification Organization [CVO]),

e. Management Service Agreements,

f. Medicaid Accountable Care Organization (ACO),

g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and

h. CHP and DDD Subcontracted Health Plan.

A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

3. "Dual Eligible" means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: a Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member

(a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

4. "Dual Eligible Special Needs Plan (D-SNP)" means a type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII) program covered health benefits and full Medicaid (Title XIX) program covered health benefits.
5. "Dual Marketing" means Marketing efforts specifically targeting a contractor's Member who is eligible for Medicare and Medicaid.
6. "Financial Sponsor" means any monies or in-kind contributions provided to an organization other than attendance fees or table fees, to help offset the cost of an event.
7. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a member enrolled with that Contractor of record.

8. "Marketing" means any communication from Contractors to a Member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Member to enroll with the Contractor, or to not enroll or disenroll with another Contractor's Medicaid product as specified in 42 CFR 438.104. Marketing does not include communication to any Member about a Qualified Health Plan, as specified in 45 CFR 155.20.
9. "Marketing-Health Message" means a slogan or statement on Marketing Materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.
10. "Marketing-Health Related" means an event that has a direct or indirect health care purpose, and/or it supports or contributes to any AHCCCS initiative or program goal. Giveaway items shall have a Health Message or a health care purpose to be considered health-related.
11. "Marketing Materials" means materials produced in any medium, by or on behalf of the Contractor that can reasonably be

interpreted as intended for Marketing purposes. This includes general audience materials such as general circulation brochures, Contractor's website and other materials that are designed, intended, or used to increase Contractor membership or establish a brand.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "Potential Member" means a Medicaid-eligible recipient who is not yet enrolled with a Contractor or a Member during Annual Enrollment Choice (AEC).
14. "Promotion" means any activity in which Marketing Materials are given away or displayed with the intent to increase the Contractor's membership.
15. "Social Networking Application" means web-based services or platforms, excluding the Contractor's State mandated website content, member portal, and provider portal, for online collaboration that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and

instant messaging services – collectively also referred to as social media (e.g., Facebook).

16. "Subcontractor" means

    a. A provider of health care who agrees to furnish covered services to Members.

    b. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

    c. An individual, agency, or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease, or leases of real property, to obtain space, supplies equipment or services provided under the AHCCCS agreement.

POLICY

A. MARKETING MATERIALS, GIVEAWAYS, EVENTS, SPONSORSHIPS, PRESS RELEASES AND DIVISION LOGO NAME USE

1. Materials and Giveaways

a. The Division shall use Member Marketing Materials during Marketing activities that have been previously approved as Member information under Division Operations Policy Manual Policy 404, only if they comply with the requirements of this policy.

b. The Division shall submit a description and image of Marketing Materials and Marketing items or giveaways for approval to AHCCCS as required under this policy and as specified in the AHCCCS Contract.

c. The Division shall not distribute approved materials and giveaways after two years from the date of approval.

d. The Division shall submit any changes or amendments to previously approved materials in advance to AHCCCS for approval.

e. The Division shall submit templates for flyers or posters that advertise regular meetings or events where only the dates and times of the events change.

f. The Division shall distribute approved templates for a period of two years from the date of approval.

d. The Division shall distribute health educational materials without prior AHCCCS approval if the materials are:

   i. Health-related; and

   ii. Developed based on information from an approved, recognized organization as listed on ACOM Policy 404, Attachment A.

e. The Division shall submit for approval materials considered Marketing Materials that include Division specific information related to the Division Integrated Contract.

f. The Division shall ensure that:

   i. The value of any Marketing item or giveaway to the general public by the Division must not exceed $15.00;

   ii. Giveaway items are health related, or if non health related, include a Health Message on the item;

   iii. All Marketing Materials identify the Division as a AHCCCS provider and are consistent with the requirements for information to Members described in the AHCCCS Contract and in Division policies;

iv. All Marketing Materials that have been produced by the Division and refer to contract services shall specify: "Contract services]are funded in part under contract with the State of Arizona Department of Economic Security/Division of Developmental Disabilities";

v. Marketing Materials that are distributed by the Division are distributed to its entire contracted GSA, exclusion of any particular group or class of Members would be considered to be a discriminatory Marketing practice; and subject to contract action.

g. The Division shall not market directly to Members eligible for the Division;

h. The Division shall not encourage or induce a Member to select a particular AdSS when completing the application and may not complete any portion of the application on behalf of the Potential Member.

2. Events

a. The Division shall participate in Health-Related Marketing events listed as pre-approved events in Section A.2.e. of this document, with the additional requirement that the pre-approved event also contains either:
   i. A health related; or
   ii. Health education component.

b. The Division shall submit a request for prior approval if the event is not specified as a pre-approved event in the contract for prior approval, containing the event name and date with the location and address.

c. The Division's participation in events shall be substantive; an unmanned booth with handouts is not acceptable.

d. The Division shall obtain approval from AHCCCS to attend pre-approved events when the following criteria apply:
   i. The Division pays sponsorship fees;
   ii. The Division donates benefits or items;
   iii. The Division plans to distribute materials not previously approved by AHCCCS within the last two years;

iv. Any event determined by the Division to not be in the best interest of the State of Arizona.

v. The Division is not certain if an event would qualify as pre-approved, in which case the Division shall submit a request for approval to AHCCCS prior to the event, including the name, date, location, and the address of the event.

e. The Division may attend the following pre-approved, health related events:

i. Back to School Events;

ii. College or University Events;

iii. DES Health or Resource Events if open to all AHCCCS plans;

iv. Women, Infants and Children (WIC) Health or Resource Events-if open to all AHCCCS plans;

v. Events where health education is a component;

vi. Jobs Fairs as specific in Contract and ACOM Policy 407;

vii. Community Center or Recreational Events;

viii. Community or Family Resource Events;

ix. Provider Events that the Contractor is contracted with;

x. Faith Based Events;

xi. Farmers Market Events;

xii. Health Educations Forum, community sponsored;

xiii. Safety Events;

xiv. Immunization Clinics;

xv. Senior Events;

xvi. Shopping Mall Events;

xvii. AHCCCS Contractor's Event that is created and sponsored by the Contractor for its own Members only.

f. The Division shall not participate in Marketing activities at the following events:

i. Events that are not health related or do not have a health education component;

iii. WIC Offices, except those listed on the approval list;

iv. Job Fairs, except those listed on the approval list;

v. County or State Fairs;

vi. Bi-national Health Events;

vii. Political Events;

viii. Pharmacy Events not open to all AdSSs;

ix. Swap Meets;

3. Sponsorships

The Division may participate as a Financial Sponsor of Health-Related Marketing events that are listed as pre-approved in Section A.2.e. in accordance with ACOM 101.

4. Press Releases

The Division may issue press releases or announcements about program innovations and events that promote the goals of the Division.

i. Press releases that do not include Division-specific information related to the Division Integrated Contract do not require prior AHCCCS approval.

ii. All other press releases must be submitted to AHCCCS for prior approval.

5. Division Logos and Name Inclusion

The Division shall be responsible for preventing misuse of the Division's name and logo.

i. Upon receiving AHCCCS approval for an event, the Division's logo can be included on event flyers or websites that are produced by hosting organizations without prior approval.

ii. The use of the Division's name or logo is prohibited for television advertising of the event.

iii. If the Division is a Financial Sponsor for the event, the event flyers or websites will require prior approval by AHCCCS.

B. RESTRICTIONS

The Division shall not participate in the following Marketing activities:

a. Television advertising;

b. Direct mail advertising;

c. Social Networking Applications;

d. Marketing of non-mandated services;

e. Utilization of the word "free" in reference to covered services;

f. Listing of providers in Marketing Materials who do not have signed contracts with the Division;

g. Inaccurate, misleading, confusing or negative information about AHCCCS; and any information that may defraud Members or the public; or

h. Discriminatory Marketing practices as specified in A.A.C. R9-22-501 et seq, A.A.C. R9-28-501 et seq, A.A.C. R9-31-501 et seq;.

C. DIVISION RESPONSIBILITIES

1. The Division shall report their Marketing costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any Marketing costs included in an allocation from a parent or other related corporation.
2. The Division shall review and revise all materials on a regular basis in order to reflect current practices.

3. The Division shall submit any changes or amendments to previously approved materials in advance to the Division for approval as indicated above.
4. The Division CEO or designee shall sign and submit to AHCCCS, ACOM 101, Attachment A, Marketing Attestation Statement as specified in Section F3, Contractor Chart of Deliverables, addressing the compliance of its plan with the requirements of this policy, including submissions from the AdSSs with Division submissions.
5. The Division shall submit to AHCCCS, ACOM 101, Attachment B, Marketing Activities Report, as specified in Section F3, Contractor Chart of Deliverables including the previous six months of Marketing activities in which the Division was a participant, including submissions from the AdSSs with Division submissions.

D. SUBMISSION REQUIREMENTS

1. The Division shall submit all Marketing Materials including, giveaways, event requests, sponsorships and press releases as individual requests for approval at least 21 days prior to

dissemination as specified in the AHCCCS Contract. Section F3, Contractor Chart of Deliverables.

a. Bulk submissions, including more than one event, sponsorship, press release, are not permitted with the exception of giveaway items.

b. Giveaway items shall be submitted for approval separately from any event or sponsorship submission and may consist of more than one giveaway.

c. All submissions shall be complete and include all corresponding documents.

2. The Division shall ensure the following criteria are completed when requesting an expedited review, when a 21-day notice is not possible:

a. Follow the submission requirements as noted above; and

b. Indicate the reason for the shortened timeframe.

3. The Division shall resubmit any Marketing Materials for review and approval if any substantive changes or modifications of previously approved materials have been made. Resubmissions require inclusion of:

a. Date the material was previously approved;

b. Reason for update; and

c. All clearly identified content revisions.

4. The Division may request a reconsideration of any AHCCCS decision by submitting a written request for reconsideration and following the submission requirements for Marketing Materials as specified in Contract. The Division may provide information in support of its request for reconsideration.

102 DDD ADMINISTRATIVE FORMS AND OTHER WRITTEN MATERIAL

EFFECTIVE DATE: April 26, 2023
REFERENCES: ACOM 404; DES 1-05-03

PURPOSE

To provide a consistent and structured framework for the development, approval, and storage of DDD Administrative Forms and other non-policy, non-procedure written material.

DEFINITIONS

1. "DDD Administrative Form" means any standardized form used only by employees of the Division of Developmental Disabilities (DDD) in the performance of their jobs.
2. "Job Aide" or "Desk Aide" means a tool or device that serves as a reminder or instruction on the implementation and use of a standard work or procedure..
3. "Standard Work" means a documented standardized and discrete process specific to a single work unit.

POLICY

A. DDD Administrative Forms

1. DDD staff shall not utilize or consider for official use any DDD Administrative Form that has not complied with DES 1-05-03, DES 1-05-03-01, and this policy.
2. DDD staff shall not utilize as proof of contract compliance, remedy of a corrective action plan, or in response to any legal or administrative request for official documents any DDD Administrative Form that has not met the requirements of DES 1-05-03, DES 1-05-03-01, and this policy.
3. DDD staff shall follow the process in DDD procedure POL-001-ALL Development or Revision of Division Administrative Forms for all new and revised DDD Administrative Forms.

B. Standard Work

1. DDD staff shall receive approval from the Executive Leader or their designee over the specific functional area prior to utilizing any new or revised Standard Work.
2. Each DDD functional area that utilizes Standard Work shall establish a standard methodology for internal approval of Standard Work and routing to the DDD Policy Administrator or their designee.

3. The DDD leader or their designee of each functional area shall ensure that all Standard Work approved under the specifications of this policy are sent to the DDD Policy Unit for storage and maintenance.

C. Job Aides and Desk Aides

1. DDD staff shall not use any Job Aide or Desk Aide as an official part of their job until it has been approved in writing by the Executive Leader or their designee of the associated functional area.
2. The Executive Leader of the associated functional area or their designee shall send all approved Job Aides and Desk Aides to the DES Policy Unit for storage.

D. Flyers, Pamphlets, and Posters

DDD employees shall reference DES policy DES 1-05-03 and associated DES procedures for the revision, creation, and maintenance of flyers, pamphlets, and posters.

E. Material Intended for Members

DDD staff shall comply with the stipulations of Arizona Health Care Cost Containment System ACOM 404 regarding written materials intended in whole or in part for the use of Members.

103 FRAUD, WASTE, AND ABUSE

REVISION DATE: 4/10/2024

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901, A.R.S. § 36-2918, A.R.S. § 36-2957, A.R.S. § 36-2903.01(K); A.A.C. R9-22-702; 42 CFR 455.101, 42 CFR 438.608, 42 CFR Part 438, Subpart H, 42 CFR 455, 42 CFR 455, Subpart A, 42 CFR 455, Subpart B, 42 CFR 455.2, 42 CFR 455.23, 42 CFR 455.101, 42 CFR 455.436; ACOM Policy 103, Attachment A; ACOM Policy 103, Attachment A-1; Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime; ACOM Policy 103, Attachment B; ACOM Policy 103, Attachment C; ACOM Policy 424; the Division Medical Policy 950, Credentialing and Recredentialing Processes; Attachment F3, Contractor Chart of Deliverables State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act.

PURPOSE

This Policy applies to the Division of Developmental Disabilities (Division). The purpose of this Policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged Fraud,

Waste, or Abuse involving Division program funds regardless of the source. This Policy also addresses additional responsibilities regarding regulatory compliance with program integrity, and programmatic requirements.

DEFINITIONS

1. "Abuse" means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program as outlined in 42 CFR 455.2.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including:
    a. Claims processing, including pharmacy claims
    b. Pharmacy Benefit Manager (PBM)
    c. Dental Benefit Manager

d. Credentialing, including those for only primary source verification through Credential Verification Organization [CVO]

e. Medicaid Accountable Care Organization (ACO)

f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner

g. CHP and the Division Subcontracted Health Plan

i. A person, individual or entity, who holds an Administrative Services Subcontract is an administrative services subcontractor.

ii. Providers are not administrative services subcontractors.

3. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a Provider as specified in 42 CFR 455.101.

4. "Contract" means the Division's contract with AHCCCS.

5. "Corporate Compliance Officer" means an individual located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be

a management official, available to all Division employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position. The Corporate Compliance Officer shall be an onsite management official who reports directly to the Contractor's Chief Executive Officer (CEO) and Board of Directors, if applicable. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract as specified in 42 CFR 438.608.

6. "Credible Allegation of Fraud" means the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis as specified in 42 CFR 455.2.
7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person, including any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

8. "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency as outlined in 42 CFR 455.101.
9. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
10. "Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.
11. "Waste" means over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

POLICY

A. The Division shall:

1. Have in place internal controls, policies, and procedures to:

a. Prevent, detect, and report credible Fraud, Waste, and Abuse activities to AHCCCS-OIG.

b. Implement a suspension, termination, or exclusion of a provider from the Contractor's network of providers.

2. Have a Corporate Compliance Program that complies with the Division's contract with AHCCCS and all state and federal laws, including 42 CFR Part 438, Subpart H and is developed under the Contractor's corporate compliance plan including:

   a. Program integrity goals and objectives;

   b. Descriptions of internal and external controls employed by the Division to ensure compliance with State and Federal law; and

   c. The Division's corporate compliance activities, as outlined in ACOM 103.

3. Submit the Division's written Corporate Compliance Plan to AHCCCS-OIG annually as specified in the Contract.

4. Submit to AHCCCS-OIG an external audit plan/schedule and audit report of all individual provider audits using ACOM 103 Attachment C.

a. In each audit report, the Division shall include:

i. An objective, scope, estimated dollars at risk, current audit results, key audit findings, recommendations, corrective actions required, and conclusion;

ii. Copies of the report for each audit scheduled completed; and

iii. If an audit was not completed timely, include a reason why and a date when the audit will be completed.

b. The Division shall submit a minimum of 20 audits semiannually.

c. The Division shall submit follow-up audits on a separate ACOM 103 Attachment C and not count toward the required minimum audit numbers as stated in this subsection.

5. Submit complete, accurate, and current disclosure information, as described in 42 CFR Part 455, Subpart B and as specified in Contract, upon execution of a Contract with the State and upon

renewal of extension of the Contract utilizing Attachment A and Attachment A-1.

a. The Contractor shall ensure review of its response by its legal counsel prior to submitting disclosure information.

b. As specified in Contract, the Contractor shall submit all information electronically, without any exceptions.

c. AHCCCS/Office of Administrative Legal Services (OALS) and AHCCCS-OIG reviews the Contractor's submitted disclosure information for completeness and AHCCCS-OIG screens and confirms that persons listed in the submitted information are not excluded from participation in the Medicaid program.

6. Complete all information as specified in ACOM 103 Attachment A and Attachment A-1 to enable AHCCCS-OIG to confirm that persons with an ownership or control interest in the aDivision are not excluded from participation in the Medicaid program.

a. The Division shall obtain and disclose the information regarding the ownership and control interest of administrative services subcontractors.

b. The Division shall retain the results of the disclosure of ownership and control and the disclosure of information on persons convicted of crimes and report to AHCCCS-OIG.

c. The Division shall complete and submit an attestation as specified in ACOM 103 Attachment A along with the disclosure information described in this subsection and that the information provided is accurate, complete, and truthful.

d. Consistent with 42 CFR 457.990 and 42 CFR 438.606, the Division's Assistant Director (Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer) or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer shall sign the attestation.

e. The Division's failure to provide all complete and accurate disclosures and an attestation signed by an individual with appropriate authority may result in the withholding of payments under the Contract or the recovery, recoupment, or offset of any monies remitted without limitation.

7. Disclose, and require its administrative services subcontractors to disclose, to AHCCCS/OIG the identity of any employee or person with ownership or control interest who is excluded from participation in any federal healthcare programs.
8. Comply with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 457.1285, and 42 CFR 438.608(a)(6)].
9. As a condition for receiving payments, establish written policies, and ensure adequate training and ongoing education for all of its employees including management, Members, and any subcontractors or Agents of the Division regarding the following:
    a. Detailed information about the Federal False Claims Act;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal liability or penalties for false claims and statements; and
    d. The whistleblower protections under law.
10. Ensure adequate training addressing Fraud, Waste, or Abuse prevention, recognition and reporting, and encourage Division

employees, Members, and any subcontractors to report Fraud, Waste, or Abuse without fear of retaliation.

11. Ensure an internal reporting process relating to the reporting of Fraud, Waste, or Abuse that is well-defined is made known to all Division employees, Members, and any subcontractors.
12. Conduct research and proactively identify changes for program integrity that are relevant to the~~ir~~ corporate compliance program, and periodically review and revise the Fraud, Waste, or Abuse policies or guidance from the AHCCCS to reflect such changes due to rules, regulations, or new initiatives.
13. Regularly attend and participate in AHCCCS-OIG work group meetings.
14. Respond promptly and not later than 30 calendar days to requests for information from AHCCCS-OIG.
15. Cooperate with AHCCCS-OIG regarding any allegation of Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.

16. Have a method of verifying with Members that they received the services billed by Providers to identify potential service or claim Fraud.
17. Perform periodic audits through Member contact and report the results of these audits as specified in ACOM Policy 424.
18. Maintain compliance with all State and Federal laws and regulations related to Fraud, Waste, or Abuse even if not directly specified in this Policy.

B. REPORTING RESPONSIBILITIES

1. Fraud, Waste, and Abuse
    a. If the Division discovers, or is made aware, that an incident of alleged Fraud, Waste, or Abuse has occurred or is occurring, the Division shall report the incident to AHCCCS-OIG as specified in Contract and by completing and submitting the "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program" form available on the AHCCCS-OIG webpage, and attach all pertinent documentation that could assist AHCCCS in its investigation;

b. If the Division identifies an incident that warrants self-disclosure, the Division shall report incident within ten calendar days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage and attach all pertinent documentation that could assist AHCCCS in its investigation;

c. When the Division refers, or is aware that a subcontractor has referred, a case of alleged Fraud, Waste, or Abuse to AHCCCS-OIG, the Division shall take no action to recoup, offset, or act in any manner inconsistent with AHCCCS-OIG's authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, or impose a civil monetary penalty;

d. The Division shall conduct preliminary review work regarding a referral at the request of AHCCCS-OIG in order to expand the allegation and obtain documentation to support the investigation being conducted by AHCCCS-OIG;

e. The Division shall provide documentation requested by AHCCCS-OIG within 30 calendar days of the request;

f. The Division may receive notification from AHCCCS-OIG when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation;

g. The Division shall ensure proper disposition of any matters returned by AHCCCS-OIG as non-Medicaid Fraud, Waste, or Abuse in accordance with any applicable laws and contracts;

h. The Division shall adhere to the requirement that AHCCCS-OIG has the sole authority to handle and dispose of any matter involving Fraud, Waste or Abuse and assign to AHCCCS the right to recoup any amounts overpaid to a Provider as a result of Fraud, Waste or Abuse.

i. The Division shall forward anything of value that could be construed to represent the repayment of any amount expended due to Fraud, Waste or Abuse that is recovered to AHCCCS-OIG within 30 days of its receipt.

j. The Division shall ensure the requirements outlined in subsection (i) apply to any actions undertaken by the Division on behalf of a Contractor by a subcontractor, as specified in the AHCCCS Minimum Subcontractor Provisions (MSPs).

k. The Division shall relinquish all claims to any monies received by AHCCCS as a result of any program integrity efforts, including:

   i. Recovery of an overpayment;

   ii. Civil monetary penalties or assessments;

   iii. Civil settlements or judgments;

   iv. Criminal restitution;

   v. Collection by AHCCCS or indirectly on AHCCCS' behalf by the Office of the Attorney General; or

   vi. Other, as applicable.

l. The Division shall report to AHCCCS, as specified in Contract, and the Division Medical Policy 950, any credentialing denials including:

   i. That are the result of licensure issues;

ii. Quality of care concerns;

iii. Excluded, terminated, or otherwise sanctioned providers; or

iv. Alleged Fraud, Waste, or Abuse.

C. THE DIVISION'S RESPONSIBILITIES RELATED TO FRAUD, WASTE AND ABUSE

1. The Division shall:

   a. Process all referrals of allegations of suspected Member and provider Fraud, Waste, or Abuse.

   b. Oversee, monitor, and review all documents and functions as they relate to Fraud, Waste, and Abuse prevention, detection, and reporting.

   c. Maintain and monitor a tracking system of Fraud, Waste, and Abuse referrals.

   d. Ensure all Division employees, subcontractors, Providers, Agents, and Members receive adequate training and information regarding Fraud, Waste, and Abuse prevention, identification and reporting.

e. Assure Division employees, subcontractors, Providers, Agents, and Members that they can report Fraud, Waste, and Abuse without fear of retaliation.

f. Develop and maintain open channels of communication with AHCCCS-OIG, subcontractors, Providers, Agents, and Members to combat Fraud, Waste, and Abuse at all levels in the System.

g. Develop and maintain open channels of communication with DES-OIG in the prevention and detection of Fraud, Waste, and Abuse.

h. Make referrals to AHCCCS-OIG to investigate cases of potential Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.

i. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of Providers to ensure their compliance.

j. Ensure that the Division is in compliance with its federal obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion, and

Checks, and Criminal Convictions Checks, and all other federal requirements related to Provider Screening and Enrollment.

SUPPLEMENTAL INFORMATION

1. AHCCCS/Office of Inspector General (AHCCCS/OIG) is responsible for reviewing suspected incidents of fraud, waste, and/or abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with the authority or obligations vested in AHCCCS/OIG under State or Federal law, rule, regulations, or policies.

2. AUTHORITY

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations relating to Fraud, Waste, and Abuse involving the programs administered by AHCCCS. Pursuant to 42 CFR 455, Subpart A, and an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action.

AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

a. Pursuant to A.R.S. § 36-2918, AHCCCS-OIG has the authority to issue subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the AHCCCS-OIG.

b. Pursuant to A.R.S. §§ 36-2918 and 36-2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

c. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, AHCCCS-OIG is authorized to receive and share restricted

criminal justice information with other federal, state and local agencies.

d. Pursuant to federal law, AHCCCS-OIG shall suspend payments to providers where it determines that a credible allegation of fraud exists as specified in 42 CFR 455.23.

e. Pursuant to state and federal law, AHCCCS is required in certain circumstances, and in other circumstances it may, act to suspend, terminate, or exclude any person (individual or entity) from participation in the AHCCCS Program.

104 CONTINUITY OF OPERATIONS AND RECOVERY/EMERGENCY PREPAREDNESS PLAN

EFFECTIVE DATE: April 2, 2018

REFERENCES: 42 CFR 483.475, 28 CFR 0.85, 22 U.S.C 38 § 2656f (d)(2), ACOM 104, uslegal.com, fema.gov, dema.az.gov, cms.gov, and ready.gov

This policy outlines the Continuity of Operations and Recovery Plan, for the Division of Developmental Disabilities (DDD), including the Continuity of Operations and Recovery Plan/Emergency Preparedness Plan for the Division's Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), in conformance with CMS Final Rule 42 CFR 483.475, "Medicare and Medicaid Programs, Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers;" and in conformance with ACOM 104.

The Division must be able to recover from any disruption in business operations as quickly as possible. This recovery can be accomplished by the activation of a Continuity of Operations and Recovery Plan that contains strategies for recovery. The Continuity of Operations and Recovery Plan is part of the federal government's Continuity of Operations Programs (COOP) requirements and the AHCCCS Contractor Operations Manual.

Division Responsibilities

The Division's Continuity of Operations and Recovery Plan assures AHCCCS that the provision of covered services will occur as stated in its contract [42 CFR 438.207 and 42 CFR 438.208]; and as stated in the CMS Emergency Preparedness requirements [42 CFR 483.475] for ICFs/IID. This policy outlines the policy and procedures requirement for 42 CFR 483.475 in conjunction with ACOM 104.

42 CFR 483.475 requires the following four elements in the ICF/IID Continuity of Operations and Recovery/Emergency Preparedness Plan.

- Risk Assessment and Planning – identifying potential risks to the entity using an "all hazards" approach
- Policies and Procedures – reflective of the risk assessment and to include training and testing procedures
- Communication Plan – communication within the entity and across local community health care providers, in conjunction with state and local public health departments
- Training and Testing – to be conducted annually for all staff

Continuity of Operations and Recovery Plan

A. The Division:

1. Reviews, tests, and updates the plan at least annually, to manage unexpected events and the threat of such occurrences, which may negatively and significantly impact business operations and the ability to deliver services to members
2. Ensures that all staff are trained at least annually and are familiar with the Plan and understand their respective roles

3. Designates a Continuity of Operations and Recovery Coordinator and furnishes AHCCCS with contact information as part of the Plan

4. Requires ICFs/IID to develop and maintain an Emergency Preparedness/Continuity of Operations and Recovery Plan

5. Maintains policies and procedures, as required by the Centers for Medicare and Medicaid Services (CMS), that address:

    a. The provision of subsistence needs for staff and members (food, water, medical and pharmaceutical supplies)

    b. Temperatures to protect client health and safety; emergency lighting; fire detection/extinguishing/alarms

    c. Sewage and waste disposal

    d. Tracking of members and staff during an emergency

    e. Evacuation and sheltering in place

    f. Availability of medical documentation

    g. The use of volunteers in an emergency

    h. Arrangements with other ICFs/IID and providers to receive members

    i. Other mitigation and response strategies as applicable

B. The Plan:

1. References local resources

2. Identifies:

    a. Key member priorities

    b. Key factors that could cause disruption

    c. Any additional priorities identified as critical, including communication systems (e.g., telephone, website, and email), providers' receipt of prior authorization approvals and denials, members receiving transportation, and timely claims payments

3. Contains:

    a. Specific timelines for resumption of services as well as the percentage of recovery at certain hours, and the key actions required meeting those timelines

    b. Planning and training for:

        i. Electronic/telephonic failure

ii. Complete loss of use of the main site location and any satellite offices in and out of state

iii. Loss of primary computer system/records

iv. Extreme weather conditions

v. Communication during a business disruption. (The name and phone number of a specific contact in the Division of Health Care Management, and AHCCCS Security at 602-417-4888 if disruption occurs outside of normal business hours.)

vi. Other mitigation and response strategies as applicable

c. Documented periodic testing and training at least annually

Resources

For more information on Continuity of Operations Planning and Emergency Preparedness, visit the websites of the following organizations:

- Federal Emergency Management Agency (FEMA) – fema.gov
- Arizona Department of Emergency and Military Affairs – dema.az.gov
- Centers for Medicare and Medicaid Services (CMS) – cms.gov
- Ready.gov.

108 SECURITY RULE COMPLIANCE

EFFECTIVE DATE: April 29, 2020
REFERENCES: 42 CFR 438.100(d) and 42 CFR 438.208(b)(4); 45 CFR Parts 160, 162, and 164; Section F3, Contractor Chart of Deliverables

This policy applies to the Division Developmental Disabilities (The Division).

Definitions

A. Breach - An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised. As stated in Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act issued in August 2009.

B. Health Insurance, Portability, and Accountability Act (HIPAA) - The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

C. HIPAA Privacy Rule - The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients' rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

D. HIPAA Security Rule - Established national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information.

E. Health Information Technology for Economic and Clinical Health Act (HITECH) -

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

F. Protected Health Information – Individually identifiable health information as described in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

- Created or received by a health care provider, health plan, employer, or health care clearinghouse.
- Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual.

Protected health information excludes information:

- In education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g
- In records described at 20 USC 1232g(a)(4)(B)(IV)
- In employment records held by a covered entity in its role as an employer
- Regarding a person who has been deceased for more than 50 years.

G. Information Technology (IT) Risk Analysis - The assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic protected health information held by a covered entity, and the likelihood of occurrence.

H. Information Technology (IT) Risk Management - The actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic protected health information and meeting the general security standards.

Data Security Audit

The Division must develop policies and procedures to ensure the privacy of protected health information, the security of electronic protected health information, and breach notification to members [42 CFR 438.100(d) and 42 CFR 438.208(b)(4)].

The Division must have a security audit performed by an independent third-party annually. If the Division performs in multiple AHCCCS lines of business, one comprehensive audit may be performed covering all systems for all lines of business or separate audits may be performed.

The audit must include, at a minimum, a review of the following:

1. Compliance with all security requirements as outlined in ACOM Policy 108, Attachment A, AHCCCS Security Rule Compliance Summary Checklist.
2. The Division policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Division's business practices, and the production processing systems. The Division's policies and procedures must include the requirements for the Breach Notification Rule.

Audits performed in the second and subsequent years of the contract will focus primarily on remediation of prior findings and system and policy changes identified since the prior audit.

AHCCCS Security Compliance Report

The Division must submit the AHCCCS Security Rule Compliance Report to AHCCCS annually as described in Section F3, Contractor Chart of Deliverables, by uploading the report to a secure AHCCCS Share Point site. The timeframe audited may be calendar year, fiscal year, or contract year and must be noted in the report. The report must include all findings detailing any issues and discrepancies between the AHCCCS Security Audit Checklist requirements and the Division's policies, practices and systems, and as necessary, a corrective action plan. In addition, the report must include written decisions regarding all addressable specifications.

The Division will verify that the required audit has been completed and the approved corrective action plan is in place and implemented as part of Operational Reviews.

The Division does not intend to release detailed audit reviews; however may, at its discretion, release a summary level of results.

AHCCCS Security Rule Compliance Checklist

A. Instructions

The AHCCCS Security Rule Compliance Checklist, located in the AHCCCS Operations Manual, identifies security rule requirements for administrative, physical, and technical safeguards. The Compliance Checklist must be signed and dated by the Chief Executive Officer or his/her designee verifying the information and must be submitted with the annual report.

B. Implementation Specifications

1. Required Specifications

If an implementation specification is identified as "required" (indicated with an "R" on the checklist), the specification must be implemented.

Addressable Specification: The concept of "addressable implementation specifications" was developed to provide covered entities additional flexibility with respect to compliance with the security standards. Addressable implementation specifications are indicated with an "A" on the checklist.

In meeting standards that contain addressable implementation specifications, a covered entity must do one of the following for each addressable specification:

a. Implement the addressable implementation specifications.

b. Implement one or more alternative security measures to accomplish the same purpose.

c. Not implement either an addressable implementation specification or an alternative.

The covered entity must decide whether a given addressable implementation specification is a reasonable and appropriate security measure to apply within its particular security framework. For example, a covered entity must implement an addressable implementation specification if it is reasonable and appropriate to do so, and must implement an equivalent alternative if the addressable implementation specification is unreasonable and inappropriate, and there is a reasonable and appropriate alternative. This decision will depend on a variety of factors, such as, among others, the entity's risk analysis, risk mitigation strategy, what security measures are already in place, and the cost of implementation.

The decisions that a covered entity makes regarding addressable specifications must be documented in writing. The written documentation should include the factors considered as well as the results of the risk assessment on which the decision was based.

2. IT Risk Analysis

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(A), for Risk Analysis, requires a covered entity to, *"conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity."*

IT Risk analysis is the assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic PHI held by a covered entity and the likelihood of occurrence. The risk analysis may include taking inventory of all systems and applications that are used to access and house data and classifying them by level of risk. A thorough and accurate risk analysis would consider all relevant losses that would be expected if the security measures were not in place, including loss or damage of data, corrupted data systems, and anticipated ramifications of such losses or damage.

3. IT Risk Management

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(B), for IT Risk Management, requires a covered entity to *"implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR. 164.306(a) [(the General Requirements of the Security Rule)]."* IT Risk management is the actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic PHI and to meet the general security standards.

4. Compliance Status

If the covered entity complies with the requirement, insert a "C" in the column. If the requirement is not met, insert "NC" for non-compliant.

5. Compliance Documentation

List policies, procedures, and processes used to determine compliance with the Implementation Specification.

109 INSTITUTION FOR MENTAL DISEASE 15 DAY LIMIT

REVISION DATE: 10/01/2021, 2/24/2021, 3/26/2020
EFFECTIVE DATE: March 25, 2020
REFERENCES: 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

Purpose

This Policy applies to the Division of Developmental Disabilities (the Division) covered DDD Tribal Health Program (THP) population, which is managed as a Fee-For-Service (FFS) program along with the Division's oversight of each Administrative Services Subcontractor (AdSS). This policy establishes requirements the Division will follow for compliance with managed care regulation 42 CFR 438.6(e), "Payments to MCOs for and Prepaid Inpatient Health Plans (PIHPs) for enrollees that are a patient in an institution for mental disease."

Definitions

A. Day - A calendar day unless otherwise specified.

B. Institution - An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services, to four or more persons unrelated to the proprietor.

C. Institution for Mental Disease (IMD) - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an institution for a mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010].

D. IMD Stay - The total number of calendar days of an inpatient stay in an institution for mental disease beginning with the admission date through discharge, but not including the date of discharge unless the member expires.

Policy

Medically necessary IMD Stays are covered for individuals under the age of 21 (except as noted below under "Members Turning 21 or 65 Years of Age") and for adults 65 years of age and older. For adult members age 21 and older but under the age of 65 (referred to in this policy as "adult member age 21-64"), coverage is subject to the limitations and requirements outlined in this policy. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services or settings at 42 CFR 438.3(e)(2)(i) through (iii).

In accordance with 42 CFR 438.6(e), IMD Stays are covered for adult members age 21-64, so long as the IMD Stay is no longer than 15 cumulative days during a calendar month.

The following provider types are considered to be IMDs subject to the limitations and requirements outlined in this policy:

A. B1-Residential Treatment CTR-Secure (17+Beds)

B. B3-Residential Treatment Center-Non-Secure

C. B6-Subacute Facility (17+Beds)

D. 71-Psychiatric Hospital

Requirements

A. Members remain enrolled and eligible for all medically necessary services during the entire IMD Stay whether the stay exceeds 15 cumulative days during a calendar month. The Division is responsible for the payment of these services.

B. For any IMD stay that exceeds 15 days, neither the IMD Stay nor any other medically necessary services provided during the length of that IMD Stay may be paid with Title XIX funding, including administrative funding for Title XIX services.

C. The Division, when responsible for behavioral health services, shall complete and submit to AHCCCS the AHCCCS Contractors Operational Manual *Policy 109 Attachment A – IMD Placement Exceeding 15 days* to the Division, within one business day of identification of an IMD Stay greater than 15 days.

D. Submission of Attachment A will result in a change to the member's physical and behavioral health enrollment/assignment with the Division resulting in an adjustment to the Capitation.

E. The Division shall continue to submit encounters for all medically necessary services, including the IMD Stay, regardless of the length of the IMD Stay, and regardless if AHCCCS recoups the capitation payment for that month; that is, the Division is not permitted to recoup payments to providers. AHCCCS will use encounters to audit Division compliance with this policy. Encounters related to the IMD Stay will not be considered in the reconciliation and reinsurance processes.

F. The Division must maintain a network of providers adequate to provide members with adequate access to behavioral health services and ensure the member receives care in the setting most appropriate for the member's needs.

Capitation Recoupment

A. When an adult member's IMD Stay is longer than 15 cumulative days during the calendar month, AHCCCS will recoup the Division's entire monthly capitation payment for that member.

B. The change to a member's enrollment/assignment to non-Capitated will trigger the recoupment.

C. When two different entities are responsible for physical health services and behavioral health services for the member, AHCCCS must recoup the entire monthly capitation payment from both entities.

D. The capitation recoupment will occur whether the Division pays the IMD.

E. This recoupment applies whether the member is dual eligible or the member has third party insurance coverage.

F. The Division will be notified of the contract type change/recoupment via the 834 and 820 files from AHCCCS.

G. After funds have been recouped, AHCCCS will make a capitation payment to the Division equal to a pro-rated amount of the monthly capitation payment for each day the member is not in an IMD during the calendar month.

Members Turning 21 Or 65 Years of Age

A. The IMD restriction does not apply for a member admitted prior to age 21 and turns 21 during the IMD Stay until the member turns 22 years of age during the IMD Stay. The Division is not required to report an IMD Stay greater than 15 days when the member is admitted prior to age 21 even if the member turns 21 during the same IMD Stay as long as the member is discharged prior to age 22.

B. For members who turn age 65 during an IMD Stay, all the days of the IMD Stay while the member is age 64 must be counted against the 15-day limit, and all the IMD Stay days when the member is 65 must not be counted against the limit.

The Division must report an IMD Stay greater than 15 days when the member is admitted prior to age 65 even if the member turns 65 during the same IMD Stay. After funds have been recouped, AHCCCS will make a capitation payment to the Division equal to a pro-rated amount of the monthly capitation payment for each day the member is age 65 or older during the IMD Stay.

110 MENTAL HEALTH PARITY

REVISION DATES: 2/16/22, 3/24/21
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR Part 457 and 42 CFR Part 438

PURPOSE

This Policy applies to the Division's internal practices which could impact Mental Health Parity and oversight of each Administrative Services Subcontractor (AdSS) whose contract includes this requirement. This Policy outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 42 CFR Part 457 and 42 CFR Part 438.

AHCCCS will facilitate Mental Health Parity requirements for Tribal Health Program members who are receiving part of their services through the Division.

DEFINITIONS

Aggregate Lifetime Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP).

Annual Dollar Limit - A dollar limitation on the total amount of specified benefits that may be paid in a fiscal year 12-month period under a MCO, PIHP, or PAHP.

Benefit Package - Benefits provided to a specific population group or targeted residents (e.g., individuals determined to have a serious mental illness [SMI]) regardless of the Health Care Delivery System.

Cumulative Financial Requirements - Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.

Health Care Delivery System - The health care delivery system refers to the structure and organization of covered services and benefit packages available to AdSS members. Delivery systems can be fully integrated (all covered services administered by a single AdSS) or partially integrated (Members enrolled with an AdSS may receive covered services by multiple AdSS or via fee-for-service arrangements).

Medical/Surgical Benefits (M/S) - Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. Medical/surgical benefits include long-term care services.

Mental Health Benefits - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the

State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

Substance Use Disorder Benefits - Items or services for substance use disorders, as defined by the State and in accordance with applicable Federal and State law. Any disorder defined by the State as being or not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include long-term care services.

Treatment Limitations - Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

POLICY

A. MHPAEA Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the MHPAEA final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to Mental Health/Substance Use Disorder (MH/SUD) benefits than to Medical/Surgical (M/S) benefits. MHPAEA specifically:

1. Prohibits the application of annual or lifetime dollar limits to MH/SUD benefits unless aggregated dollar limits apply to at least one third of medical benefits;

2. Prohibits the application of financial requirements (e.g., copays) and Quantitative Treatment Limitations (QTLs) (e.g., day or visit limits) on MH/SUD benefits that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in that same classification; and

3. Prohibits the application of Non-Quantitative Treatment Limits (NQTLs) (e.g., prior authorization) on MH/SUD benefits in any classification unless the NQTL, as written and in operation, is applied to the MH/SUD benefits comparably and no more stringently than to M/S benefits in the same classification.

B. Mental Health Parity Analysis Requirements

The Division is responsible for performing the initial and ongoing parity analyses. MH/SUD or M/S benefits are provided to members through the AdSS. The AdSS are responsible for completing initial and ongoing parity analyses and submitting them to the Division. The Division is responsible for ensuring compliance within the Division and for all AdSS.

1. Parity requirements apply to all MH/SUD benefits provided to members.

2. The parity analysis must be conducted and assessed at least annually and ongoing for events warranting a parity analysis as described below.

3. The parity analysis must be conducted for each benefit package regardless of Health Care Delivery System.

   a. The benefit package includes the covered services to ALTCS eligible members.

   b. A benefit package includes M/S and MH/SUD benefits, including long-term care benefits.

C. Standard Parity Requirements

1. Benefit Packages

   Division benefit packages and Health Care Delivery Systems are defined as covered services available to children and adult members who are enrolled with the Division and ALTCS eligible, and Medicare cost sharing. Members up to the age of 21 are designated as children for the purpose of the benefit package.

   The Division shall adhere to all applicable established benefit packages and covered services when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

2. Defining MH/SUD and M/S Benefits

   MH/SUD benefits are items and services for MH/SUD conditions regardless of the type of AdSS or type of provider that delivers the item/service. The Division defines MH/SUD and M/S conditions using the ICD-10-Clincial Modification (ICD- 10). For purposes of parity, MH and SUDs are those conditions in ICD-10, chapter 5, "Mental, Behavioral and Neurodevelopmental Disorders," sub-chapters 2-7 and 10- 11.

   a. Subchapter 1, "Mental Disorders Due to Known Physiological Conditions," is excluded from the MH condition definition (and included in the M/S condition definition) because the physiological condition is primary for these diagnostic codes; and

   b. Similarly, sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the MH condition definition (and included in the M/S condition definition) because these are neurodevelopmental conditions, which are separate and distinct from mental and behavioral conditions, as indicated by the chapter title.

   The Division uses these definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, the Division applies the defined classifications outlined below.

In order to conduct the analysis, each service is assigned to one of four classifications: inpatient, outpatient, emergency care, and prescription drug. The Division shall apply the established benefit mapping when conducting the parity analysis. Refer to AHCCCS Contractor Operations Manual (ACOM), Chapter 100, Policy 110, Attachment A (AZ Parity Summary Benefit Package Mapping) for the benefit mapping. Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

a. Inpatient: Includes all covered services or items provided to a member in a setting that requires an overnight stay including behavioral health placement settings;

b. Outpatient: Includes all covered services or items provided to a member in a setting that does not require an overnight stay, which does not otherwise meet the definition of inpatient, prescription drug, or emergency care services;

c. Emergency care: Includes all covered emergency services or items to treat an emergency medical condition delivered in an emergency department setting; and

d. Prescription drugs: Covered medication, drugs, and associated supplies and services that require a prescription to be dispensed, which includes drugs claimed using the NCPDP claim forms.

Parity requirements for financial requirements, quantitative treatment limits, and non-quantitative treatment limits apply by classification (e.g., as inpatient, outpatient, emergency, and pharmacy).

The Division applies the defined classifications when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

4. Testing MH/SUD Financial Requirements, Quantitative Limits, Annual Dollar Limits, and Non-Quantitative Treatment Limits

a. When applicable, the Division shall conduct limit testing as part of the initial parity analysis and shall re-assess compliance when changes may impact parity compliance. Testing limits includes:

i. Identifying and evaluating financial requirements and quantitative treatment limits using a 2-part, claims-based test (if applicable). The Division determined that the 2-part, claims-based test is not necessary when performing or overseeing the initial mental health parity.

ii. Identifying and testing aggregate lifetime and annual dollar limits (if applicable) using a multi-part claims-based test. The Division did not identify any of these limits applicable to any MH/SUD services and as a result, no review or testing is necessary.

iii. Identifying NQTLs and applying the NQTL information-based test to each NQTL.

b. Quantitative treatment limits are numerical limits on benefits based on the frequency of treatment, number of days, days of coverage, days in a waiting period, or similar limits on treatment scope or duration. In accordance with this Policy, the Division shall not apply quantitative treatment limits to any MH/SUD services in any classification in any benefit package, with the exception that hour limits currently applied to respite services (600 hours/year) and visit limits (15 visits per Contract Year) currently applied to rehabilitative occupational therapy services in the outpatient classification are permissible under the parity requirements.

c. NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits.

i. Examples of NQTLs published in the Final MHPAEA Rule include:

1) Medical management standards (e.g., medical necessity criteria and processes or experimental/investigational determinations);

2) Prescription drug formulary;

3) Admission standards for provider network;

4) Standards for accessing out-of-network providers;

5) Provider reimbursement rates (including methodology);

6) Restrictions based on the location, facility type, or provider specialty;

7) Fail-first policies or step therapy protocols; and

8) Exclusions based on failure to complete a course of treatment.

ii. AHCCCS identified the following NQTLs as part of the initial MHPAEA compliance determination:

1) Utilization management NQTLs,

2) Medical necessity NQTLs,

3) Documentation requirements NQTLS, and

4) Out-of-network/geographic area coverage NQTLs.

iii. The Division shall not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the Division as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits in the classification, and

iv. Once NQTLs are identified, the Division shall collect and analyze information about the processes, strategies, evidentiary standards, and other factors applicable to each NQTL, in writing and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis by the Division or AdSS

1. The Division is responsible for administering a fully integrated contract and shall perform a parity analysis when there is a change in the Division's operations that may impact parity compliance including but not limited to:

   a. Changes to Financial Requirements (FRs) or QTLs;

   b. Changes to Benefit Packages, utilization requirements, covered services, or service delivery structures (i.e., change in the subcontractors performing administrative functions);

   c. Substantive changes to policies or procedures of the Division (or subcontractors performing administrative functions on the Division's behalf) that impact benefit coverage, access to care for provider contracting. The Division shall track, ongoing, all policy changes that are approved by the Division's Policy Review Team and review each for potential Mental Health Parity concerns. If a potential Mental Health Parity concern is identified, the Mental Health Parity Subcommittee will be convened to review the issues and determine the actions needed for correction.

2. If the Division identifies any changes or deficiencies noted in the above, the Division is required to attach the Mental Health Parity analysis for those FR/QTLs and NQTLs impacted by the changes. Utilizing ACOM Policy 110 Attachment C and shall include:

   a. Any actual Parity issues identified,

   b. The FR/QTLs or NQTLs associated with the Mental Health Parity concern,

c. The applicable Benefit Package(s) and affected classification(s), and

d. The nature of the Mental Health Parity compliance issue and the actions taken to address the parity issue.

3. When the Division contracts with any AdSS that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package the AdSS shall perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis shall be submitted to the Division as specified in the AdSS Contract with the Division. The Division shall ensure AdSS compliance with this policy and results of the analysis shall be submitted to AHCCCS as requested by AHCCCS.

4. The AdSS shall report as specified in the AdSS Contract with the Division, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation and applied no more stringently to MH/SUD benefits than for M/S benefits. The Division shall review reports received from the AdSS to ensure AdSS compliance.

5. The Division shall also report as specified in the AHCCCS Contract, utilizing AMPM Policy 1020 Attachment F, a description of the self-monitoring activities, as well as the Division's oversight of the AdSS, for parity compliance in operation, ensuring that FR/QTLs and NQTLs are, in operation applied no more stringently to MH/SUD Benefits than for M/S Benefits.

6. In the event the Division or the AdSS complete a contract modification, amendment, novation, or other legal act changes which limits, or impacts compliance with the mental health parity requirement, the Division and/or the AdSS shall conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the Division and/or the AdSS must provide documentation of how the parity requirement is met, with the submission of the contract change, and how sustained compliance will be achieved. The Division and/or the AdSS must certify compliance with parity requirements prior to the effective date of the contract changes.

7. The AdSS shall report mental health parity deficiencies as specified in the AdSS Contract with the Division and develop a corrective action plan to be in compliance within the same quarter as the submission. The Division shall review the corrective action plan submitted by the AdSS and monitor to ensure compliance.

8. The Division shall report mental health parity deficiencies as specified in the AHCCCS Contract and develop a corrective action plan to be in compliance within the same quarter as the submission.

9. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the parity analysis by the Division and each AdSS.

10. The Division uses any data collection and documentation template for the parity analysis; however, the following elements must be clearly documented:

a. Methodology, processes, strategies, evidentiary standards, and other factors applied;

b. All financial requirements, AL/ADLs, QTLs and identified NQTLs AdSSs must minimally report NQTL analysis results for prior authorization, concurrent review, medical necessity, outlier, documentation, and out of area criteria, but must also assess and document for the presence of other potential NQTLs:

i. Monitoring mechanisms and aggregated results as applicable (e.g., denial rates);

ii. Findings;

iii. Components of the analysis that are determined to be non-compliant with parity along with a detailed plan to resolve identified deficiencies; and

iv. The Division and each AdSS shall analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

11. If there have been no changes that affect the Division's benefit package, utilization, or Health Care Delivery Systems, the Division shall submit an annual attestation (AHCCCS Contractor's Operations Manual, Policy 110, Attachment B - Mental Health Parity Attestation Statement) certifying ongoing compliance with mental health parity requirements as specified in AHCCCS Contract. These same attachments are also required from each AdSS for delivery to the Division as appropriate.

12. The Division and each AdSS shall make available upon request to members and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. The Division and each AdSS shall also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

13. The Division and each AdSS may be required to respond to inquiries from the Division, AHCCCS or an AHCCCS contracted consultant. Inquiries may include policies and procedures requiring review to determine compliance with mental health parity regulations.

E. Division Oversight of AdSS Mental Health Parity

1. Each AdSS is required to send their Mental Health Parity reports to the Division for review. This will occur at a minimum annually and when changes are made as addressed in this policy. The Division shall review the reports submitted by the AdSS to ensure AdSS compliance.

2. The Division shall review AdSS compliance with Mental Health Parity analyses, methodology, processes, and other related functions during its annual operational review of the AdSS, including but not limited to:

a. The AdSS policies and procedures for monitoring compliance with Mental Health Parity.

b. The AdSS completed analysis demonstrating compliance with Mental Health Parity as outlined in this policy.

c. The AdSS' process when a deficiency is identified and the plan of how the AdSS will come back into compliance.

203 CLAIMS PROCESSING

REVISION DATE: 11/8/2023, 3/30/2022, 10/01/2019

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 C.F.R. §§ 160, 162, and 164; 42 C.F.R. § 438.242(a)-(b); 42 C.F.R. § 447.45(d)(5)-(6); 42 § C.F.R. 447.46; 42 C.F.R. § 457.1233(d); A.R.S. § 36-2903.01; A.R.S. § 36-2903.01(G); A.R.S. § 36-2904; A.R.S. § 36-2943(D); ACOM 201; ACOM 203; ACOM 412; ACOM 434; AHCCCS Contract

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division of Developmental Disabilities (the Division).

DEFINITIONS

1. "Clean Claim" means a claim that may be processed without obtaining additional information from the Provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
2. "Member" means the same as "client" as defined by A.R.S. § 36-551.

3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.
4. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
5. "Receipt Date" means the day a claim is received at the Division's specified claim mailing address or received through direct electronic submission to the Division's electronic claims processing system.

POLICY

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The Division shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. The Division shall ensure that claims processes and systems generate information in the following areas:
    a. Service utilization;
    b. Claim disputes;

c. Member grievances and appeals; and

d. Disenrollment for reasons other than loss of Medicaid eligibility.

3. The Division shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:

a. The Division's subcontract;

b. The Division's Provider manual;

c. The Division's website; or

d. Other Provider platforms.

4. The Division shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date electronically received by the Division.

5. The Division shall recognize the paid date of the claim as the date on the check or other form of payment.

B. CLAIM TIMELY FILING

1. The Division shall, unless a contract specifies otherwise, adjudicate claims for each form type as follows:

a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and

b. 99% within 60 days of receipt of the Clean Claim.

2. The Division shall not pay the following claims as specified in A.R.S. § 36-2904(G):

a. Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or

b. Claims submitted as Clean Claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

3. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization (MCO), when one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

4. If the Provider submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:

a. 60 days from the date of the recoupment;

b. 12 months from the date of service; or

c. 12 months from the date that eligibility is posted;

whichever date is later.

5. The Division shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes stated in item 3 of this section.

6. The Division shall process a claim for payment if the AHCCCS Director's decision reverses a decision to deny, limit, or delay authorization of services, and the disputed services were received while an appeal was pending.

a. The Provider shall have 90 days from the date of the reversed decision to submit a Clean Claim to the Division for payment.

b. The Division shall not deny claims for untimely filing if the claims are submitted within 90 days from the date of the reversed decision.

c. Additionally, the Division shall not deny claims submitted as a result of a reversed decision because a Member failed

to request continuation of services during the appeal or hearing process.

7. The Division shall adhere to the claim payment requirements in this policy for both contracted and non-contracted Providers.

C. DISCOUNTS

1. The Division shall, unless a subcontract specifies otherwise, apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the Clean Claim was received (A.R.S. § 36-2903.01(G)).
2. The Division shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS

1. The Division, in the absence of a subcontract specifying other late payment terms, shall pay interest on late payments.
2. The Division shall pay interest on late payments for hospital Clean Claims as follows:

a. The Division shall pay slow payment penalties or interest on payments made after 60 days of receipt of the Clean Claim.

b. The Division shall pay interest at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. § 36-2903.01).

c. The Division shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The Division shall adjudicate a claim for authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS Provider, or a home and community based (HCBS) ALTCS Provider within 30 calendar days after receipt by the Division.

4. The Division shall pay interest on payments made after 30 days of receipt of the Clean Claim for licensed skilled nursing facility, assisted living ALTCS, or HCBS ALTCS as follows:

a. At the rate of 1% per month; and

b. Prorated on a daily basis from the date the Clean Claim is received until the date of payment.

5. The Division shall, for non-hospital Clean Claims, pay interest on payments made after 45 days of receipt of the Clean Claim as follows:
   a. At the rate of 10% per annum; and
   b. Prorated daily from the 46th day until the date of payment.
6. The Division shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission,not the claim dispute.
7. The Division shall report the interest paid as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The Division shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or the assigned representative interested in and capable of electronic submission of:
   a. Eligibility verifications;

b. Claims;

c. Claims status verifications; and

d. Prior authorization requests; or

e. The receipt of electronic remittance.

2. The Division shall make claim payments via electronic funds transfer (EFT).

3. The Division shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The Division shall generate an electronic remittance advice related to the payments or denials to Providers that include at a minimum:

a. The reason(s) for denials and adjustments;

b. A detailed explanation or description of all denials; payments, and adjustments;

c. The amount billed;

d. The amount paid;

e. Application of coordination of benefits COB and copays;

f. Providers rights for claim disputes;

g. Detailed instructions and timeframes for the submission of claims disputes and corrected claims; and

h. A link or supplemental file where claims dispute or corrected claims submission information is explained.

2. The Division shall send the related remittance advice with the payment, unless the payment is made by EFT.

3. The Division shall send any remittance advice related to an EFT to the Provider no later than the date of the EFT.

G. GENERAL CLAIMS PROCESSING REQUIREMENTS

1. The Division shall use nationally recognized methodologies to correctly pay claims including:

a. Medicaid National Correct Coding Initiative for professional, ambulatory surgery centers, and outpatient services;

b. Multiple procedure or surgical reductions; and

c. Global day evaluation and management bundling standards.

2. The Division’s claims payment system shall assess and apply data-related edits, including:

a. Benefit package variations;

b. Timeliness standards;

c. Data accuracy;

d. Adherence to AHCCCS policy;

d. Provider qualifications,

e. Member eligibility and enrollment; and

f. Over-utilization standards.

3. The Division shall, if a claim dispute is overturned in full or in part, reprocess and pay the claim(s):

   a. In a manner consistent with the decision; and

   b. Within 15 business days of the decision.

4. The Division's claims payment system shall not require a recoupment of a previously paid amount when:

   a. The Provider's claim is adjusted for data correction; excluding payment to a wrong Provider; or

   b. An additional payment is made.

5. The Division shall submit encounters in accordance with AHCCCS' standards and thresholds.

6. The Division shall adhere to the following requirements when processing claims:

a. Medicare cost sharing for Members covered by Medicare and Medicaid;

b. COB and third party liability requirements per the AHCCCS Contract and ACOM 434;

c. Claims recoupments and refunds requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS Claims Dashboard Reporting Guide; and

d. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 C.F.R. §§ Parts 160, 162, and 164.

7. The Division, when cost avoiding a claim, shall apply the following payment provisions:

a. Claims from Providers contracted with the Division: The Division shall pay the difference between the contracted rate and the primary insurance paid amount, not to exceed the Division’s contracted rate.

b. Claims from Providers not contracted with the Division: The Division shall pay the difference between the AHCCCS capped-fee-for-service rate and the primary insurance paid

amount, not to exceed the AHCCCS capped-fee-for claims processing by Administrative Services Subcontractors (AdSS) Contractors.

H. CLAIMS SYSTEM AUDITS

1. The Division shall regularly audit payments to contracted and non-contracted Providers to verify that:
   a. Payments are accurate per the Provider contract terms or letter of authorization; and
   b. Emergency services Providers are paid at the current AHCCCS fee-for-service rate for non-contracted Providers.
2. The Division shall ensure audit reports are shared with the Business Operations Administrator, Business Operations Deputy Administrator, and Corporate Compliance.
3. The Division shall correct deficiencies noted in claims system audit reports and issue corrective action plans as applicable to contracted and non-contracted Providers.
4. The Division shall audit three months of claims data for both contracted and non-contracted Providers.

5. The Division shall utilize HHS-OIG RAT-STATS to generate statistically significant random samples for claims systems audit reviews.
6. The Division shall conduct the interest paid audit in January, April, July, and October.
7. The Division shall conduct the negotiated rate audit in February, May, August, and November.
8. The Division shall conduct the override audit in March, June, September, and December.
9. The Division shall regularly audit contracted Providers, both large groups and individual practitioners:
    a. At least once every five-year period;
    b. Any time a contract change is initiated; and
    c. Within six months of onboarding new Providers
10. The Division and DES-Internal Audit Administration (DES-IAA) shall adhere to the AHCCCS approved Corporate Compliance audit schedule for contracted Providers.
11. DES-IAA shall also conduct Provider audits based upon corrective action plans initiated by the Division.

12. The Division shall conduct annual audits for compliance with the Deficit Reduction Act of 2005.
13. The Division shall require contracted Providers that receive at least five million dollars in Medicaid payments annually to establish written policies for all employees.
    a. The Division shall require contracted Providers to submit the following policy documentation that includes detailed information of the following:
        i. Federal False Claims Act;
        ii. Remedies for false claims and statements;
        iii. Any state laws pertaining to civil or criminal penalties for false claims and statements;
        iv. Whistleblower protections under Federal False Claims Act and state laws; and
        v. Role of such laws in preventing and detecting fraud, waste and abuse.
    b. Organization compliance program
    c. Employee handbook, with specific discussion of:
        i. The State and federal laws referenced above;

ii. The rights of employees to be protected as whistleblowers; and

iii. The entity's policies and procedures for detecting fraud, waste, and abuse.

I. ADSS CLAIMS PROCESSING

The Division shall contract with health plans and delegate the processing of acute care claims. Refer to the AdSS Operations Manual, 203 Claims Processing policy for further details.

205 GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT REQUIREMENTS FOR NON-CONTRACTED PROVIDERS

EFFECTIVE DATE: 11/6/2019

REFERENCES: 42 CFR 414.605, A.R.S. §36-2201, 9 A.A.C. 22, Article 211, A.A.C. R9-25-101(18), 42 CFR 438.114(a), A.R.S. §36-2202, A.R.S. §36-2204, and A.R.S. §36-2212, 9 A.A.C. 22, A.R.S. § 36-2239(H), and AMPM Policy 310-BB.

Purpose

To provide ground ambulance transportation reimbursement requirements. It is limited to the Division of Developmental Disabilities (the Division) and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Definitions

A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS, level 1 (**ALS1**) as transportation by ground ambulance vehicle, medically necessary supplies and services, either an ALS assessment by ALS personnel or provision of at least one ALS intervention. Advanced life support, level 2 (**ALS2**) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:

- Manual defibrillation/cardioversion,
- Endotracheal intubation,
- Central venous line,
- Cardiac pacing,
- Chest decompression,
- Surgical airway, or
- Intraosseous line.

B. Ambulance - Ambulance as defined in A.R.S. §36-2201.

C. Basic Life Support (BLS) - 42 CFR 414.605, describes BLS as transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least one of the staff members must be certified, at a minimum, as an emergency medical technician-basic (EMT-Basic) by the State of local authority where the services are furnished and be legally authorized to operation all lifesaving and life-sustaining equipment on board the vehicle.

D. Emergency Ambulance Services - Emergency ambulance services are as described in 9 A.A.C. 22, Article 211.

E. Emergency Ambulance Transportation - Ground or air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the DDD member's condition.

F. Emergency Medical Care Technician (EMCT) - As defined in A.A.C. R9-25-101(18).

G. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

H. Emergency Medical Services - Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

Policy

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by the Division at a percentage, prescribed by law, of the Ambulance provider's ADHS-approved fees for covered services. These rates are contained in the AHCCCS Capped Fee for Service (FFS) Fee Schedule for Certificate of Necessity Providers and will be used by the Division for reimbursement when no contract exists with the provider.

For Ambulance providers, whose fees are not established by ADHS, and no contract exists with the provider, the AHCCCS Capped FFS Fee Schedule is for Ground Transportation will be used by the Division.

Emergency Ground Ambulance Claims are Subject to Medical Review

Claims are submitted with documentation of medical necessity and a copy of the trip report, with the following information:

A. Medical condition, signs, symptoms, procedures, and treatment.

B. Transportation origin, destination, and mileage (statute miles).

C. Supplies.

D. Necessity of attendant, if applicable.

E. Name and DHS numbers of the attendants providing care along with the signature of the trip report author.

Claims submitted without such documentation are subject to denial. The Division will process the claims within the timeframes established in 9 A.A.C. 22, Article 7. *Emergency* transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

Criteria and Reimbursement Processes for Advanced Life Support (ALS) and Basic Life Support

A. Advanced Life Support (ALS) level

1. In order for Ambulance services to be reimbursable at the ALS level, all of the following criteria shall be satisfied**:**

   a. The Ambulance shall be ALS licensed and certified in accordance with A.R.S. §36**-**2202, A.R.S. §36**-**2204, and A.R.S. §36**-**2212,

   b. Emergency Medical Care Technician (EMCT) are present and EMCT services/procedures are medically necessary, based upon the member's symptoms and medical condition at the time of the transport, and

   c. EMCT services/procedures and authorized treatment activities were provided.

B. Basic Life Support (BLS) level

1. In order for Ambulance services to be reimbursable at the BLS level, the following requirements will be met:

   a. The Ambulance must be BLS licensed and certified in accordance with A.R.S. §36**-**2212 and A.A.C. R9-25-201.

   b. EMCT are present

   c. EMCT services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport.

   d. EMCT services/procedures and authorized treatment activities were provided.

Claims submitted without such documentation are subject to denial. The Division processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

Non-Emergent Ground Ambulance Transportation Payment Provisions

A. Non-emergent Ambulance transportation is subject to review for medical necessity by the Division. Medical necessity criteria is based upon the medical condition of the member. Non- emergent transportation by Ambulance is appropriate if:

1. Documentation supports that other methods of transportation are

contraindicated.

2. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an Ambulance.

Non-emergent transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the Division's discretion, non-emergent Ambulance transport may not require prior authorization or notification. This may include after-hours calls. An example is an Ambulance company which receives a call from the emergency room to transport a nursing facility member back to the facility and the Division cannot be reached.

All hospital-to-hospital transfers are paid at the BLS level unless the transfer meets ALS criteria. This includes transportation between general and specialty hospitals.

C. Transportation reimbursement is adjusted to the level of the appropriate alternative transportation when circumstances do not necessitate an Ambulance transport, or the services rendered at the time of transport are deemed not medically necessary. Ambulance providers that have fees established by ADHS are reimbursed in accordance with A.R.S. § 36-2239(H).

Refer to *AMPM Policy 310-BB* for additional requirements for coverage of transportation.

302 PRIOR PERIOD COVERAGE RECONCILIATION: ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 36-2905 and § 36-2944.01; A.A.C. R9-22-101; Patient Protection and Affordable Care Act, Section 9010; ACOM 412

Due to the uncertainty regarding actual utilization and medical cost experience during the Prior Period Coverage (PPC) period, the Division intends to limit the financial risk to its Administrative Services Subcontractors (ADSS). The PPC Reconciliation applies to dates of service effective in Contract Year Ending (CYE) 19 and Forward, and is based upon prior period expenses and prior period net capitation as described in this policy. The Division will recoup/reimburse a percentage of the AdSS's profit or loss for all risk groups as described below. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis, which is October 1 to September 30.

Definitions

A. Access to Professional Service Initiative (APSI) - Effective October 1, 2018, the Division seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to members and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS's rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the definition outlined in ACOM Policy 325.

B. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) built into the rates multiplied by the actual PPC member months for the contract year being reconciled.

C. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

D. Prior Period Coverage (PPC) - The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility until the date the member is enrolled with an AdSS. Refer to A.A.C. R9-22-101. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for the Division via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service (FFS) and the member will be enrolled with the Contractor only on a prospective basis. The time period for prior period coverage does not include the time period for prior quarter coverage.

E. PPC Capitation - Capitation payment for the period of time from the first day of the

month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.

F. PPC Medical Expense - Total expenses covered under the contract for services provided during the PPC time period, which are reported through **fully adjudicated encounters**. This will exclude APSI expenses.

G. PPC Net Capitation - PPC capitation less the administrative component, the health insurer fee capitation adjustment, APSI capitation and the premium tax component.

H. PPC Reconciliation Risk Groups - Populations subject to this reconciliation include all PPC risk groups except State Only Transplants and Adult Group above 106% FPL (Adults > 106%) (formerly known as Newly Eligible Adults or NEAD) (Acute Care Contractors Only).

I. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 and §36-2944.01 for all payments made to AdSSs for the Contract Year.

Policy

A. General

1. The reconciliation must relate solely to fully adjudicated PPC medical expense for all PPC reconciliation risk groups. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to AHCCCS cost settlement will not be included in the reconciliation, the non-enhanced portion of the payment will be included in the reconciliation. The enhanced portion of a payment for APSI that is subject to a unique reconciliation as outlined in ACOM Policy 325 will also be excluded from this reconciliation.

2. The reconciliation will limit the AdSS's profits and losses to 2% of the AdSS's PPC net capitation for all PPC reconciliation risk groups combined (See Attachment A for calculation). Any losses in excess of 2% will be reimbursed to the AdSS, and likewise, profits in excess of 4% will be recouped. The full PPC period is eligible for this reconciliation.

B. Division Responsibilities

1. No less than six months after the contract year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows:

   PPC Net Capitation

   Less: PPC Medical Expense

   Equals: Profit/Loss to be reconciled adjusted for PCP Parity

   The Division may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation.

PPC capitation and medical expense to be included in the reconciliation are based on the **date of service** for the contract year being reconciled.

2. The Division will compare fully adjudicated encounter information to financial statements and other AdSS submitted files for reasonableness.

3. The Division will provide the AdSS with the data used for the initial reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

4. A second and final reconciliation will be performed no less than 12 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide the AdSS with the data used for the final reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

5. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

C. AdSS Responsibilities

1. The AdSS must submit encounters for PPC medical expense and those encounters must reach a fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the medical expenses used in the reconciliation.

2. The AdSS must maintain financial statements that separately identify all PPC transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide.

3. The AdSS must monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis.

4. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments by the initial reconciliation due date. It is also the responsibility of the AdSS to correct (including adjudication of corrected encounters) any identified encounter data issues no later than 12 months after the end of the contract year being reconciled. Reconciliation data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

5. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file).

6. If the AdSS performs recoupments/refunds/recoveries on PPC claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due to the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.

305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155

The Division contracts with Administrative Services Subcontractors (AdSS) and delegate's responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual (same policy number and name as stated above) for the Division policy governing AdSS responsibilities regarding this topic.

314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019

This policy describes the method used to auto-assign members to an Administrative Services Subcontractor (AdSS) and the assignment of available models.

A. Prior to auto-assignment to an AdSS, assignment to a model must be completed.

1. Regarding Annual Enrollment Choice, members who are newly eligible for the Division and ALTCS, and members already enrolled in a plan, may select an available model prior to the start of a new contract.

2. If the member does not select an available model, the Division will assign to Model A.

B. Upon award of a new contract, the Division will auto-assign members as follows:

1. Prior to the start of the contract (choice period), the Division gives current members a choice to select from the newly awarded AdSS contractors.

2. If a member does not select an AdSS during the choice period and the member's current AdSS is awarded a contract, the Division assigns the member to the same AdSS.

3. If a member does not select an AdSS during the choice period and the member's current AdSS is NOT awarded a contract, the Division reassigns the member to one of the newly contracted AdSS.

4. Auto-assignment to a newly contracted AdSS will continue until the number of members assigned to the newly contracted AdSS reaches 50% of the number of members assigned to the AdSS that continued to contract.

5. If all AdSS are new, the Division gives the members a choice to select an AdSS prior to the start of the contract.

C. Ongoing, the Division will auto assign to the available AdSS in a revolving sequence. The Division may change the auto assignment process at any time during the term of the contract in response to AdSS-specific issues (e.g., imposition of an enrollment cap), when in the best interest of the ALTCS Program and/or the state, or to recognize and reward AdSS performance across a variety of factors of importance to the Division.

317 CHANGE IN ORGANIZATIONAL STRUCTURE

REVISION DATE: 10/1/2018

EFFECTIVE DATE: May 13, 2016

REFERENCES: ACOM Policy 438, ACOM 439, ACOM 103; AHCCCS Contract Attachment F3, Contractor Chart of Deliverables, AHCCCS Contract Section D, Corporate Compliance; 42 CFR 106, 42 CFR Subpart B

Purpose

This policy identifies the requirements for submitting changes in the Division's organizational structure resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature or resulting from a planned change in a Management Service Agreement (MSA) Subcontractor. This policy also identifies the Division's role in monitoring and evaluating changes in organizational structure, as defined below, for a Management Service Agreement subcontractor.

Definitions

A. Acquisition – an acquiring, by one company, of all of a target company's assets, capital, or stock.

B. Administrative Services Subcontract - agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:

1. Claims processing, including pharmacy claims
2. Credentialing, including those requirements for only primary source verification
3. Management Service Agreements (MSAs)
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

C. Articles of Incorporation - basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

D. Change In Organizational Structure - any of the following:

1. Acquisition
2. Change in Articles of Incorporation
3. Change in ownership
4. Change of MSA subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet Division contractual requirements)

5. Joint venture

6. Merger

7. Reorganization

8. State agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature

9. Other applicable changes that may cause a change in any of the following:

   a. Employer Identification Number/Tax Identification Number (EIN/TIN)

   b. Critical member information, including the website, member or provider handbook and member ID card

   c. Legal entity name.

E. Change in Ownership - any change in the possession of equity in the capital, stock, profits, or voting rights, with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non- stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

F. Joint Venture - business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants' other business.

G. Management Service Agreement (MSA) - type of subcontract with an entity in which the entity's management delegates all or substantially all management and administrative services necessary.

H. Merger - Two companies join together to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

I. Performance Bond - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

J. Reorganization - An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.

Change in Organizational Structure

A change in organizational structure includes any of the following:

A. Acquisition

B. Change in Articles of Incorporation

C. Change in Ownership

D. Change of MSA Subcontractor

E. Joint Venture

F. Merger

G. Reorganization

H. Other applicable changes that may cause:

1. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

2. Changes in critical member information, including the website, member or provider handbook, and member ID card, or

3. A change in legal entity name.

In addition, a change in organizational structure may require a contract amendment to the Division's contract with AHCCCS. If the Division does not obtain prior approval, or AHCCCS determines that a change in the Division's organizational structure is not in the best interest of the state, AHCCCS may terminate the contract. Similarly, a change in organizational structure may require a contract amendment to the AdSS contract with the Division. If the AdSS does not obtain prior approval, or the Division determines that a change in the AdSS organizational structure is not in the best interest of the state, the Divisiion may terminate the contract. The Division may offer open enrollment to the members assigned to the AdSS should a change in organizational structure occur. The Division will not permit one organization to own or manage more than one contract within the same line of business in the same Geographic Service Area (GSA).

Transition Plan

The Division submits a summary of all changes in organizational structure and a transition plan to AHCCCS 180 days prior to the effective date of the change.

Items in the transition plan, for which information is not yet available for submission, or is still considered draft, must be noted and submitted, or resubmitted, to AHCCCS no later than 90 days prior to the effective date.

As part of the transition plan, the Division will complete an assessment of the following:

A. Any potential interruption of services to members including steps to ensure there are no interruptions

B. The ability to maintain and support the contract requirements

C. Major functions of the Division, as well as Medicaid programs, are not adversely affected

D. The integrity of a fair, competitive procurement process for MSA Subcontractors.

Notification to AHCCCS

When notifying AHCCCS, the considerations listed above, and the following information is included in the summary:

A. Any material change to operations as specified in ACOM Policy 439 and AHCCCS Contract, Section D

B. The state or federal legislation, rule, or action that necessitates a change in Organizational Structure

C. A description of the following:

1. Any changes to the management and staffing of the organization currently overseeing services provided under the contract

2. Any changes to existing Management Services Subcontracts

3. Any changes to the administration of critical components of the organizations, information systems, prior authorization, claims processing, or grievances

4. The plan for communicating the change to members, including a draft notification to be distributed to affected members and providers

5. The planned changes to critical member information, including the website, member and provider handbook, and member ID card

6. Any anticipated changes to the network

7. Any changes in federal or state funding that directly impact the Medicaid line of business.

D. Upon AHCCCS approval of the transition plan, any additional information requested by AHCCCS will be submitted within 120 days of the change, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

The Division submits the following no later than 45 days prior to the effective date of the change in organizational structure and commencement of operations under the new structure, as specified in Contract, Attachment F3, Contractor Chart of Deliverables:

A. Information regarding the Disclosure of Ownership and Control

B. Disclosure of Information on Persons Convicted of a Crime in accordance with 42CFR 455, Subpart B, 42 CFR 455.436, State medicated Director Letters 08-003 and 09-001

C. AHCCCS Contract Section D, Corporate Compliance, and AHCCCS ACOM Policy 103

For a change of MSA Subcontractor, the Division follows the process for the review and approval of the new MSA Subcontractor as outlined in AHCCCS ACOM Policy 438.

Changes in Organizational Structure for an MSA Subcontractor

MSA Subcontractors that also have a contract with AHCCCS must notify the Division at the same time notification is given to AHCCCS. As appropriate, the Division must collaborate with AHCCCS in monitoring and evaluating the transition plan.

The Division evaluates and monitors the transition plan for MSA Subcontractors that do not have a contract with AHCCCS.

320 – HEALTH INSURER PROVIDER FEE

EFFECTIVE DATE: April 29, 2020

REFERENCES: A.R.S. § 36-2905, Section 9010 of the Patient Protection and Affordable Care Act; IRS Form 8963; ACOM Policy 320 Attachment A and Attachment B; Section F3, Contractor Chart of Deliverables

The purpose of this Policy is to define what the Division will submit to AHCCCS and the process by which AHCCCS will provide funding to the Division for the Health Insurance Provider Fee.

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility excluding Indian Health Services, for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual (Chapter 320, Health Insurer Fee) for the Division policy governing AdSS responsibilities regarding this topic.

321 PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: 10/01/2019

REFERENCES: AHCCCS Contract #YH6-0014 Section D, Program Requirements, E-Prescribing. ACOM 321 Payment Reform- E-Prescribing.

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility excluding Indian Health Services, for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Policy 321 Payment Reform – E-Prescribing for the Division policy governing AdSS responsibilities regarding this topic.

404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

REVISION DATE: 1/10/2024, 10/26/2022

REVIEW DATE: 8/4/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10;42 CFR 438.10(c)(4)(ii); 42 CFR 438.310(d)(3);42 CFR 438.10(d)(4); 42 CFR 438.10(f)(1); 42 CFR 457.1207; A.R.S. § 46-297; A.A.C R9-22-504; ACOM 404; ACOM 404, Attachment A , Attachment B , Attachment C ; ACOM 406, Attachment B,

PURPOSE

This policy establishes requirements for the Division of Developmental Disabilities' (Division) Member information and the approval process for Member Information Materials developed or used by the Division. This policy pertains to oral and written communication disseminated to the Division's enrolled Members, and to the content of the Division's website.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" or "AdSS" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims;

b. Pharmacy Benefit Manager (PMB);

c. Dental Benefit Manager;

d. Credentialing, including those for only primary source verification;

e. Medicaid Accountable Care Organization (ACO);

f. Service Level Agreements with any Division or Subsidiary of a corporate parent owner; and

g. CHP and DDD Subcontracted Health Plan.

h. A person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Dual Eligible Special Needs Plan" or "D-SNP" means a type of health benefits plan offered by a Centers for Medicare and Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII)

program covered health benefits and full Medicaid (Title XIX) program covered health benefits.

3. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. "File and Use" means a process whereby the AdSS submits qualifying Member Information Materials to the Division prior to use and can proceed with distributing the materials without any expressed approval from the Division.
5. "Human Immunodeficiency Virus" or "HIV" means a Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease. HIV is also commonly transmitted through direct contact with certain bodily fluids (e.g., sharing syringes for intravenous substance use) such as blood, semen, rectal fluids and vaginal fluids, and breast milk.
6. "Incentive Items" for the purpose of this policy means items that are used to encourage behavior changes in enrolled Members or health promotion incentives to motivate Members to adopt a healthy lifestyle and/or obtain health care services.

7. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
8. "Member Information Materials" means any materials given to Division membership. This includes, but is not limited to; Member handbooks, Member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a Member's phone.
9. "Prior Authorization" or "PA" means a process by which AHCCCS or the Division, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable Contract provisions. Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.
10. "Value-Added Services" means services, benefits, or positive incentives that promote healthy lifestyles and improve health

outcomes among Members, including items previously defined as Member "Incentive Items."

11. "Vital Materials" means written materials that are critical to obtaining services which include, at a minimum, the following:
    a. Member Handbooks
    b. Provider Directories
    c. Consent Forms
    d. Appeal and Grievance Notices
    e. Denial and Termination Notices

POLICY

A. MEMBER INFORMATION MATERIALS

1. The Division shall comply with the requirements in ACOM 404 for all Member Information Materials, as well as the following related requirements:
    a. Cultural Competency, Language Access Plan and Family/Patient Centered Care (ACOM 405),
    b. Member Handbook and Provider Directory (ACOM 406),
    c. Social Networking activities (ACOM 425),
    d. Member ID Cards (ACOM 433),

e. Change in Contractor Organizational Structure, or change in contractor name (ACOM 317),

f. Material Changes (ACOM 439),

g. Notice of Adverse Benefit Determination and Notice of Extension samples of templates (ACOM 414),

h. The Division Contract, Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters, when indicated; and

i. Maternal Child Health/EPSDT Member outreach information (AMPM Exhibit 400-3).

2. The Division shall attest it is in compliance with Member information requirements by signing and submitting ACOM 404, Attachment C.

3. The Division shall provide all Member Information Materials to Members and potential Members in a manner and format that may be easily understood and is readily accessible by Members and potential Members.

4. The Division shall inform Members that Member information is available in paper form, without charge and upon request, and shall provide it upon request within five business days.
5. The Division shall use state developed Member notices as indicated in contract and policy.
6. The Division shall make a good faith effort to give written notice to Members who received primary care from, or who are seen on a regular basis by, a provider who is terminated from the network. Written notice shall be provided to the Member:
    a. Within the latter 30 calendar days prior to the effective date of the provider termination, or
    b. 15 calendar days after the receipt or issuance of the provider termination notice.
7. The Division shall submit draft Member notifications to AHCCCS that are components of a material change even if previously submitted as a Member Information Material.
8. The Division shall ensure website checklist items are passed on to its Subcontracted Health Plans and are easily and readily

available for Members on its website, including links to Subcontracted Health Plan Member Information Materials.

B. LANGUAGE, READABILITY, INTERPRETATION AND TRANSLATION REQUIREMENTS

1. The Division shall ensure all Member Information Materials include taglines in the prevalent non-English languages in Arizona and include large print, conspicuously visible font size, explaining the availability of translation or interpretation services with the Division's toll free and TTY/TDY telephone numbers for customer service, which shall be available during normal business hours.
2. The Division shall provide Members with the Division's toll free and TTY/TDY nurse triage line telephone number which shall be available 24hr/7days a week.
3. The Division shall make Vital Materials available in the prevalent non-English language spoken for each Limited English Proficiency (LEP) population.
4. The Division shall not substitute Oral Interpretation services for written translation of Vital Materials.

5. The Division shall ensure translation of Vital Materials is accurate and culturally appropriate.
6. The Division shall translate all written materials for Members into Spanish regardless of whether or not the materials are vital.
7. The Division shall ensure that all information prepared for distribution is written in an easily understood language and format for readability through the following measures:
    a. Maintain the information at a sixth grade reading level as measured on the Flesch-Kincaid scale.
    b. Use a font size no smaller than 12 point.
    c. Member Information Materials are made available in alternative formats and in an appropriate manner that takes into consideration special needs including:
        i. Visual limitation,
        ii. Other disabilities, or
        iii. Limited reading proficiency.
    d. Large print materials are made available using a conspicuously visible font size.

8. The Division shall makes oral interpretation services, as well as written translation of documents from English into the Member's preferred language, available to Members at no cost. Services for all non-English languages and the use of auxiliary aids such as TTY/TDY and American Sign Language are available.

C. VALUE-ADDED SERVICES

1. The Division shall offer Value-Added Services to Members which promote healthy lifestyles and improve health outcomes when opportunities arise.
2. The Division shall not offer Value-Added Services to Members to influence continued enrollment with the Division.
3. The Division shall not offer Value-Added Services such as Incentive Items that are exchangeable for items prohibited.
4. The Division shall offer Value-Added Services in a culturally sensitive, unbiased, and equitable manner.
5. The Division shall not receive compensation for Value-Added Services and shall not report the cost of Value-Added Services as allowable medical or administrative costs.

D. MATERIALS NOT REQUIRING SUBMISSION TO AHCCCS

1. Division staff shall not submit the following materials to AHCCCS for approval:
    a. Customized letters for individual Members.
    b. Information sent by the Division to Members enrolled in a Medicare Dual Special Needs Plan (D-SNP) that clearly and exclusively relates to their Medicare benefits and services.
    c. Health related brochures developed by a nationally recognized organization included in ACOM 404 Attachment A do not require submission to AHCCCS prior to distribution to Members, unless they reference any of the following, in which case the Division shall not distribute them at all, although the Division may utilize them to develop their own materials:
        i. Services which are not medically necessary,
        ii. Services which are not AHCCCS covered benefits; or
        iii. Services which do not align with Division policy.
2. The Division shall submit a request to add additional names of other organizations to ACOM 404 Attachment A upon identifying an organization missing from the list.

3. The Division shall refer to ACOM 404 for updates when considering using information from organizations listed in Attachment A.
4. The Division shall review the content of materials developed by the organizations listed in Attachment A to ensure that:
    a. The services are covered by the Division.
    b. The information is accurate.
    c. The information is culturally sensitive.
5. The Division shall supplement or replace educational brochures customized for Medicaid Members developed by outside entities to educate Members.

E. MEMBER NEWSLETTER CONTENT AND REQUIREMENTS

1. The Division shall develop and distribute, at a minimum, two Member newsletters during each contract year.
2. The Division shall submit newsletters to AHCCCS in the form of an initial mock-up version of what the Member will be receiving, in addition to the individual articles referencing readability levels.
3. The Division shall not use the File and Use review process for the Member newsletter.

4. The Division shall include at a minimum, the following in the Member newsletter at least annually except as otherwise indicated:
    a. Educational information on chronic illnesses and ways to self-manage care;
    b. Reminders of flu shots and other preventative measures at appropriate times;
    c. Medicare Part D issues;
    d. Cultural Competency, other than translation services;
    e. Contractor specific issues in each newsletter;
    f. Tobacco cessation information;
    g. HIV/AIDS testing for pregnant women;
    h. Suicide Prevention information;
    i. Opioid/Substance Use information;
    j. Information on Peer and Family Supports;
    k. Contractor contact information and 988 Crisis Hotline information in each newsletter;

l. Educational information on how the Division is addressing health equity and resources to assist with Social Determinants of Health;

m. Where to find resources for support with health-related social needs, which may include a link to the Division's Community Resource Guide;

n. Information on the Division's integration efforts to improve overall Member health outcomes~~,~~ as applicable;

o. Information on Non-Title XIX/XXI Services as appropriate; and

p. Other information required by the Division or AHCCCS.

F. WEBSITE CONTENT

1. The Division shall ensure the Division website contains all of the information required in ACOM 404 - Attachment B.
2. The Division shall provide written notice to Members of the availability for the newsletter if newsletters are provided electronically.
3. The Division shall submit ACOM 404 Attachment B to AHCCCS annually.

4. The Division shall ensure:
    a. All information is located on the Division's website in a manner that Members can easily find and navigate from the Division's home page.
    b. Information is in a format that can be retained and printed by the Member.
    c. Websites are specific to the Division's Medicaid program and shall not include links or references to private insurance.
5. The Division shall include links and references to the Division's Medicare programs and services that exclusively promote coordination of care for Members enrolled in both Medicare and Medicaid on the Division's website.
6. The Division shall refer to ACOM 404 for the approval process for additional information added to the Division's website that is directly related to Members or potential Members, refer to requirements outlined in this Policy.

G. SUBMISSION, REQUIREMENTS AND RESTRICTIONS FOR ALL OTHER MATERIALS

1. The Division shall submit to AHCCCS all other Member Information Materials intended for dissemination to Division Members 15 calendar days before they are to be released, for File and Use review.
2. The Division shall request an expedited review if a 15-day notice is not possible.
3. Division staff requesting an expedited review shall ensure the request is expedited.
4. Division staff requesting an expedited review shall ensure the reason for the shortened time frame is indicated in the request.
5. Division staff shall consider factors and materials which may require additional time to be reviewed include Member Information Materials which are:
    a. A component of new initiatives;
    b. Special projects;
    c. Consisted of bulk submission.
6. The Division shall submit Member Information Materials to AHCCCS for approval, prior to using them for marketing purposes as specified in ACOM 101.

7. The Division may disseminate the Member information as indicated in their request upon the expiration of the 15-day time period~~,~~ unless AHCCCS notifies the Division otherwise.
8. Division staff submitting Member Information Materials to AHCCCS for approval shall consider Member materials submitted outside of standard business hours will be considered received the following business day.
9. Division staff submitting Member Information Materials to AHCCCS for approval shall consider State holidays that fall on business days are not counted as part of the 15-day review period.
10. The Division shall not consider Member Information Materials developed for services under contract with AHCCCS to be proprietary to the Division.
11. The Division shall submit the following information to AHCCCS prior to releasing Member Information Materials:
    a. A cover letter containing
        i. a description of the purpose,

ii. the process the Division will use to disseminate the material, and

iii. the reading level of the material level as measured on the Flesch-Kincaid scale.

b. A copy, transcript, screenshot, or other documentation of the material as intended for distribution to its Members or potential Members. Translations of the materials into other languages as required by this policy, are not required to be submitted.

12. The Division shall inform all Members of any changes considered to be significant by AHCCCS, 30 calendar days prior to the implementation date of the change. These changes include:
    a. AHCCCS covered drug list;
    b. Cost Sharing;
    c. Prior Authorization;
    d. Service Delivery;
    e. Covered Services; and
    f. Other changes as required by AHCCCS.
13. The Division shall ensure:

a. All materials are labeled with the Division's name or logo, including:
    i. Member material located on the Division's website;
    ii. Email messages;
    iii. Voice or text-recorded phone messages delivered to the Member's phone; and
    iv. Other information as requested by AHCCCS.
b. Information contained within the material is:
    i. Accurate;
    ii. Updated regularly; and
    iii. Appropriately based on changes in benefits, Contract, policy, or other relevant updates.
c. Updated Member information is re-submitted for approval, including:
    i. The date the material was previously approved;
    ii. The reason for the update; and
    iii. Clearly identify all content revisions.
d. A log is kept for all Member Information Material distributed each year, the log shall identify:

i. The date the material was originally submitted to AHCCCS; and

ii. Resubmission dates.

e. The log of Member Information Materials is made available to AHCCCS upon request.

f. Member Information Materials:

i. Do not directly or indirectly refer to the offering of private insurance,

ii. Do not include inaccurate, misleading, confusing or negative information about AHCCCS or the Division, or any information that might defraud Members.

g. Member Information Materials do not use the word "free" in reference to covered services.

h. Member Information Materials directly relate to the administration of the Medicaid program, or relate to health and welfare of the Member.

i. Member Information Materials do not have political implications; and,

j. Retention materials do not refer to competing plans.

405 CULTURAL COMPETENCY, LANGUAGE ACCESS PLAN, AND FAMILY/ MEMBER CENTERED CARE

EFFECTIVE DATE: July 19, 2023

REFERENCES: 42 CFR 457.1230(a), 42 CFR 457.1201(d), 42 CFR 438.206(c)(2), 42 CFR 438.3(d)(4), and 45 CFR Part 92; ACOM 405.

PURPOSE

The purpose of this Policy is to set forth Division requirements for providing health care services in a culturally and linguistically competent manner.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor (AdSS)" means an agreement that delegates any of the requirements of the Contract with Arizona Health Care Cost Containment System (AHCCCS), including, but not limited to the following:
    a. Claims processing, including pharmacy claims,
    b. Pharmacy Benefit Manager (PMB),
    c. Dental Benefit Manager,
    d. Credentialing, including those for only primary source verification,
    e. Management Service Agreements,

f. Medicaid Accountable Care Organization (ACO),

g. Service Level Agreements with any Division or Subsidiary of a corporate parent owner; and

h. DDD Subcontracted Health Plan. A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.

2. "Cultural Competency" means a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables that system, agency, or those professionals to work effectively in cross-cultural situations.

a. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

b. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

3. "Family-Centered" means care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate the member directs the involvement of the family to ensure person-centered care.

4. "Interpretation" for the purpose of this policy means the conversion of oral communication from one language into another while maintaining the original intent.

5. "Language Assistance Service" means services including, but not limited to:

a. Oral language assistance, including Interpretation in non-English languages provided in-person or remotely by a Qualified Interpreter for an individual with Limited English Proficiency, and the use of qualified bilingual or

multilingual staff to com]municate directly with individuals with Limited English Proficiency,

b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages other than English; and

c. Taglines.

6. "Limited English Proficiency (LEP)" means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be Limited English Proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

7. "Linguistic Need" means, for the purposes of this policy, the necessity of providing services in the member's primary or preferred language, including sign language, and the provision of interpretive and Translation services.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone,a video remote interpreting (VRI) service, or an on-site appearance:
   a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,
   b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness; and
   c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.
10. "Qualified Translator" means for the purpose of this policy, a translator who:
   a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

b. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

c. Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

11. "Translation" means, for the purpose of this policy, the conversion of written communication, while taking into consideration the cultural context, content and spirit of the message, while maintaining the original intent.

12. "Vital Materials" means information, provided to the member, which assists the member to receive covered services through the Arizona Long Term Care System (ALTCS) program. These materials include but are not limited to:

a. Member handbooks,

b. Notices of Adverse Benefit Determinations,

c. Notices of Appeal Resolution,

d. Consent forms,

e. Member notices,

f. Communications requiring a response from the member,

g. Grievance, appeal, and request for state fair hearing information, or

h. Written notices informing members of their right to Interpretation and Translation services.

POLICY

A. CULTURAL COMPETENCY PLAN (CCP)

1. The Division shall develop and maintain a comprehensive Cultural Competency program that:

   a. Is inclusive of those with LEP and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity.

   b. Includes measurable and sustainable goals,

   c. Is available in a written format,

d. Describes how care and services will be delivered in a culturally competent manner, and shall include all information as specified in ACOM 405 Attachment A,

2. The Division shall identify a staff member responsible for implementation and oversight of all requirements for the Cultural Competency program and plan.

3. The Division shall require its workforce to adhere to all Cultural Competency requirements as specified in this Policy.

4. The Division's CCP shall also include:

   a. A description of the method(s) used for evaluating the cultural diversity of its membership to assess needs and priorities to provide culturally competent care to its membership,

   b. An evaluation of its network, outreach services, and other programs to improve accessibility and quality of care for its membership,

   c. A description of the method(s) used for evaluating health equity and addressing health disparities within the Division's service delivery,

d. A description of the provision and coordination needed for linguistic and disability related services; and

e. A description of education and training that includes:

   i. Methods used to train its workforce to ensure that services are provided in a culturally competent manner to members of all cultures,

   ii. Training customized to fit the needs of the workforce based on the nature of the contacts with providers and members,

   iii. Cultural Competency training for the entirety of the workforce during new employee orientation and annually thereafter,

   iv. Methods used to train members of the workforce with direct member contact,

   v. Education designed to make members of the workforce and AdSSs aware of the importance of providing services in a culturally competent manner and understanding of health literacy,

vi. The Division shall also make additional efforts to train or assist its workforce and Division AdSSs with how to provide culturally competent services; and

vii. The Division shall track workforce participation in Cultural Competency trainings.

B. TRANSLATION AND INTERPRETATION SERVICES

1. The Division shall ensure access to oral Interpretation, Translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request, and at no cost to the member.
2. The Division shall provide Translation and Interpretation services that are accurate, timely, and that protect the privacy and independence of the individual with LEP.
3. The Division shall ensure Translation services are provided by a Qualified Translator, and Interpretation services are provided by a Qualified Interpreter.
    a. The Division shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to

use an adult accompanying the member with LEP for Interpretation in the following situations:

i. When danger is imminent or there is a threat to the welfare or safety of the member, and no Qualified Interpreter is immediately available; or

ii. After receiving the Division's offer and recommendation to use a Qualified Interpreter, the member with LEP requests the accompanying adult to interpret or facilitate the communication, the accompanying adult agrees to provide the communication assistance, and reliance on the accompanying adult for assistance is reasonable under the circumstances.

b. Division staff shall advocate for use of Qualified Interpretation services when an adult accompanying the member is providing communication assistance and:

i. There is a concern that the Interpretation is not accurate; or

ii. The content of the conversation is potentially inappropriate to be shared or provided with the accompanying adult.

c. The Division shall only permit reliance upon minor children for Interpretation assistance when:

i. In an urgent emergency situation when danger is imminent, or there is a threat to the welfare or safety of the member; and

ii. There is no Qualified Interpreter immediately available.

d. The Division staff shall follow up with a Qualified Interpreter to verify information after the emergency is over, in the event that a minor child has been relied upon to provide Interpretation assistance.

e. The Division shall not rely on a minor child for Translation of documents.

4. The Division shall ensure Translations and Interpretations are provided in the following manner:

a. All written materials for members shall be translated into Spanish regardless of whether or not the materials are vital.

i. Vital Materials shall be made available in the prevalent non-English language spoken for each LEP population in the Division's service area.

ii. Oral Interpretation services shall not substitute for written Translation of Vital Materials.

b. Oral Interpretation services available at no cost to the member.

i. This applies to sign language and all non-English languages, not just those identified as prevalent.

ii. Information shall be made available on which providers speak languages other than English.

5. The Division shall provide member information materials in compliance with ACOM Policy 404.

6. The Division shall:

a. Utilize licensed interpreters for the Deaf and the Hard of Hearing, and

b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the member upon request. Auxiliary aids include:

i. Computer aided transcriptions,

ii. Written materials,

iii. Assistive listening devices or systems,

iv. Closed and open captioning; and

v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

C. CULTURAL COMPETENCY PLAN ASSESSMENT REPORTING

1. The Division shall assess its CCP for effectiveness. The assessment shall include modifications as appropriate based on evaluation of the CCP. The CCP Assessment shall consider the following:

a. Linguistic Need,

b. Comparative member satisfaction surveys,

c. Outcomes for certain cultural groups,

d. Translation and Interpretation services and utilization,

e. Member complaints and grievances,

f. Provider feedback; and

g. Division employee surveys.

2. The Division shall track and trend identified issues, and actions taken to resolve those identified issue(s).

3. The CCP shall also address how the Division communicates its progress in implementing and sustaining the CCP goals to all stakeholders, members, and the general public.

4. The CCP Assessment shall be submitted with ACOM 405 Attachment A to the DDD Compliance department.

D. LANGUAGE ACCESS PLAN

1. The Division shall submit a Language Access Plan with ACOM 405 Attachment A annually, that indicates how the needs of members with LEP are met.

2. The Language Access Plan shall address each of the following elements:

a. Assessment: Needs and Capacity

Processes to regularly identify and assess the language assistance needs of its members, as well as the processes

to assess the Division's capacity to meet these needs according to the elements of this plan.

b. Language Assistance Service

The Division shall provide the established point of contact for members who need Language Assistance Services. The Division shall include the process used to ensure that the interpreters used are qualified to provide the service and understand interpreter ethics and member confidentiality needs.

c. Written Translations

Processes to identify, translate, and make accessible in various formats vital materials in accordance with assessments of need and capacity conducted as specified in assessment.

d. Policies and Procedures

Written policies and procedures ensuring members with LEP have meaningful access to programs and activities.

e. Notification of the Availability of Language Assistance at No Cost

Processes to ensure meaningful access to the Division's programs including notifying current and potential members with LEP about the availability of language assistance at no cost. Notification methods may include multilingual taglines in member materials, as well as statements on forms including electronic forms such as agency websites. The results as specified in the Needs and Capacity Assessment above should be used to determine the languages in which the notifications should be translated.

f. Workforce Training

Description of employee training to ensure management and staff understand and can implement the policies and procedures of the Language Access Plan.

g. Assessment: Access and Quality

Processes to regularly assess the accessibility and quality of language assistance activities for members with LEP, maintain an accurate record of Language Assistance

Services, and implement or improve LEP outreach programs and activities in accordance with customer need.

h. Stakeholder Consultation

Process for engaging stakeholder communities to identify language assistance needs of members with LEP, implement appropriate language access strategies to ensure members with LEP have meaningful access in accordance with assessments of member need and evaluate progress on an ongoing basis.

i. AdSS Assurance and Compliance

Processes for ensuring AdSSs understand and comply with their obligations under civil rights statutes and regulations enforced by AHCCCS related to language access.

E. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

The Division shall provide Family-Centered care in all aspects of the service delivery system for members with special health care needs. The additional responsibilities of the Division for support of Family-Centered care include but are not limited to:

1. Recognizing the family as the primary source of support for the member's health care decision-making process. Service systems and personnel shall be made available to support the family's role as decision makers;
2. Facilitating collaboration among members, families, health care providers, and policymakers at all levels for the:
    a. Care of the member,
    b. Development, implementation, evaluation of programs; and
    c. Policy development.
3. Promoting a complete exchange of unbiased information between members, families, and health care professionals in a supportive manner at all times;
4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, economic diversity, gender, gender identity, and individuality within and across all families;
5. Implementing practices and policies that support the needs of members and families, including medical, developmental,

educational, emotional, cultural, environmental, and financial needs;

6. Participating in Family Centered Cultural Competency Trainings,
7. Facilitating family-to-family support and networking,
8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family;
9. Acknowledging that families are essential to the members' health and well-being and are crucial allies for quality within the service delivery system; and
10. Appreciating and recognizing the unique nature of each member and their family.

F. SUPPLEMENTAL INFORMATION

The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids, and the complete rules and regulations regarding the profession of interpreters in the State of Arizona.

406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

REVISION DATE: 11/8/2023, 12/21/2022

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 457.1207; 42 CFR 438.10, 42 CFR 438.102; ACOM 404-Attachment C, ACOM 406-Attachment A; ACOM 406-Attachment B

PURPOSE

This policy sets forth guidelines for development, review, and distribution of Member Handbooks and Provider Directories.

DEFINITIONS

1. "Business Day" means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
3. "Multi-Specialty Interdisciplinary Clinic (MSIC)" - means a facility where specialists from more than one specialty meet with Members and their families in order to provide interdisciplinary services to treat Members.
4. "Planning Document'' means a written plan developed through

an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such Services and supports.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
6. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. GENERAL REQUIREMENTS

1. The Division shall provide annually a Member Handbook and Provider Directory to the Responsible Person.
2. The Division shall ensure the Member Handbook contains all information required, as identified in ACOM 406 Attachment A, including definitions as required by Centers for Medicare and

Medicaid Services (CMS) specified in ACOM 406 Attachment B, Definitions for AHCCCS Members.

3. The Division shall ensure required information is incorporated into the Division's Member Handbook in the order identified on the Checklist.
4. The Division shall submit the Member Handbook as described in the section "Member Handbook Review Process" of this policy.
5. The Division may publish information modifying or expanding the contents of the Division's Member Handbook, if the Division identifies a need.
6. The Division may distribute modified or expanded content in the form of inserts and supply these inserts with subsequently distributed Member Handbooks, if the Division identifies the need.
7. The Division shall update paper provider directories at least quarterly and electronic provider directories no later than 30 days after the Division receives updated provider information.

8. The Division shall ensure that the electronic versions of the Member Handbook and the Provider Directory meet the following requirements:
    a. The format is readily accessible;
    b. The information is located in a place on the DDD website that is prominent and readily accessible;
    c. In a machine readable format which can be electronically saved-and printed;
    d. The information is consistent with federal content and language requirements;
    e. The information is available in paper form upon request, at no cost, and will be provided within five Business Days of the request; and
    f. The information adheres to the requirements identified in Policy 416 of the Division Operations Policy Manual.
9. The Division shall ensure the Member Handbook and the Provider Directory adhere to language and format requirements as outlined in Division Operations Policy 404.

B. MEMBER HANDBOOK REVIEW PROCESS

1. The Division shall submit to AHCCCS the Division's Member Handbook, along with a track changes version reflecting changes from the previous contract year, annually.
2. The Division shall annually submit a cover letter to include the requirements as identified in Attachment A, as specified in the AHCCCS contract, or, as directed by AHCCCS.
3. The Division shall provide a final copy of the Member Handbook to AHCCCS, after AHCCCS has provided approval of a draft.
4. The Division shall ensure the Member Handbooks and Provider Directories issued by Subcontracted Health Plans (AdSS) align with the requirements of ACOM 406.

C. DISTRIBUTION REQUIREMENTS

1. Provider Directory:
    a. The Division shall provide a Provider Directory to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.
    b. The Division shall provide the Provider Directory in either hard copy or electronic format.

c. The Division shall provide written notification via electronic mail or via postal mailing that outlines where the directory can be found on the Division's website.

i. The Division shall include this notification in the Member Handbook or mail the notice separately.

ii. The Division shall obtain approval for this notice in accordance with ACOM 404.

iii. The Division shall give the Responsible Person the option to obtain a hard copy version of the Provider Directory.

2. Member Handbook:

a. The Division shall provide the Member Handbook to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.

b. The Division shall provide a hard copy of the Member Handbook to each Responsible Person.

c. Division Support Coordinators shall:

i. Provide to and review the Member Handbook with the Responsible Person annually, and

ii. Document this review in the Acknowledgement of Publications section of the member's planning document.

3. The Division may, at its discretion, require AdSSs to provide written notification that the AdSS's Member Handbook and Provider Directory are available on the AdSS' website, upon request via electronic mail, or by postal mailing.
4. The Division shall make copies of the Member Handbook available to known consumer and family advocacy organizations and other human service organizations when requested.
5. The Division may be required to update Member Handbooks throughout the contract year, if the Division identifies a need to address program changes for inclusion, through inserts in the Member Handbook:
   a. The Division shall incorporate these changes in subsequently distributed handbooks through inserts until the handbooks are updated with the new information, and
   b. The Division shall post the content of the insert on the Division website.

6. The Division shall:

    a. Ensure Member Handbook and Provider Directory requirements are delegated to AdSSs.

    b. Review AdSS's Member Handbooks and Provider Directories for approval in accordance with ACOM 406.

D. PROVIDER DIRECTORY CONTENT

1. The Division shall have a user-friendly, searchable, electronic Provider Directory on the Division's website.
2. The Division shall also make available in an electronic and hard copy format a Provider Directory.
3. The Division shall include the following provider information in the Provider Directory:

    a. Provider name as well as any group affiliation,

    b. Provider address, ensuring virtual-only status is indicated for virtual-only providers in place of a physical address;

    c. Provider telephone number,

    d. Web site Uniform Resource Locator (URL), as appropriate,

    e. Specialty as appropriate,

    f. Non-English languages spoken,

g. Whether or not the provider is accepting new patients,

h. Information for the Long Term Services and Supports (LTSS) Providers, as applicable.

i. The provider's cultural and linguistic capabilities, including languages, including American Sign Language offered by the provider or a skilled medical interpreter at the provider's office.

j. The location of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract,

k. A designation identifying network offices that offer reasonable accommodations for Members including but not limited to: physical access, accessible equipment and culturally competent communications and a description of how the Responsible Person can obtain details of the accommodations for specific providers;

l. Innovative service delivery mechanisms such as field clinics and virtual clinics and an Integrated Medical Record

to provide Multi-Specialty, Interdisciplinary Care when needed in other areas of the State;

m. Information on the services, offered through telemedicine and mobile providers, and how to access these services; and

n. Physicians, psychiatrists, laboratory, x-ray, and therapy services available onsite at the MSIC.

407 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: October 1, 2018

REFERENCE: AHCCCS Contractor Operations Manual (ACOM) Policy 407

PURPOSE

The purpose of this policy is to describe the Division's requirements regarding:

1. Monitoring and collection of information about the workforce;
2. Collaborative planning of workforce development initiatives, including the recruitment and employment of members of the Division into healthcare roles; and
3. When needed, the provision of direct assistance to Qualified Vendors and AdSS Health Plans to develop the workforce.

DEFINITIONS

1. "Competency" means a worker's demonstrated ability to intentionally, successfully, and efficiently perform the basic requirements of a job, multiple times, at or near the required standard of performance.

2. "Competency Development" means a systematic approach for ensuring the workers are adequately prepared to perform the basic requirements of their jobs.
3. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
4. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
5. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and or connecting workers to information.
6. "Workforce Development Alliance (WFDA)" means a coalition of the Workforce Development (WFD) Administrators from each contractor that jointly plan and conduct WFD activities for a particular line of business.
7. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources

that the Division implements, including monitoring and addressing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to provider organizations to strengthen their WFD programs.

8. "Workforce Development Plan (WFD-P)" means the blueprint for ensuring the ongoing growth and development of the network's workforce.

POLICY

A. GENERAL

1. The Division shall work with AHCCCS, Qualified Vendors, and Administrative Services Subcontractors (AdSS) to ensure members of the Division receive services from a workforce that is qualified, capable, and sufficiently staffed.
2. The Division shall ensure that providers acquire, develop, and deploy a sufficiently staffed and qualified workforce that capably delivers services to members.
3. The Division shall generate policies that shape worker, workplace, and workforce development practices.

4. The Division shall ensure that provider workforce management and development processes align with AHCCCS workplace and workforce development policies.
5. The Division shall:
    a. Monitor the performance of the network;
    b. Collect information about the workforce;
    c. Develop plans to strengthen the workforce; and
    d. When needed, directly assist providers to develop and maintain a qualified, capable, and sufficiently capacitated workforce.
6. The Division shall ensure that subcontracted provider organizations are deploying a qualified, sufficiently staffed workforce that capably provides services to members of the Division in an interpersonally, clinically, culturally, and technically effective manner.
7. The Division shall offer training and resources to providers to assist professionals and family caregivers with managing stress and burnout as required by the Report of Abuse & Neglect Prevention Task Force.

B. ESTABLISH AND MAINTAIN A WORKFORCE DEVELOPMENT OPERATION

The Division shall:

1. Establish and maintain a Workforce Development Operation (WFDO).
2. The WFDO shall work together with Network Management, Quality Management, and Cultural Competency programs to ensure the provider workforce has the capacity needed to provide services and the diversity and capability required to competently deliver them.
3. Name a Workforce Development Administrator to lead the WFDO who shall:
    a. Manage the AdSS and Qualified Vendors' network specific process of continuous workforce quality development and improvement;
    b. Be a collaborating partner in the statewide WFDA; and
    c. Have a professional background, authorities, and ongoing training and development needed to lead the WFDO as specified in the AHCCCS contract.

4. Equip the WFDO with the organizational personnel and information processing support required to execute the following responsibilities of the WFDO:
    a. Monitor and assess current workforce capacity and capability;
    b. Forecast and plan future or needed workforce capacities and capabilities;
    c. Deliver technical assistance to provider organizations to strengthen their WFD programs;
    d. Monitor, assess, forecast, plan, and provide technical assistance both independently and in coordination with the WFDOs of the other Contractors by:
        i. Independently acting on the workforce needs of the provider network as identified by the network and quality management departments.
        ii. Coordinating with other WFDOs of Contractors to:
            1) Achieve statewide system and industry specific WFD goals;

2) Ensure that WFD processes, such as system-wide orientation and training programs, are uniformly applied; and

3) Prevent the miscommunication of WFD priorities as well as mitigate administrative burden associated with developing the workforces of the statewide provider community.

5. Ensure the provider workforce has access to, and follows, all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, guidance documents, manuals, contracts, and other agency generated plans.
6. Ensure that providers have access to all the resources necessary to engage designated audiences and satisfy the WFD requirements as specified in AHCCCS policies, guidance documents, manuals, contracts, and other agency generated plans.

C. WORKFORCE DEVELOPMENT PLAN

1. The Division shall produce a Workforce Development Plan (WFD-P) as specified in ACOM 407 Attachment A in collaboration with:
    a. Providers;
    b. Members of the Division and their families; and
    c. Other stakeholders, including but not limited to:
        i. Other Contractors and industry;
        ii. Education groups; and
        iii. Community groups.
2. The Division shall ensure the WFD-P:
    a. Determines areas where, relative to network and quality requirements, specific increases in workforce capacity and/or worker competency and capability are needed;
    b. Determines if the WFD programs of a single provider, or WFD programs of the provider network, for acquiring, developing, and maintaining a sufficiently staffed, diverse, and capable workforce should be enhanced to ensure compliance with the Division's network and quality requirements; and

c. Develops and implements a plan of action designed to increase or improve workforce capacity and/or capability by working collaboratively with providers to develop the workforce and/or enhance their current WFD programs.

3. The Division shall ensure the Network WFD-P includes, but is not limited to, the following components:
   a. Description of the Division's WFDO;
   b. Workforce Profile;
   c. Workforce Capacity Assessment, Developmental Goals, and Work Plan; and
   d. Workforce Capability/Competency Assessment, Development Goals, and Work plan.
4. The Division shall submit the WFD-P to AHCCCS as specified in the Contract.

D. MONITOR WORKFORCE DEVELOPMENT ACTIVITIES

1. The Division shall develop and maintain workforce development policies and a WFD Plan.
2. The Division shall ensure Qualified Vendors and AdSS Health Plans develop and maintain workforce development policies and

a WFD Plan as part of the routine monitoring process, and ensure:

a. The provider workforce has access to, and is in compliance with, all workforce training and/or competency requirements specified in federal and state law, Division policies, guidance documents, manuals, contracts, other agency generated plans.

b. All Division required training content or competency descriptions are incorporated into the appropriate orientation, basic, specialized, or advanced levels of education or training program and evaluated processes, and are made available to provider personnel.

c. There are processes for:

    i. Documenting training;

    ii. Verifying qualifications, skills, and knowledge of personnel; and

    iii. Retaining required training and competency transcripts and records.

d. All initiatives specified in the Network WFD-P are routinely monitored and evaluated.

E. WORKFORCE DATA

1. The Division shall collect and analyze required and ad hoc workforce data that:
   a. Proactively identifies potential challenges and threats to the viability of the workforce,
   b. Conducts analysis of the potential impact of the challenges and threats to access to care for members,
   c. Develops and implements interventions to prevent or mitigate threats to workforce viability, and
   d. Develops indicators to measure and monitor workforce sustainability.
2. The Division shall use the collected data to directly assist the AHCCCS WFD Administrator develop a comprehensive workforce assessment and forecast of WFD priorities.

F. PROVIDER TECHNICAL ASSISTANCE

1. The Division shall determine the need, scope, and the most effective and efficient methods for providing technical assistance to providers.
2. As needed, the Division shall provide technical assistance to providers to develop, implement, and improve programs for workforce recruitment, selection, evaluation, education, training, and retention that may include:
    a. Workforce development planning,
    b. Talent identification and acquisition,
    c. Competency based training and development programs and systems,
    d. Workforce retention and promotion strategies, and
    e. Workplace culture development.

412 CLAIMS RECOUPMENT

REVISION DATE: 7/10/2019
EFFECTIVE DATE: May 20, 2016
INTENDED USER(S): Division Claim staff

REFERENCES: DES/DDD AHCCCS Contract, Section D; ACOM Policy 203, 434; AHCCCS Claims Dashboard Reporting Guide; A.R.S. §§ 36-2901, 35-214; A.A.C. R9- 22-701 et seq., R9-28-701 et seq., The Deficit Reduction Act of 2005 (Public Law 109-171); 42 CFR 438.600 et seq.

This policy identifies the AHCCCS requirements for the Division's claims recoupment and refund activities.

Definitions

A. Day **-** Calendar day unless otherwise specified.

B. Provider - Any individual or entity that contracts with AHCCCS or the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a Provider delivering services. For the purposes of this policy, a Provider delivering services pursuant to A.R.S. §36-2901.

C. Recoupment - The process the Division takes to recover all or part of a previously paid claim(s). Recoupments include Division initiated/requested repayments, as well as overpayments identified by the Provider where the Division seeks to actively withhold or withdraw funds to correct the overpayment from the Provider.

D. Refunds - An action initiated by a Provider to return an overpayment to the Division. In these instances, the Provider writes a check or transfers money to the Division directly.

Policy

The Division is responsible for reimbursing Providers and coordinating care for services provided to a member pursuant to state and federal regulations, including, but not limited to A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq.

The Division is required to follow AHCCCS Recoupment provisions as outlined in Contract and Policy. For requirements for adjudication and payment of claims and encounters, refer to ACOM Policy 203. The Division's claims processes, as well as its prior authorization, and concurrent and retrospective review processes, minimize the likelihood of the need to recoup paid claims.

An adjustment that is completed within 30 days from the date of the original payment does not require AHCCCS prior approval, but will be tracked and made available to AHCCCS upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

Adjustments completed more than 30 days from the date of the original payment *may* require AHCCCS prior approval, as outlined below.

Individual Recoupments in Excess of $50,000

Prior to initiating any individual Recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Division submits a written request for approval *as specified in Contract* (30-days) or earlier if the information is available, in the format detailed below:

A. A detailed letter of explanation will be submitted with the following:

1. How the need for recoupment was identified.
2. The systemic causes resulting in the need for a recoupment
3. The process that will be utilized to recover the funds
4. Methods to notify the affected Provider(s) prior to recoupment
5. The anticipated timeline for the project
6. The corrective actions that will be implemented to avoid future occurrences.
7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted
8. Other recoupment action(s) specific to this Provider within the contract year.

B. An electronic file containing the following:

- AHCCCS member ID
- Date of service
- AHCCCS claim number
- Date of payment
- Amount paid
- Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s) shall include a minimum of the following:

1. How the need for the recoupment was identified.
2. The process that will be utilized to recover the funds.
3. The anticipated timeline for the recoupment.
4. The Provider's right to file a claim dispute.
5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.
6. Listing of impacted claim numbers.

Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

Recoupment of Payments Initiated More Than 12 Months From the Date of Original Payment

The Division is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of *a clean claim* unless prior approval is obtained from AHCCCS. Retroactive recoveries involving commercial insurance payor sources are not included in this discussion. For Coordination of Benefits involving third party liability recoveries see *ACOM Policy 434 and the Division's Operations Manual Chapter 434 Coordination of Benefits & Third Party Liability.*

A. To request approval from AHCCCS, the Division submits a request in writing with all of the following information:

   A detailed letter of explanation will be submitted with the following:

   1. How the need for recoupment was identified.
   2. The systemic causes resulting in the need for a recoupment.
   3. The process that will be utilized to recover the funds.
   4. Methods to notify the affected Provider(s) prior to recoupment.
   5. The anticipated timeline for the project
   6. The corrective actions that will be implemented to avoid future occurrences.
   7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.

B. An electronic file containing the following:

   - AHCCCS member ID
   - Date of service
   - AHCCCS claim number
   - Date of payment
   - Amount paid
   - Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication includes at a minimum:

   1. How the need for the recoupment was identified.
   2. The process that will be utilized to recover the funds.

3. The anticipated timeline for the recoupment.

4. The Provider's right to file a claim dispute.

5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.

6. Listing of impacted claim numbers.

Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

The Division continuously tracks recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the Division reports the cumulative recoupment monthly as outlined in the AHCCCS Claims Dashboard Reporting Guide and as specified in the Division's contract.

AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of AHCCCS.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating factors such as validity, accuracy, and efficiency of the Division's processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing Provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Division by electronic mail contingent upon receipt of all required information from the Division.

Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Division has *no more than 120-days* to complete the project and submit the following as stated in the Division's contract:

A. Notification of the submission for the voided or replacement encounters (which reaches adjudicated status within 120-days of the approval of the recoupment) and the appropriate associated information for all impacted encounters for recouped claims.

B. Upon completion of the recoupment project, a separate electronic file containing all of the following information for all recouped claims (this is independent of the 837 file(s) submitted through Encounters):

- AHCCCS member identification number
- Date of service
- Original AHCCCS CRN
- New AHCCCS CRN

- Health Plan allowed amount
- Health Plan paid amount
- Provider identification number.

Note: The Division submits the above information for each adjudicated encounter. Dependent on the size and/or volume of the recoupment request, AHCCCS may require the Division to submit an external file in order to directly update impacted encounters in the timeframe prescribed above.

Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in administrative action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of amending the encounter data, AHCCCS may adjust related reinsurance payments, reconciliation payments, or any other amounts paid to the Division that are impacted by the recoupment.

Data Processes for Refunds

Upon receipt of refund from a Provider, the Division has 120-days from the date of the refund to void or replace related encounters. All voided or replaced encounters reaches an adjudicated status within the 120-day timeframe.

A. The Division identifies the following for all refunds received and provide this information to AHCCCS upon request:

1. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred.
2. The corrective actions that will be implemented to avoid future occurrences, if applicable.
3. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund.
4. List of impacted claim numbers.

Attestation

All documentation and data submitted by the Division for purposes of recoupment and refund activities certified by the Division as specified in 42 CFR 438.600 et seq. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Division failed to comply with any provisions of AHCCCS Policy 412 – Claims Recoupment, the Division may be subject to administrative actions.

414 REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

REVISION DATE: 9/6/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 U.S.C. 1396d(r)(5), 42 CFR 438.404(b)(2), 42 CFR 438.10(c)(4)(ii), ACOM Policy 414 , AMPM Policy 430

PURPOSE

This policy sets forth Division requirements for Notices of Adverse Benefit Determination relating to Title XIX/XXI coverage and authorization of services.

DEFINITIONS

1. "Adverse Benefit Determination" means the denial or limited authorization of a service request or the reduction, suspension, or termination of a previously approved service.
2. "Appeal" means a request for review of an Adverse Benefit Determination.
3. "Calendar Days" means every day of the week including weekends and holidays.
4. "Expedited Service Authorization Request" means a request for

services in which either the requesting provider indicates, or the Division determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.

5. "Legal Holidays" means Legal Holidays, as defined by the State of Arizona are:

   a. New Year's Day – January 1

   b. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January

   c. Lincoln/Washington Presidents' Day – 3rd Monday in February

   d. Memorial Day – Last Monday in May

   e. Independence Day – July 4

   f. Labor Day – 1st Monday in September

g. Columbus Day – 2nd Monday in October

h. Veterans Day – November 11

i. Thanksgiving Day – 4th Thursday in November

j. Christmas Day – December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

6. "Member" means the same as "Client" as defined in A.R.S. §36-551.

7. "Notice of Adverse Benefit Determination " means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the Division regarding the Service Authorization Request and includes the information required by this Policy.

8. "Notice of Extension" or "NOE" means a written notice to a Member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if the criteria

for a service authorization extension are met.

9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

10. "Service Authorization Request" means a request by the Member, the representative, or a provider for a physical or behavioral health service for the Member that requires Prior Authorization (PA) by the Division.

11. "Working days" means "Working Day" as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:

    a. A legal holiday falls on one of these days; or

    b. A legal holiday falls on Saturday or Sunday and the Division is closed for business the prior Friday or following

Monday.

POLICY

A. NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The Division shall provide a written Notice of Adverse Benefit Determination to the Responsible Person and the provider when the Division decides to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services .

2. The Division shall use the AHCCCS-developed Member Notice of Adverse Benefit Determination templates as specified in 42 CFR 438.10(c)(4)(ii).

    a. The templates shall not be altered except for the areas designated in the template that permit alteration and the removal of the header.

    b. Refer to ACOM Policy 414 Attachment A for the Notice of Adverse Benefit Determination template for Service Authorization Requests that do not pertain to medications.

3. The Division's Member Handbook shall inform the Responsible Persons:

   a. Of their right to make a complaint to the Division about an inadequate Notice of Adverse Benefit Determination;

   b. If the Division does not resolve the complaint about the Notice of Adverse Benefit Determination to the Responsible Person's satisfaction, the Responsible Person may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at MedicalManagement@azahcccs.gov; and;

   c. The Division and its providers shall be prohibited from taking punitive action against Responsible Persons exercising their right to Appeal.

   d. That the Division shall inform the Responsible Person that oral interpretation services are available in any language, and alternative communication formats are available for Responsible Persons that are deaf or hard of hearing or

blind or have low vision.

B. RIGHT TO BE REPRESENTED

1. The Division shall acknowledge the Responsible Person's right to be assisted by a third-party representative, including an attorney, during an Appeal of an Adverse Benefit Determination.

2. The Division shall have an Appeals process that registers the existence of the third-party representative.

3. The Division shall ensure the required communications related to the Appeals process occur between the Division and the third party representative.

    a. The Division shall provide the Responsible Person's third party representatives, upon request, timely access to documentation relating to the decision under Appeal.

    b. The Division shall be consistent with federal privacy laws by making reasonable efforts to verify the identity of the third party representative and the authority of the third

party representative to act on behalf of the Responsible Person.

c. The Division may require the third party representative to provide written authorization signed by the Responsible Person.

d. The Division shall promptly communicate to the Responsible Person when the Division questions the authority of the third party representative or the sufficiency of the written authorization.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

1. The Division shall provide a Notice of Adverse Benefit Determination that meets the language requirements as outlined in Division Operations Policy 404.

2. The Division shall provide a Notice of Adverse Benefit Determination that clearly explains the Member-specific reasons for the Division's determination and the information needed so

the Responsible Person can make an informed decision regarding Appealing the determination and how to Appeal the decision.

3. The Division shall clearly inform the Responsible Person when the reason for the Notice of Adverse Benefit Determination denial of a Service Authorization Request is due to the lack of necessary information, and will give the Responsible Person the opportunity to provide the necessary information.

4. The Division shall provide a Notice of Adverse Benefit Determination that is consistent with 42 CFR 438.404 and includes an explanation of the specific facts that pertain to the decision:

   a. The requested service;

   b. The level of service which which may include a request for an enhanced staffing ratio,

   c. The reason or purpose of the requested service;

   d. The reasons for the Adverse Benefit Determination the

Division made or intends to make with respect to the requested service consistent with 42 CFR 438.404(b)(1);

e. The effective date of a service denial, limited authorization, reduction, suspension, or termination;

f. The right of the Responsible Person to be provided, upon request and at no cost to the Responsible Person, reasonable access to and copies of all documents, records, and other information relevant to the Responsible Person's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2);

g. The legal basis for the Adverse Benefit Determination including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable, reference to the general legal authorities alone is unacceptable;

h. Where the Responsible Person can find copies of the legal basis:

i. Reference to the benefit provision, guideline, protocol, or other criterion which the denial is based upon.

ii. An accurate URL site, when a legal authority or an internal reference to the Division's policy manual is available online.

i. A listing of legal aide resources

j. The Responsible Person's right to request an Appeal and the procedures for filing an Appeal of the Division's Adverse Benefit Determination, including information on exhausting the Division's Appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c) including if the Division fails to make a decision in a timely manner regarding the Member's Appeal request;

k. The procedures for exercising the Responsible Person's rights as described in 42 CFR 438.404(b)(4);

l. The circumstances under which an Appeal process can be expedited and how to request it; and

m. Explanation of the Member's right to have benefits continue pending the resolution of the Appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Responsible Person may be required to pay the costs of continued services if the Appeal is denied as specified in 42 CFR 438.420(d), and

n. A statement that the provider who requested the Service Authorization has the option to request a peer-to-peer discussion with the Division's Medical Director.

i. The Division shall allow the provider sufficient time for a peer-to-peer to occur before the Division issues its decision regarding the Service Authorization

Request.

ii. The Division shall allow at least 10 business days for the provider to request a peer-to-peer review.

5. The Division shall not cite the lack of medical necessity as a reason for denial, unless the Notice of Adverse Benefit Determination also explains why the service is not medically necessary for the particular Member in this instance.

6. The Division shall include potential alternative options for consideration that may address the Member's condition when citing lack of medical necessity as a reason for the Adverse Benefit Determination.

7. The Division shall provide a Notice of Adverse Benefit Determination that states the reasons supporting the denial, reduction, limitation, suspension, or termination of a service.

8. The Division shall utilize a board-certified professional when citing lack of medical necessity and provide evidence of such

upon AHCCCS request.

9. The Division shall not provide a Notice of Adverse Benefit Determinations that does not give an explanation of why the service has been denied, reduced, limited, suspended, or terminated and merely refer the Responsible Person to a third party for more information.

10. The Division shall provide a Notice of Adverse Benefit Determinations that includes a statement referring a Responsible Person to a third party for more help when the third party can explain treatment alternatives in more detail.

D. EPSDT

1. The Division shall cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX Member who is younger than 21 years of age when these provisions are applicable and shall specify the reason(s) why the service fails to correct or ameliorate defects

or physical or behavioral health conditions or illnesses.

2. The Division shall explain the denial, reduction, limitation, suspension, or termination of the requested EPSDT service in accordance with AMPM 430 and this Policy.

3. The Division shall specify why the requested service does not meet the EPSDT criteria and is not covered.

4. The Division shall also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

E. RESPONSIBLE PERSON COMPLAINTS REGARDING THE ADEQUACY OR UNDERSTANDIBILITY OF THE NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The Division shall review the initial Notice of Adverse Benefit Determination against the content requirements of this Policy when a Responsible Person complains about the adequacy of a Notice of Adverse Benefit Determination.

2. The Division shall issue an amended Notice of Adverse Benefit Determination consistent with the requirements of this Policy when the Division determines the original Notice of Adverse Benefit Determination is inadequate or deficient.

3. The Division shall begin the timeframe for the Responsible Person to Appeal and continuation of services from the date of the amended Notice of Adverse Benefit Determination when an amended Notice of Adverse Benefit Determination is required.

F. TIMEFRAMES FOR SERVICE AUTHORIZATIONS

All references to "days" in this Policy mean "Calendar Days" unless otherwise specified.

1. The Division shall ensure completion and issuance of the service authorization decision when a Service Authorization Request is

submitted within the following timeframes, including requests that are standard requests and expedited requests.

a. The Division shall consider the date and time the Division or one of its AdSS' receives the request, whichever is earlier, to be considered the date and time of receipt.

b. The Division shall use the date and time to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The Division may use electronic date stamps or manual stamping for logging the receipt.

c. The Division shall make sufficient attempts to obtain the information or clarification and document all attempts for Service Authorization Requests lacking sufficient clinical information necessary to render the decision or the required clarification.

2. Standard authorization decision timeframe for Service Authorization Requests

a. The Division shall issue service authorization decisions as expeditiously as the Member's condition requires but no later than 14 Calendar Days from receipt of the request for the service regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

b. The Division may issue a NOE of up to 14 additional Calendar Days when the criteria for a service authorization extension are met as specified in section (H) of this Policy.

3. Expedited Service Authorization Decision Timeframe for Service Authorization Requests:

a. The Division shall issue an expedited service authorization decision, as expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and

Sunday) or legal holiday as defined by the State of Arizona.

b. The Division shall issue a NOE of up to 14 additional Calendar Days, when the criteria for a service authorization extension are met as specified in section (H) of this Policy.

4. Expedited Service Authorization Request treated as a standard request:

a. The Division shall treat the Expedited Service Authorization Request as a Standard Authorization Request when the Expedited Service Authorization Request fails to meet the requirements for expedited consideration.

b. The Division shall have a process included in the Division's policy for prior authorization (PA) that describes how the Responsible Person and provider shall be notified of the change to a standard authorization request and be given an opportunity to provide additional information, refer to

Provider Policy Manual Chapter 17.

c. The Division shall permit the requesting provider to send additional documentation supporting the need for an Expedited Service Authorization request.

5. Service authorization decisions not reached within the timeframes:

a. The Division shall consider a Service Authorization Request decision that is not reached within the required timeframes for a standard or expedited request, as a denial when the Division has not made a decision.

b. The Division shall issue a Notice of Adverse Benefit Determination denying the request on the date that the timeframe expires.

6. Service authorization decisions not reached within the extended timeframes:

a. The Division shall consider a Service Request Authorization

decision that is not reached within the timeframe noted in the NOE as a denial.

b. The Division shall issue a Notice of Adverse Benefit Determination denying the service request on the date that the timeframe expires as specified in 42 CFR 438.404(c)(5).

G. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

1. The Division shall mail the Notice of Adverse Benefit Determination within the following timeframes:

   a. For termination, suspension, or reduction of a previously authorized service, the Division shall mail the Notice of Adverse Benefit Determination at least 10 Calendar Days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice [42 CFR 431.211, 42 CFR 438.404(c)(1)];

b. For standard service authorization decisions that deny or limit services, the Division shall provide a Notice of Adverse Benefit Determination:

i. As expeditiously as the Member's health condition requires, but no later than 14 Calendar Days from the receipt of the request, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona, unless there is a NOE. For extension timeframes, refer to NOE requirements in this Policy [42 CFR 438.404(c)(3) and (4), 42 CFR 438.210(d)(1)];

ii. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless

there is a NOE. For extension timeframes, refer to NOE requirements in this Policy.

H. NOTICE OF EXTENSION (NOE) REQUIREMENTS

1. Notice of Extensions (NOE) Timeframes

   a. The Division shall extend the timeframe to make a service authorization decision for both standard and Expedited Service Authorization Requests when:

      i. The Responsible Person or provider, with the Responsible Person’s written consent, requests an extension, or

      ii. The Division shall document all attempts made to the requesting provider for the needed information.

      iii. The Division shall notify the Responsible Person of the reason for the extension and attempt to obtain the Member's approval before the Division pursues an extension due to lack of sufficient clinical

information.

2. The Division shall not pursue the NOE until the Division has made sufficient attempts to first obtain the necessary information from the Responsible Person or provider within the standard or expedited timeframe, whichever is applicable. Refer to 42 CFR 438.404(c)(4) and 438.210(d).

3. The Division shall document all attempts to obtain the necessary information.

4. The Division shall notify the Member of the reason for the extension and attempt to obtain the Member's approval before the Division pursues an extension due to lack of sufficient clinical information.

5. The Division shall not send the NOE until the Division has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)];

   a. For standard Service Authorization Requests, the Division

may extend the 14 Calendar Day time frame to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the service request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona;

b. For an Expedited Service Authorization Request, the Division may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona;

c. When the Division justifies the need for additional information is in the Member's best interest. The Notice of NOE shall not be sent until the Division has made sufficient attempts to obtain the necessary information from the Responsible Person [42 CFR 438.404(c)(6), 42 CFR

438.210(d)(2)(ii)].

d. For Standard Service Authorization requests, the Division may extend the 14-Calendar Day timeframe to make a decision by up to an additional 14 Calendar Days, not to exceed 28 Calendar Days from the Service Authorization Request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

e. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations in this Policy when the prior authorization requests lack sufficient information from the prescriber.

f. For an expedited Service Authorization Request (requests that do not involve medication), the Division may extend the 72-hour timeframe to make a decision by up to an additional 14 Calendar Days, regardless of whether the

due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

6. When the Division extends the timeframe to make a decision, in accordance with 42 CFR 438.210(d)(1) the Division shall:

   a. Provide the Responsible Person written notice of the reason for the decision to extend the timeframe, including what information is needed in order to make a decision, and in easily understood language, as outlined in Division Operations Policy 404;

   b. Inform the Responsible Person of the right to file a grievance or complaint if the Responsible Person disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and;

   c. Issue and carry out the decision as expeditiously as the Member's condition requires and no later than the date the extension expires consistent with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii).

415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

REVISION DATE: 1/17/2024, 3/22/2023

REVIEW DATE: 10/10/2023

EFFECTIVE DATE: October 1, 2018

REFERENCES: ACOM 415, 417, and 439; ACOM 415 Attachments A, B, D, F; ACOM 417 Attachment A, B; 9 A.A.C. 22, Articles 1 and 2; A.R.S. §§ 36-2901, 36-3407; 42 CFR 457.1230, 42 CFR 438.207(b), Section F3, Contractor Chart of Deliverables

PURPOSE

The purpose of this policy is to establish Division requirements for the Division's submission of the Network Development and Management Plan and other periodic network reports to AHCCCS.

DEFINITIONS

1. "Attachment" means attachment to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) 415.
2. "Contract" means the Division's contract with AHCCCS.

POLICY

A. NETWORK DEVELOPMENT AND MANAGEMENT PLAN

1. The Division shall develop and maintain a provider Network Development and Management Plan (NDMP) that assures AHCCCS that the provision of covered services will occur as stated in the Contract [42 CFR 457.1230, 42 CFR 438.207(b)].
2. The Division shall evaluate/review activity and performance during the Contract year prior to the NDMP's submission date and address the Division's plan for network development and related activity during the Contract year in which it was submitted.
3. The Division shall specify in the NDMP the process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.
4. The Division shall include in the NDMP a comprehensive description of elements identified in Attachment B and shall

submit as specified in Contract. In the submission, the Division shall include the following:

a. Attachment A, Network Attestation Statement.

b. Attachment B, Network Development and Management Plan Checklist, in Microsoft Word format.

c. Attachment F, the Centers of Excellence Checklist (COE), in Microsoft Word format.

d. The Centers of Excellence (COE).

B. PERIODIC NETWORK REPORTING

1. Provider Changes Due to Rates Report

   a. The Division shall submit Attachment D, as specified in Contract.

   b. The Division shall submit changes resulting in a material change to the network to AHCCCS as specified in ACOM Policy 439.

2. Service Delivery Standard Report

   a. The Division shall submit the Home and Community Based Services (HCBS) Service Delivery Standard Report as

specified in the Contract. The Division shall include the following in the report:

i. A description of the metrics used by the Division to measure the timeliness of its service delivery and its performance under those metrics,

ii. A summary of the Division's performance under these metrics, and

iii. A trended analysis of the current performance.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

Durable Medical Equipment (DME) Wheelchair Service Delivery Reporting;

Provider Network Development and Management Plan;

Provider/Network Changes Due to Rates Report Attachment D and E;

Centers of Excellence Attachment to Provider Network Development and Management Plan, HCBS Standard Delivery Report.

416 PROVIDER INFORMATION

REVISION DATE: 1/3/2024, 10/1/2019

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR 438.102

PURPOSE

This Policy establishes provider information requirements.

DEFINITIONS

1. "Americans With Disabilities Act" or "ADA" means the Americans with Disabilities Act of 1990, as amended, that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in 42 U.S.C. 126 and 47 U.S.C. 5.
2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical

and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources.

a. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.

b EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

c. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Home and Community Based Services" or "HCBS" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care.
    a. A PCP may be:
        i. A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17;
        ii. A practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25;
        iii. A certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or
        iv. A naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

b. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

6. "Provider" means any person or entity that contracts with the Division to provide a covered service to Members in accordance with A.R.S. § 36-2901.

7. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

8. "Value-Based Purchasing" or "VBP" means a payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals and measures in accordance with the VBP strategy selected for the contract.

   a. VBP is a non-encounterable payment and does not reflect payment for a direct medical service to a member.

   b. VBP payment will typically occur after the completion of the contract period but could include quarterly or semiannual payments if contract terms specify such

payments in recognition of successful performance measurement.

POLICY

A. PROVIDER MANUAL

1. The Division shall develop, distribute, and maintain a provider manual, ensuring that each contracted provider is made aware of the provider manual available on the Division's website or, if requested, issued a hard copy of the provider manual. The Division shall make available a provider manual to any individual or group that submits claim and encounter data.
2. The Division shall ensure that all providers, whether contracted or not, meet the applicable AHCCCS requirements that relate to covered services and billing.
3. The Division shall ensure that the provider manual provides information regarding the following:
    a. The ability of a member's Primary Care Provider (PCP) to treat behavioral health conditions within the scope of their practice.

b. Introduction to the Division that explains the Division's organization and administrative structure.

c. Provider responsibility and the Division's expectation of the provider.

d. Division's provider service departments and functions including the expected response times for provider inquiries.

e. Listing and description of covered and non-covered services, requirements, and limitations, including behavioral health services.

f. Appropriate and inappropriate use of the emergency department.

g. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

    i. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings, and immunizations.

ii. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.

h. Description of dental services coverage and limitations.

i. Description of maternity and family planning services.

j. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.

k. Process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

l. Grievance and appeal system process and procedures for providers and enrollees.

m. Billing and encounter submission information.

n. Policies and procedures relevant to the providers that contain:

i. Utilization management;

ii. Claims submission;

iii. Criteria for identifying provider locations that provide physical access, accessible equipment, and reasonable accommodations for Members with physical or cognitive disabilities; and

iv. PCP assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.

o. Procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, that contains:

i. Members' name,

ii. Members' date of birth,

iii. Members' AHCCCS ID,

iv. AHCCCS ID of the assigned PCP, and

v. Effective date of member assignment to the PCP.

p. Policies relevant to payment responsibilities that contain:

i. Description of the Change of Contractor policies as specified in ACOM Policy 401 and ACOM Policy 406, and

ii. Nursing Facility and Alternative Home and Community Based Service (HCBS) setting contract termination procedures as specified in ACOM Policy 421.

q. Reimbursement policies, including reimbursement for Members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

r. Cost sharing responsibility.

s. Explanation of remittance advice.

t. Criteria for the disclosure of member health information

u. Medical record standards.

v. Prior authorization and notification requirements, including a listing of services which most frequently used services which require authorization, and instructions on how to

obtain a complete listing of services that require authorization.

w. Requirements for out of state placement for members.

x. Claims medical review.

y. Concurrent review.

z. Coordination of Care requirements, including designation of an Employment Coordinator as the statewide point of contact for the referral of Members requesting employment services from the Division.

aa. Credentialing and re-credentialing activities.

bb. Fraud, waste, and abuse as specified in ACOM Policy 103.

cc. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.

dd. Minimum Required Prescription Drug List (MRPDL) information, including:

i. How to access the MRPDL, electronically or by hard copy upon request, and

ii. How and when updates are communicated.

ee. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including prior authorization and limits specified in AMPM Policy 310-V, the Contractor's monitoring process for prescribers in AMPM Policy 310-FF, and informed consent requirements in AMPM Policy 320-Q.

ff. AHCCCS appointment standards.

gg. Requirements pertaining to duty to warn and duty to report as specified in AMPM Policy 960.

hh. Submission requirements under the AHCCCS DUGless Portal Guide for behavioral health providers regarding their responsibilities for submitting to AHCCCS demographic information.

ii. Americans with Disabilities Act (ADA) and Title VI Of the Civil Rights Act of 1964 requirements, as applicable.

jj. Process providers use to notify the Division for changing an address, contact information, or other demographic information.

kk. Information on services available through the AHCCCS Provider Enrollment Portal and how to access the portal and how to update provider registration data including current population groups sets served.

ll. Eligibility verification.

mm. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964, and access to interpretation services for Members who speak a language other than English, including Sign Language.

nn. Peer review and appeal process.

oo. Medication management services as described in the contract.

pp. A Member's rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including, to:

i. Be treated with dignity and respect.

ii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

iii. Participate in treatment decisions regarding his or her health care, including the right to refuse treatment.

iv. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

v. Request and receive a copy of the medical records, and to request that the medical records be amended or corrected, as specified in 45 CFR part 164 and applicable state law.

vi. Exercise his or her rights and the exercise of those rights shall not adversely affect service delivery to the Member.

qq. Notification that the Division has no policies that prevent the provider from advocating on behalf of the Member as specified in 42 CFR 438.102.

rr. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

ss. General and informed consent for treatment requirements.

tt. Advance directives.

uu. Transition of members.

vv. Encounter validation studies.

ww. Incidents, accidents, and deaths reporting requirements as specified in AMPM Policy 960.

xx. A pre-petition screening, court ordered evaluations, and court ordered treatment.

yy. Behavioral health assessment and service planning requirements:

i. As specified in AMPM Policy 320-O;

ii. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650;

iii. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040;

iv. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P;

v. Partnership requirements with families and family-run organizations in the children and adult behavioral health system; and

vi. Peer support and recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

4. The Division shall include the following information in the provider manual:

a. Housing criteria for individuals determined to have an SMI,

b. Seclusion, restraint, and emergency response reporting requirements, and

c. The SMI grievance and appeal process.

5. The Division shall include guidance in the Provider Manual on which services are the responsibility of DDD qualified vendors and which services are the responsibility of providers contracted with the DDD subcontracted health plans, and directions on how providers unsure of these responsibilities can obtain guidance.

B. REQUIRED NOTIFICATIONS

1. In addition to the updates required in this section, the Division shall require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division shall provide prior notification.
2. The Division shall provide written or electronic communication to contracted providers in the following instances:
    a. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, the Division shall provide written notice of the reason for declining any written request for inclusion in the network.
    b. Material Changes - The Division shall notify providers in advance of any Material Change to the Provider Network or business operations as specified in ACOM policy 439.
    c. Division Policy and Procedure Changes – For any change in policy, process, or protocol including prior authorization, retrospective review, or performance and network standards that affects or can reasonably be foreseen to affect the Division’s ability to meet performance standards

of the Division contract with AHCCCS, the Division shall notify:

i. The designated operations compliance officer to which the Division is assigned, sixty calendar days before a proposed change, and

ii. Affected provider, thirty calendar days before the proposed change.

d. AHCCCS Guidelines, Policy, and Manual Changes - The Division shall notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals.

e. Division Provider Manual Changes - The Division shall notify its providers when modifications are made to the provider manual.

f. Subcontract Updates

i. If the AHCCCS Minimum Subcontract Provisions are modified, the Division shall issue a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts.

ii. The Division shall amend the affected subcontracts on their regular renewal schedule or within six calendar months of the update, whichever comes first.

g. Termination of Contract – The Division shall provide, or require its subcontractors to provide, written notice to hospitals and provider groups at least 90 calendar days prior to any contract termination, other than contracts between subcontractors and individual practitioners, without cause.

h. Disease and Chronic Care Management – The Division shall disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

417 APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING, AND REPORTING

REVISION DATE: 2/28/2024, 3/22/2023, 10/1/2019
REVIEW DATE: 10/10/2023
EFFECTIVE DATE: January 16, 2019
REFERENCES: 42 CFR 438.206; 42 CFR 438.206(b)(4); 42 CFR 438.206(c)(1)((i)-(vi); 42 CFR 438.207(b); 42 CFR 457.1230(a); A.R.S. § 8-512.01; ACOM 415; ACOM 417, ACOM 417 Attachments A and B.

PURPOSE

This policy outlines the Appointment accessibility and availability standards and the Division's oversight and monitoring of the Administrative Services Subcontractors (AdSS) to ensure compliance with the Division's network sufficiency requirements. This policy outlines the process for the Division to report Service Provider Appointment accessibility and availability to the Arizona Health Care Cost Containment System (AHCCCS).

DEFINITIONS

1. "1800 Report" means an AHCCCS-generated document, provided quarterly that identifies Primary Care Physicians (PCPs) with a

panel of more than 1800 AHCCCS Members.

2. "Appointment" means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or Service Provider in Service Provider and service categories identified in this policy.

3. "Network Development and Management Plan" or "NDMP" means a plan the Division develops and maintains to ensure the provision of covered services will occur as stated in the Contract. The Network Development and Management Plan (NDMP) specifies the Division process to develop, maintain, and monitor an adequate Service Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.

4. "Service Provider" means an agency or individual operating under a contract or service agreement with the Department to provide services to Division Members.

5. "Urgent Care Appointment" means an Appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

A. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
   a. Annual Operational Review of each AdSS,
   b. Review and analyze deliverable reports submitted by the AdSS, and
   c. Conduct oversight meetings with the AdSS for the purpose of:
      i. Reviewing compliance,
      ii. Addressing concerns with access to care or other quality of care concerns,
      iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

B. APPOINTMENT STANDARDS FOR THE ADSS

1. The Division shall require adherence to service accessibility standards and the contractual Appointment standards contained in 42 CFR 457.1230(a) and 42 CFR 438.206.

2. The Division shall require a comprehensive Service Provider network that provides access to all services covered under the Contract for all Members of the Division.

3. The Division shall require contracted services be covered through an out of network Service Provider until a network Service Provider is contracted if the network is unable to provide medically necessary services required under the Contract.

4. The Division shall require adherence with using the results of Appointment standards, monitoring to validate it has an adequate network of Service Providers ensuring timely service

coverage, and to reduce unnecessary emergency department utilization.

5. The Division shall require adherence with having written policies and procedures about educating it's Service Provider network regarding Appointment time requirements.

6. The Division shall require:

   a. A corrective action plan be developed when Appointment standards are not met.

   b. A corrective action plan be developed in conjunction with the Service Provider when appropriate.

C. GENERAL APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following Appointment standards are met:

1. For primary care Service Provider Appointments:

   a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition

requires but no later than two business days of request, and

b. Routine care Appointments scheduled within 21 calendar days of request.

2. For specialty Physician Appointments, including dental specialists:

a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days from the request, and

b. Routine care Appointments scheduled within 45 calendar days of referral.

3. For dental Service Provider Appointments:

a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than three business days of request.

b. Routine care Appointments scheduled within 45 calendar days of request.

4. For maternity care Service Provider Appointments:

Initial prenatal care Appointments for enrolled pregnant Members provided as follows:

a. First trimester, Appointments scheduled within 14 calendar days of request;

b. Second trimester, Appointments scheduled within seven calendar days of request;

c. Third trimester, Appointments scheduled within three business days of request; and

d. High risk pregnancies, Appointments scheduled as expeditiously as the Member's health condition requires and no later than three business days of identification of high risk by the AdSS or maternity care Service Provider, or immediately if an emergency exists.

D. PSYCHOTROPIC MEDICATION APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following psychotropic medication Appointment standards are adhered to:

1. Assess the urgency of the need immediately; and
2. Provide an Appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the Member:
   a. Does not run out of needed medications; or
   b. Does not decline in the Member's behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

E. GENERAL BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR THE ADSS

The Division shall require the following general behavioral health

Appointment standards are met:

1. For behavioral health Service Provider Appointments:

   Urgent need Appointments scheduled as expeditiously as the Member's health condition requires but no later than 24 hours from identification of need.

2. Initial assessment:

   Scheduled within seven calendar days after the initial referral or request for behavioral health services.

3. Initial Appointment:

   a. Scheduled within time frames indicated by clinical need.

   b. Scheduled no later than 23 calendar days after the initial assessment for Members age 18 years or older; and

   c. Scheduled no later than 21 days after the initial assessment for Members under the age of 18

years old.

4. Subsequent behavioral health services:

Scheduled as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

F. BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR PERSONS IN LEGAL CUSTODY OF THE ARIZONA DEPARTMENT OF CHILD SAFETY (DCS) AND ADOPTED CHILDREN

1. The Division shall require the following Appointment standards are met:

a. Rapid response:

When a child enters out-of-home placement within the time frame indicated by the behavioral health condition, but no later than 72 hours after notification by the Arizona Department of Child Safety (DCS) that a child has been or will be removed from their home;

b. Initial assessment:

Within seven calendar days after the initial referral or request for behavioral health services;

c. Initial Appointment:

Within time frames indicated by clinical need, but no later than 21 calendar days after the initial assessment; and

d. Subsequent behavioral health services:

Within the time frames according to the needs of the person, but no longer than 21 calendar days from the identification of need.

2. The Division shall require Appointment standards for Members in the legal custody of the DCS and adopted children are adhered to in order to to monitor Appointment accessibility and availability. .

G. SERVICE PROVIDER APPOINTMENT AVAILABILITY REVIEW FOR THE ADSS

1. The Division shall require regular reviews of Service Providers

are conducted to assess the availability of routine and Urgent Appointments for primary care, specialist, dental, and behavioral health Service Providers for Members in the legal custody of the Department of Child Safety (DCS) and adopted children.

2. The Division shall require the review of the availability of routine and urgent Appointments for maternity care Service Providers relating to the first, second and third trimesters, and high risk pregnancies.

3. The Division shall consider an Appointment available to be delivered through telehealth as an available Appointment where clinically appropriate.

4. The Division shall require Service Provider Appointment availability reviews be conducted as a method to ensure sufficient Service Provider network capacity.

5. The Division shall require Provider Appointment availability reviews be conducted for all Service Providers or a statistically relevant sample of Service Providers throughout the Contract year.

6. The Division shall require only using one of these methods at a time for conducting reviews:
   a. Appointment schedule review that independently validates Appointment availability;
   b. Secret shopper phone calls that anonymously validate Appointment availability; or
   c. Other methods approved by AHCCCS .
7. The Division shall supplement the monitoring efforts prescribed in (F)(1) through (F)(6) by targeting specific Providers identified through the following performance monitoring systems:
   a. The 1800 Report,
   b. Quality of care concerns,
   c. Complaints,
   d. Grievances, or
   e. The credentialing process.
8. The Division shall require any plans to change existing methodologies for Appointment availability reviews be submitted

to the Division for approval in the annual NDMP as specified in ACOM Attachment 415-B.

9. The Division shall submit this request to AHCCCSa as specified in the Contract.

H. TRANSPORTATION TIMELINESS REVIEW FOR THE ADSS

1. The Division shall monitor for adherence that medically necessary, non-emergent transportation is provided so a Member arrives on time for an Appointment, but no sooner than one hour before the Appointment, nor have to wait no more than one hour after the conclusion of the treatment for transportation home.

2. The Division shall require the following AHCCCS performance target is met: 95% of all combined completed pickup and drop off trips in a quarter are completed in the time frame specified in section (G)(1) above.

3. The Division shall require compliance with these standards be evaluated on a quarterly basis for all subcontracted transportation vendors orbrokers and require corrective action if

standards are not met.

4. The Division shall require adherence with transportation timeliness standards be monitored.

5. The Division shall require tracking for all scheduled trips that were not completed.

I. TRACKING AND REPORTING FOR THE ADSS

1. The Division shall require adherence in tracking Service Provider compliance with Appointment availability and transportation timeliness as specified in the Contract, the F3 Chart of Deliverables, and outlined below in sections (H)(2) through (H)(4).
2. The Division shall require a cover letter be submitted to AHCCCS with ACOM Attachment 417-A, including all of the following:
    a. A description of the methods used to collect the information;
    b. An explanation of whether all Service Providers in their network or a sample is being surveyed.

c. A sample of the Provider network needs to include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level;

d. A summary of the findings and an explanation of trends in either a positive or negative direction;

e. An analysis of the potential causes for these findings and trends.

f. A description of any interventions applied to areas of concern including, any corrective actions taken.

3. The Division shall require ACOM Attachment 417-B is submitted for each line of business, with a cover letter for each submission including all of the following:

a. A summary of the findings including any identified positive or negative trends for timeliness, incomplete trips, and their reason;

b. An analysis of the potential causes for these findings and

trends; and

c. A description of any interventions applied to areas of concern including, and corrective actions taken.

4. The Division shall require additional corrective action steps are provided for any reporting quarter where the average percentage of all completed trips for that quarter falls below the performance target of 95%. These steps shall include a timeline to meet the performance target of 95% of trips being completed in the time frame specified in section (G)(1) above.

5. The Division shall submit to AHCCCS a copy of ACOM Attachment 417-A and ACOM Attachment 417-B, for each of their AdSS.

6. The Division shall submit to AHCCCS a cover letter containing the information as specified in sections (H)(2) and (H)(3) and their subsections above related to each of their AdSS.

7. The Division shall annually require as a component of the NDMP, the following:

a. Conduct a review of the network sufficiency when there

has been a significant decrease in Appointment availability performance over the previous year;

b. Compare the annual average performance to the previous Contract year's average performance for each standard, Service Provider type and Appointment type subcategory specified within this Policy under the sections for General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards; and

c. Conduct a review of the sufficiency of the Service Provider network for any standard that decreased by more than five percentage points.

SUPPLEMENTAL INFORMATION

For additional information on behavioral health services and behavioral health standards for persons in the legal custody of the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. § 8-512.01, refer to AdSS Policy 449.

418 PROVIDER AND AFFILIATE ADVANCES, EQUITY DISTRIBUTIONS, LOANS, & INVESTMENTS

EFFECTIVE DATE: April 29, 2019

REFERENCES: ACOM 418 Provider and Affiliate Advances, Equity Distributions, Loans, and Investments.

Purpose

This Policy applies to Department of Developmental Disabilities (the Division). This Policy establishes requirements for Division regarding advances, equity distributions loans, loan guarantees, and investments; including but not limited to,-those to providers and related-parties or affiliates including another fund or line of business within the Division's organization.

Definitions

A. Advance - Includes but is not limited to payment to a provider or affiliate by a Contractor which is based on an estimate of Received but Unpaid Claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the Contractor.

B. Affiliate (Related Party) - A party that has, or may have, the ability to control or significantly influence a Division, or a party that is, or may be, controlled or significantly influenced by a Division. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Division and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

C. Affiliate (Related Party) Transactions - Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

D. Day - Calendar day unless otherwise specified.

E. Provider - Any individual or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901

Policy

AHCCCS reserves the right to evaluate and present all proposed Advances, equity distributions, loans, loan guarantees, and investments to the affected Providers(s), related parties, or Affiliates as part of the approval and/or notification process.

All requests must be submitted as specified in the Division Contract. AHCCCS will evaluate all requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. A written determination will be sent to the Division upon review of all required information from the Division.

Provider Advances, loans, and loan guarantees under $50,000 do not require prior AHCCCS approval but will be tracked and made available to AHCCCS upon request. AHCCCS reserves the right to request tracking logs, collection policies, and any pertinent information for all Advances, loans, or loan guarantees.

Individual and Cumulative Provider Advances, Loans, and Loan Guarantees

The Division must submit written notification to AHCCCS of any individual or cumulative Provider loans, loan guarantees, and Advances equal to or in excess of $50,000 per Provider Tax Identification Number (TIN) within a contract year. All requests for prior approval are to be submitted as specified in the Division contract. Prior approval requests must be submitted 10 Days prior to the anticipated date of distribution. All requests for approval must be in the format detailed below:

A. A detailed letter of explanation must be submitted that describes:

1. The Provider(s) name(s) and AHCCCS Identification Number(s),
2. The date the Provider and the Division initiated discussions relating to the need for the loan.
3. The systemic organizational causes resulting in the need for a loan including any mitigation strategies implemented prior to the request.
4. The process that will be used for repayment including the timeline,
5. The contingency plan for repayment should the Provider default on repayment,
6. The corrective action(s) that will be implemented to avoid future occurrences,
7. The total loan amount, and if applicable, the percentage that the Advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.
8. A copy of the written communication that will serve as notification to the affected Provider(s).

B. Upon completion of repayment or six months from the date of AHCCCS approval, whichever comes first, the Division will provide the following information to AHCCCS:

- Provider Name
- AHCCCS Provider ID
- Provider Tax Identification Number
- Date of Payment

- Amount Paid
- Amount Loaned
- Balance Due to/from the Provider

Required documentation for loan guarantees will be determined on an individual basis and communicated to the Division as part of the approval.

Routine or Scheduled Advances, Loans to Providers and Any Advances, or Loans to Affiliates

Routine/scheduled Advances or loans to Providers as a result of contractual arrangements or any Advance or loans to an Affiliate must be submitted to AHCCCS for prior approval. The request for approval must be submitted as specified in the Division contract.

AHCCCS may request additional information or periodic reconciliations related to these Advances.

Routine or Scheduled Advances, Equity Distributions, Loans, Loan Guarantees to Affiliates

The Division must submit a written request for approval to AHCCCS for any Advances, equity distributions, loans, loan guarantees or investments in /to related parties or Affiliates. This includes other funds or lines of business within its organization, within a contract year. Prior approval requests must be submitted 30 days prior to the anticipated date of distribution.

All approval requests must be in the format detailed below:

A. A detailed letter of explanation must be submitted that describes:

- The Related Party or Affiliate Name
- The Amount
- The Type of Request
- The Purpose or Reason for Request
- The Expected Date of Investment or Distribution.

426 CHILDREN'S REHABILITATIVE SERVICES APPLICATION, DESIGNATION AND COVERAGE

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 36-2912; A.A.C. R9-22-1301, A.A.C. R9-22-1302, A.A.C. R9-22-1305

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual Policy 426 Children's Rehabilitative Services Application, Designation and Coverage for the Division policy governing AdSS responsibilities regarding this topic.

431 COPAYMENT

EFFECTIVE DATE: March 25, 2020

Members eligible with the Division of Developmental Disabilities and the ALTCS Program must not be billed copayments for any medical service, including prescriptions. Members are exempt from mandatory and optional copayments.

433 MEMBER IDENTIFICATION CARDS

EFFECTIVE DATE: December 21, 2022
REFERENCES: ACOM Policy 433

PURPOSE

This policy establishes the Division of Developmental Disabilities (Division) requirements regarding the development, approval and distribution of Member Identification Cards (ID Cards) and replacement ID Cards.

DEFINITIONS

1. "834 Enrollment Transaction File" means a nightly transaction file provided by Arizona Health Care Cost Containment System (AHCCCS) to its Contractors. The file identifies newly enrolled members and enrollment changes for existing members.

POLICY

A. PROGRAMMING REQUIREMENTS

1. The Division shall determine the timeliness for issuing ID Cards when a new AdSS initiates services in the state.

2. The Division shall ensure the AdSS provides members with new ID Cards at least 14 calendar days prior to a new DDD health plan going into effect.
3. The Division shall approve the format for a combined ID Card for members dually enrolled in Medicare and the Division. The format for the combined ID Cards must:
    a. Meet the Centers for Medicare and Medicaid Services (CMS) requirements for ID Cards and be approved AHCCCS.
    b. Meet the minimum formatting requirements identified in ACOM Policy 433 Attachment A as applying to ID Cards for members dually enrolled.
    c. Adopt additional formatting features included in this policy or prescribed by CMS for the requirement of an ID Number, if the formatting does not conflict with this policy's minimum requirements.

B. FORMAT OF MEMBER IDENTIFICATION CARDS (ID CARDS)

1. The Division shall ensure ID Cards must meet the format standards outlined in this policy or as specified in ACOM Policy 433 Attachment A. The following formatting standards apply:
   a. The front of the ID card shall include:
      i. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version.
      ii. AHCCCS Logo in the approved color or black and white version no smaller than 1” long by .333” inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The AdSS must not edit or alter the approved logo, except as noted above.
      iii. Arizona Health Care Cost Containment System in Arial font no smaller than 11 points.
      iv. The following information in Arial font no smaller than 8 points:
         1) Member’s name
         2) AHCCCS ID number

3) AdSS name

4) AdSS telephone number

5) TTY/TDY telephone number for members who are deaf or hard of hearing

6) Telephone number for accessing services from the Behavioral Health services

7) The nurse triage telephone number

8) ACC-RBHA statewide crisis phone number

b. The back of the ID card includes:

i. In Arial font no smaller than 7 points:

1) The following text: "Carry this card with you at all times. Present it when you get services. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify health plan benefits, visit: UnitedHealthcare Plan – www.uhc.com

Mercy Care Plan – www.mercycareaz.org

DDD Tribal Health Program (THP) –

DDD Customer Service 1-844-770-9500 ext. 7

2) The following text in the card's mailing to the member if a card holder is not used: "To help protect your identity and prevent fraud, AHCCCS is adding pictures to its online verification tool that providers use to verify your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details."

c. The Division may include additional information on the ID card or card holder identified as appropriate, subject to the approval requirements of this policy.

d. The Division shall include the most recent version of the AHCCCS Notice of Privacy Practices (NPP) with any new ID Card mailing.

C. APPROVAL OF MEMBER IDENTIFICATION CARDS, AND OTHER COMPLIANCE REQUIREMENTS

1. The Division shall ensure the ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items are submitted for prior approval by the AdSS.
2. The Division shall approve ID Cards and other member information for their AdSS subcontractors.
3. The Division shall ensure the AdSS obtains prior approval if more than one version of an ID Card is issued to members.
4. The Division shall ensure the card holder and any letters or information mailed to the member with the ID Card complies with requirements as specified in AdSS Operations Manual, Policy 404.

435 TELEPHONE PERFORMANCE STANDARDS AND REPORTING

REVISION DATE: 03/22/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 435; Attachment A.

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Customer Service Center (CSC). This Policy establishes the Division's standards and reporting requirements regarding the Division's performance when handling Member and provider telephone calls.

DEFINITIONS

1. "Average Speed of Answer (ASOA)" means the average online wait time in seconds that the Member/provider waits from the moment the call is connected in the Division's CSC phone switch until the call is picked up by a Division CSC's representative or Interactive Voice Recognition System.
2. "Daily First Contact Call Resolution Rate (DFCCR)" means the number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed,

divided by the total number of calls received in the 24-hour period.

3. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
4. "Member Grievance" means an expression of dissatisfaction from a Member, responsible party, advocate, etc., with any aspect of a Member's care other than an adverse benefit determination.
5. "Member Inquiry" means a question, request for guidance or direction from a Member, responsible party, advocate, etc., with any aspect of a Member's care other than an adverse benefit determination.
6. "Monthly Average Abandonment Rate (MAAR)" means this is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.
7. "Monthly Average Service Level (MASL)" means the total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls

abandoned calls in the month and all calls receiving a busy signal in the month (if available).

8. "Monthly First Contact Call Resolution Rate (MFCCR)" means the sum of the DFCCRs divided by the number of business days in the reporting period.
9. "Provider Grievance" means a provider's expression of dissatisfaction with unresolved issues. and claims that are older than 30 days from the day of billing.
10. "Provider Inquiry" means any question related to provider matters or issues that can be resolved within the first call or email in less than 30 days, and billing issues including claims less than 30 days from the day of billing.

POLICY

A. TELEPHONE PERFORMANCE STANDARDS

The CSC shall adhere to the following Telephone Performance Standards for Member and provider calls on a monthly basis:

1. The ASOA shall be 45 seconds or less.
2. The MAAR shall be 5% or less.
3. The MFCCR shall be 70% or better.

4. The MASL shall be 75% or better.

B. TELEPHONE PERFORMANCE MEASURES REPORT

1. The CSC shall track performance based on standards noted above and report performance results to the DDD OIFA Administrator.
2. The CSC shall separately document performance for calls of the following types:
   a. Member Calls, and
   b. Provider Calls.
3. The CSC shall submit a monthly Telephone Performance Measures Report to the OIFA Administrator within 15 days after the reporting month.
4. The CSC, if non-compliant with any standard on this deliverable for any given month, shall include in the report steps the CSC shall follow to reduce the noncompliant performance.
5. The CSC shall notify the DDD AHCCCS Contract Compliance Officer when there are unanticipated telephone service interruptions in the toll-free phone system.

C. MEMBER INQUIRIES

1. The CSC shall document all incoming Member Inquiries.
    a. All incoming Member Inquiries shall be resolved within the first communication.
    b. If the issue needs additional follow-up for resolution or assistance, the CSC shall treat it as a Member Grievance.

D. PROVIDER INQUIRIES

1. The CSC shall document all incoming Provider Inquiries.
2. The CSC shall resolve all incoming Provider Inquiries within 30 days from the date of receipt of the inquiry.
3. The CSC shall treat inquiries not resolved within 30 days as a Provider Grievance.
4. The CSC shall identify systemic issues, if any, and document them.
5. The CSC shall inform and elevate systemic issues to the OIFA Administrator, CSC Administrator, and the functional area Deputy Assistant Director or designee.

436 NETWORK STANDARDS

REVISION DATES: 3/27/2024, 4/26/2023, 10/1/2019, 1/16/2019

REVIEW DATE: 9/12/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 § C.F.R. 438.206(b)(1); A.R.S. §§ 32-1201, 32-1901, 36-401 et seq, 36-421 et seq; A.A.C. R9-10, R9-10-101, R9-10-801 et seq, R9-22-101, R9-33-101; ACOM 415; ACOM 436; ACOM 438

PURPOSE

This policy applies to the Division's Network staff. This policy outlines Division Network Standards and the oversight and monitoring of Network Standards.

DEFINITIONS

1. "Adult Developmental Home" or "ADH" means an Alternative Home and Community Based Service (HCBS) Setting for adults (18 or older) with Developmental Disabilities (DD) which is licensed by the Department of Economic Security (DES) to provide room, board, supervision and coordination of habilitation and treatment for up to three residents as specified in A.R.S § 36-551.

2. "Assisted Living Center" or "ALC" means an assisted living facility that provides resident rooms or residential units to eleven or more residents as specified in A.R.S. § 36-401.
3. "Assisted Living Facility" or "ALF" means a residential care institution that provides supervisory care services, personal care services, or directed care services on a continuing basis in compliance with Arizona Department of Health Services (ADHS) licensing criteria as specified in 9 A.A.C. 10, Article 8.
4. "Assisted Living Home" or "ALH" means an ALTCS approved alternative home and community based services (HCBS) setting that provides room and board, and supervision, and coordination of necessary services to 10 or fewer residents.
5. "Attachment A" means, for the purpose of this policy, the ACOM Policy 436 Attachment A - Minimum Network Requirements Verifications Template document that specifies the Network Standards in which the Division and the AdSS are required to meet.
6. "Behavioral Health Outpatient and Integrated Clinic, Adult" means a class of healthcare institution without inpatient beds

that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are age 18 and above

7. "Behavioral Health Outpatient and Integrated Clinic, Pediatric" means a class of healthcare institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are under 18 years of age.
8. "Behavioral Health Residential Facility" or "BHRF" means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:
    a. Limits the individual's ability to be independent, or
    b. Causes the individual to require treatment to maintain or enhance independence.
9. "Cardiologist, Adult" means a medical doctor who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system or patients aged 18 and above.

10. "Cardiologist, Pediatric" means a medical doctor who specializes in the study or treatment of heart diseases and heart abnormalities for patients under the age of 18.
11. "Dentist, Pediatric" means a medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. § 32-1201 for patients under the age of 18.
12. "District" or "Service District" means a section of Maricopa or Pima County defined by zip code for purposes of establishing and measuring minimum Network Standards for Developmentally Disabled (DD) Group Homes and Assisted Living Facilities.
13. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
14. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a

Member enrolled with that Contractor of record, as specified in 9 A.A.C. 22, Article 1 and 9 A.A.C. 28, Article 1.

15. "Group Home" means a community residential setting for not more than six individuals with intellectual/developmental disabilities, that provides room and board and daily rehabilitation and other assessed medically necessary services and supports to meet the needs of each individual as specified in A.R.S. § 36-551.

16. "Home" means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:

    a. Health care institution as specified in A.R.S. § 36-401;

    b. Residential care institution as specified in A.R.S. § 36-401;

    c. Community residential setting as specified in A.R.S. § 36-551; or

d. Behavioral health facility as specified in 9 A.A.C. 20, Articles 1,4,5, and 6.

17. "Hospital" means a class of healthcare institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient. Refer to A.A.C. R9-10-101 et seq. and A.R.S. § 36-401-437.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Multi-Specialty Interdisciplinary Clinic" or "MSIC" means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
20. "Network" means physicians, health care Providers, suppliers and hospitals that contract with an AdSS to give care to Members.
21. "Network Standards" means, as defined in ACOM 436, the requirements the Division and AdSS must meet and monitor to

ensure that all covered services are available and accessible to Members.

22. "Nursing Facility" means, as defined in 42 § U.S.C. 1936r(a):

    a. An institution or a distinct part of an institution that:

        i. Is primarily engaged in providing to residents:

            a) Skilled nursing care and related services for residents who require medical or nursing care;

            b) Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals; or

            c) On a regular basis, health-related care, and services to individuals who, because of their mental or physical condition, require care and services above the level of room and board that can be made available to them only through institutional facilities.

        ii. Is not primarily for the care and treatment of mental diseases; and

        iii. Has in effect a transfer agreement, meeting the requirements of 42 § U.S.C. 1861(l), with one or

more hospitals having agreements in effect under 42 § U.S.C. 1866.

b. Any facility that is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of a Nursing Facility outlined in this section.

23. "Obstetrician/Gynecologist" or "OB/GYN" means a healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs or who possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders.

24. "Pharmacy" means a facility regulated by the State Board of Pharmacy and operating under A.R.S. § 32-1901.

25. "Primary Care Provider (PCP), Adult" means a person who is responsible for the management of the health care of Members who are over 21 years of age. A PCP may be a:

a. Person licensed as an allopathic or osteopathic physician;

b. Practitioner defined as a licensed physician assistant; or

c. Certified nurse practitioner.

26. "Primary Care Physician (PCP), Pediatric" means a doctor or healthcare practitioner who is responsible for the management of the health care of Members who are under 21 years of age.
27. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.
28. "Provider Affiliation Transmission" or "PAT" means a data file that provides details of the Providers within the AdSS's Network and is used to measure compliance with Network adequacy requirements.

POLICY

A. The Division shall monitor and oversee the AdSS for the minimum Network Standards.

B. The Division shall have a Network of Providers in place to meet the minimum Network Standards..

C. The Division shall assess its Network against its entire membership for the purposes of complying with Network Standards, unless otherwise noted.

D. STATEWIDE NETWORK DEFINITIONS AND STANDARDS

1. The Division shall maintain a sufficient Network of Providers to meet the service needs of its Members based upon the minimum Network requirements specified in Attachment A and as specified in the DES/DDD contract with AHCCCS.
2. If the Division delegates Network activities, the Division shall ensure subcontractor compliance with applicable Network Standards.
3. The Division shall document a sufficient Network to meet the service needs of its Members based upon the minimum Network requirements delineated in Attachment A.
4. The Division shall use the table below for defining its Network of Assisted Living Center (ALC), Assisted Living Home (ALH), and DD Group Home Providers to measure compliance with Network Standards:

Provider Category	Applies to	Required Provider Type	Member Population	Standard
Assisted Living Centers (ALC)	ALTCS E/PD and DES/DDD only	49	All	See Attachment A, ALTCS County Tables
Assisted Living Home (ALH)	ALTCS E/PD and DES/DDD only	36	All	See Attachment A, ALTCS County Tables
Group Home for persons with	DES/DDD only	25	All	See Attachment A, ALTCS County

Developmental Disabilities				Tables

5. The Division shall have contracts with a minimum number of DD Group Homes as specified in Attachment A, ALTCS County tables.
6. The Division shall have contracts with a minimum number of ALC and ALH Providers as specified in Attachment A.
7. The Division shall utilize the Attachment A tab that details the minimum Network requirements in each county to report the following minimum Network requirements:
    a. Minimum contracts within a specific city or group of cities;
    b. Contracts within specified distances to specific cities;
    c. Minimum contracts within a county; and
    d. Contracts in locations outside of a county's boundary, if applicable.
8. The Division shall allow Members to access services in the most geographically convenient location possible and to prevent

Members from traveling much greater distances to obtain care, but at the same time accommodate Network availability in each county.

E. COUNTY AND DISTRICT DEFINITIONS

1. The Division shall establish and measure minimum Network Standards for DD Group Homes, ALCs, and ALHs in Maricopa and Pima Counties by utilizing the table of AHCCCS county and District definitions below:

   a. Maricopa County

MARICOPA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Phoenix	85022, 85023, 85024, 85027, 85029, 85032, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331
DISTRICT 2	Carefree, Cave Creek, Fountain	85250, 85251, 85255, 85256, 85257, 85258,

	Hills and Scottsdale	85259, 85260, 85262, 85263, 85264, 85268
DISTRICT 3	Phoenix	85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, 85051, 85253
DISTRICT 4	Phoenix	85003, 85004, 85006, 85007, 85008, 85009, 85025, 85034, 85040, 85041, 85042, 85044, 85045, 85048
DISTRICT 5	Buckeye, Goodyear, Phoenix, Tolleson and Gila Bend	85031, 85033, 85035, 85037, 85043, 85322, 85323, 85326, 85338, 85339, 85353, 85337
DISTRICT 6	Glendale	85301, 85302, 85303,

		85304, 85305, 85306, 85308, 85310
DISTRICT 7	El Mirage, Peoria, Sun City, Sun City West, Surprise and Wickenburg	85275, 85307, 85309, 85335, 85340, 85342, 85345, 85351, 85355, 85361, 85363, 85373, 85374, 85375, 85379, 85381, 85382, 85383, 85387, 85388, 85390, 85395, 85396
DISTRICT 8	Mesa, Tempe	85120, 85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282

DISTRICT 9	Chandler, Tempe, Gilbert, Queen Creek and Sun Lakes	85140, 85142, 85143, 85222, 85224, 85225, 85226, 85233, 85234, 85242, 85243, 85248, 85249, 85283, 85284, 85296, 85297

b. Pima County

PIMA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Northwest	85321, 85653, 85658, 85701, 85704, 85705, 85737, 85739, 85741, 85742, 85743, 85745, 85755
DISTRICT 2	Northeast	85619, 85702, 85712, 85715, 85716, 85718, 85719, 85749, 85750
DISTRICT 3	Southwest	85601, 85614, 85622,

		85629, 85713, 85714, 85723, 85724, 85735, 85736, 85746, 85757
DISTRICT 4	Southeast	85641, 85706, 85708, 85710, 85711, 85730, 85747, 85748

2. The Division shall calculate compliance with minimum Network Standards specified in ACOM 436.

F. NETWORK STANDARD EXCEPTION REQUESTS

1. When the Division has exhausted its efforts to meet any Network Standard specified in this policy, the Division shall request an exception to the Network Standards from AHCCCS as specified in ACOM Policy 436 and the DES/DDD contract that includes the following required elements:
   a. The county or counties covered under the exception request;
   b. The Provider types covered under the exception request;

c. A geospatial analysis showing the current Member access to the Provider types and counties covered under the exception request;

d. An explanation describing why the Division cannot meet the established Network Standard requirements;

e. An explanation of the efforts to contract with non-contracted Providers who could bring the Division into compliance with the Network Standard, including a discussion of the appropriateness of the rates offered to non-contracted Providers;

f. The Division's proposal for monitoring and ensuring Member access to services offered by Provider types under the exception request; and

g. The Division's plan for periodic review to identify when conditions in the exception area have changed, and the exception is no longer needed.

2. The Division, when all efforts to meet Network Standards have been exhausted, shall submit an exception to the Network Standards using the following criteria:

a. The total number of Providers in the same specialty practicing in the county;

b. The geographic composition of the county;

c. Provider willingness to enter into a contract;

d. Consideration of the rates offered to non-contracted Providers to bring the Division into compliance with the standard;

e. The availability of Indian Health Services 638 (IHS/638) contract facilities available to the American Indian population in the county;

f. The availability of alternative service delivery mechanisms available, such as telemedicine, Telehealth, or virtual or mobile services; and

g. The Division's proposal for monitoring and ensuring Member access.

SUPPLEMENTAL INFORMATION

A. MONITORING AND OVERSIGHT OF AdSS NETWORK STANDARDS

1. The Division shall monitor the AdSS to ensure the AdSS has a Network in place for each county in the AdSS's assigned service

area to meet the time and distance standards specified in the table below:

PROVIDER CATEGORY	REQUIRED PROVIDER/SPECIALTY TYPE(S)
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	77 or IC
Behavioral Health Residential Facility (BHRF)	B8
Cardiologist, Adult	08 or 31 with a Specialty Code of 062 or 927
Cardiologist, Pediatric	08 or 31 with a Specialty Code of 062, 151, or 927
Crisis Stabilization Facility	02, 71,B5, B6, B7, or 77 and ICs that are authorized to provide behavioral health observation/stabilization in

	accordance with A.A.C. 9-10-1012
Dentist, Pediatric	07 with a Specialty Code of 800 or 804, C2 Federally Qualified Health Centers (FQHCs) identified by AHCCCS
Hospitals	02 or C4
Nursing Facilities	22
Obstetrician/Gynecologist (OB/GYN)	08, 19, 31, or CN with a Specialty Code of 089, 090, 091, 095, 181, or 219
Pharmacy	03 or 05
Primary Care Provider (PCP), Adult	08 or 31 with a Specialty Code of 050, 055, 060, 089, or 091 or
	19, CN with a Specialty Code of

	084, 095, or 097 or
	18 with a Specialty Code of 798
Primary Care Provider (PCP), Pediatrics	08 or 31 with a Specialty Code of 050 , 150, or 176 or
	19, CN with a Specialty Code of 084 , 087, or 097 or
	18 with a Specialty Code of 798

2. The Division shall monitor for subcontractor compliance with applicable Network Standards if the AdSS delegates Network activities.
3. The Division shall refer to the table below for monitoring AdSS compliance with the following time and distance standards:

PROVIDER CATEGORY	APPLIES TO	MEMBER POPULATION	COUNTY	STANDARD (90% of membership does not need to travel more than)
Behavioral Health Outpatient and Integrated Clinic, Adult*	All Except CHP	18 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	60 miles from their residence
Behavioral Health Outpatient	All*	under 18 years	Maricopa, Pima	15 minutes or 10 miles from their

and Integrated Clinic, Pediatric*				residence
			All Others	60 miles from their residence
Behavioral Health Residential Facility (BHRF)	All	All	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	(Report in Network Plan, Refer to ACOM Policy 415-Attachment B)
Cardiologist, Adult*	All except CHP	21 years or older	Maricopa, Pima	30 minutes or 20 miles

				from their residence
			All Others	75 minutes or 60 miles from their residence
Cardiologist, Pediatric*	All	Under 21 years	Maricopa, Pima	60 minutes or 45 miles from their residence
			All Others	110 minutes or 100 miles from their residence
Crisis Stabilization Facility	ACC-RBHA Only	All	Maricopa, Pima	15 minutes or 10 miles from their

				residence
			All Others	45 miles from their residence
Dentist, Pediatric	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Hospitals	All	All	Maricopa, Pima	45 minutes or 40 miles from their residence
			All Others	95 minutes

				or 85 miles from their residence
Nursing Facilities	ALTCS E/PD Only	Living in Own Home	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	95 minutes or 85 miles from their residence

Obstetrician /Gynecologist (OB/GYN)	All	15 to 45 years old	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	90 minutes

				or 75 miles from their residence
Pharmacy	All	All	Maricopa, Pima	12 minutes or 8 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Adult*	All Except CHP	21 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles

				from their residence
Primary Care Provider (PCP), Pediatrics*	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence

4. When monitoring the AdSS for compliance with Network Standards, the Division shall ensure Provider types marked with an asterisk are:
   a. Eligible for a telehealth standard modification; and
   b. Require 80 percent of a county's membership to meet these time and distance standards in any county where telehealth services are available for the Provider category.

5. The Division shall monitor Network Standards of AdSS contracts with Multi-Specialty Interdisciplinary Clinics (MSICs) in the assigned Geographic Service Area (GSA) in the state, as well as any MSICs which have provided services to the AdSS's Members.

B. NETWORK STANDARD REQUESTS FOR EXCEPTIONS FROM THE AdSS

1. The Division shall review Network Standard exception requests submitted by the AdSS and make a determination based on the following criteria:
   a. The total number of Providers in the same specialty practicing in the county;
   b. The geographic composition of the county;
   c. Provider willingness to enter into a contract;
   d. Consideration of the rates offered to non-contracted Providers to bring the AdSS into compliance with the standard;
   e. The availability of Indian Health Services 638 contract (IHS/638) facilities available to the American Indian population in the county;

f. The availability of alternative service delivery mechanisms available, such as telemedicine, Telehealth, or virtual or mobile services; and

g. The AdSS's proposal for monitoring and ensuring Member access.

2. Minimum Network Standards Reporting Requirements

a. The AdSS shall submit a completed Attachment A reporting its compliance with the applicable standards in this policy. Attachment A shall be submitted as specified in the contract. The AdSS shall report compliance with these requirements for each county in its assigned service area. A separate report shall be submitted for each line of business. For purposes of calculating and reporting this data:

i. The AdSS shall use its enrollment and its Network as of the last day of the reporting period (March 31 and September 30);

ii. The AdSS shall report the percentages in Attachment A, 'Time and Distance' tab rounded to the nearest tenth of a percent; and

iii. The AdSS shall report 'N/R' (None Reported) for each time and distance standard, instead of a percentage, where there are no Members meeting the population criteria in the county.;

iv. The AdSS shall report in Attachment A, "Time and Distance" tab, whether or not telehealth services are available in each county reported for each pProvider type eligible for a telehealth standard modification by the AdSS. This is identified by adding a 'Y' or 'N' in the "Telehealth Available (Y/N)" row underneath the Provider type; and

v. The AdSS shall consider in its dental Network any contracted FQHC identified annually by AHCCCS as providing dental services.

b. The AdSS shall analyze compliance with Network Standards based upon the Provider Network reported

through the Contractor Provider Affiliation Transmission (PAT) and available Electronic Visit Verification (EVV) data as required in AdSS Medical Policy 542. With the submission of Attachment A, the AdSS shall include a summary including, at a minimum, the following:

i. The AdSS strategies and efforts to address any areas of non-compliances;

ii. A summary of exceptions granted to the Network Standards specified in this pPolicy; and

iii. The results of the AdSS's monitoring of Member access to the services governed under the exception.

c. As specified in the contract, the AdSS shall submit a completed Attachment A including a summary analysis of any areas of non-compliance with Network Standards specified in this policy, including strategies and efforts to address areas of non-compliance.

3. Network Plan Requirements

a. The AdSS shall take steps to ensure Network Standards are maintained. If established Network Standards cannot

be met, the AdSS shall identify these gaps and address short- and long-term interventions in the Network Development and Management Plan (NDMP) as outlined in AdSS Operations Policy 415. When an exception has been granted, the AdSS shall address the sufficiency of Member access to the area and assess the continued need for the exception.

b. The AdSS shall report to the Division its Network gaps and short- and long-term interventions to address the gaps, in its NDMP as specified in AdSS Operations Policy 415.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS

REVISION DATE: 3/27/2024, 2/16/2022

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901, ACOM Policy 317, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, CMS document SMDL 09-001.

PURPOSE

This policy establishes guidelines and requirements for Administrative Services Subcontractors (AdSS) or Management Service Agreement (MSA), and monitoring subcontractor performance, reporting performance review results, and notifying AHCCCS of subcontractor non-compliance and corrective action plans (CAPs). Unless otherwise stated, requirements outlined in this policy for Administrative Services Subcontractors also apply to MSA.

DEFINITIONS

1. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Division's contract with AHCCCS, including:
    a. Claims processing, including pharmacy claims;
    b. Pharmacy Benefit Manager (PBM);

c. Dental Benefit Manager;

d. Credentialing, including those for only primary source verification;

e. Medicaid Accountable Care Organization (ACO);

f. Service Level Agreements with the Division or one of its subcontractors; and

g. CHP and DES/DDD Subcontracted Health Plan.

2. "Attachment A" means the Attachment A of the Administrative Services Subcontract Checklist. It is the AHCCCS deliverable template.

3. "Change in Organizational Structure" means any of the following:

a. Merger

b. Acquisition

c. Reorganization

d. Change in Articles of Incorporation

e. Joint Venture

f. Change in Ownership

g. Change of Management Services Agreement (MSA) Subcontractor

h. Other applicable changes that may cause:

i. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

ii. Changes in critical Member information, including the website, Provider handbook and Member ID card

iii. A change in legal entity name.

4. "Corrective Action Plan" or "CAP" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor or its Providers, to enhance Quality Management or Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

5. "Day" means a calendar day, unless otherwise specified.

6. "Management Service Agreement" or "MSA" means a type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.

7. "Medicaid Accountable Care Organization" or "ACO" means an entity that enters into a Value-Based Purchasing (VBP) arrangement with a Contractor which:
    a. Improves the health care delivery system by increasing the quality of care while reducing costs.
    b. Enters into VBP contracts with Provider groups or networks of groups.
    c. Coordinates Provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM), combined with quality incentives to ensure both quality outcomes and cost containment.
    d. Supports Providers participating in APMs by providing services such as data analytics, technical assistance, Provider education, and Provider recruitment.
    e. Operates as an intermediary between the Contractor and Providers, but not as a Provider of direct services to Members.

f. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS.

8. "Member" means the same as "client" as defined in A.R.S. § 36-551.

9. "Provider" means any person or entity that contracts with the Division or the AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a Provider delivering services pursuant to A.R.S. § 36-2901.

   a. Qualified Vendors are Providers.

   b. Providers are not Administrative Services Subcontractors.

10. "Quality of Care" or "QOC" means an expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

11. "Request for Proposal" or "RFP" means a document prepared by AHCCCS that describes the services required and that instructs a prospective Offeror how to prepare a response.

12. "Subcontractor" means:

    a. A provider of health care who agrees to furnish covered services to Members.

    b. A person, agency or organization with which the Contractor, or its subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

    c. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease or leases of real property to obtain space, supplies equipment or services provided under this Contract with the Division.

POLICY

A. APPROVAL OF SUBCONTRACTS

1. The Division shall submit an unredacted copy of all Management Service Agreements (MSA) and Administrative Services Subcontracts with the proposed Subcontract Checklist to the AHCCCS Division of HealthCare Management for prior approval, 60 days before the effective date of the subcontract.
2. The Division shall retain the authority to direct and prioritize

any delegated contract requirements.

3. The Division shall require that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS.
   a. The Division shall require that the AdSS notify a change in Organizational Structure of Administrative Services Subcontractor.
   b. The Division shall review the notification and determine if a complete Attachment A submission is required.
   c. If a complete Attachment A submission is required, the Division shall follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this policy.
4. The Division shall ensure the MSA contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of AHCCCS.
5. The Division shall ensure that any reorganization related to an MSA Subcontractor is submitted in accordance with ACOM Policy 317.
6. The Division shall:

a. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the public including any RFP amendments.

b. Submit final, signed copies of each contract that it enters into with subcontractors and any subsequent amendments within 30 days of e-signature date.

c. Ensure its subcontractors communicate with the Provider network regarding program standards, and changes in laws, policies, and contract.

d. Submit a cover letter that contains a high-level summary of the proposed changes when providing an amendment to an Administrative Services Subcontract.

B. MONITORING AND REPORTING

1. The Division shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and complete a formal review at least annually as outlined in 42 CFR 438.230.

2. In the formal review, the Division shall conduct a review of delegated duties, responsibilities, and financial position with the exception that the Division shall not conduct a financial

review of Administrative Services Subcontractors who are state agencies or sovereign nations.

a. The Division shall prepare written findings of the review.

b. The Division shall require the subcontractor to prepare a written response to findings of non-compliance.

c. The Division shall increase monitoring activities until compliance is achieved and maintained.

d. The Division shall notify AHCCCS within 30 days of the discovery of an Administrative Service Subcontractor's non-compliance with the following information:

    i. The subcontractor's name

    ii. Delegated duties and responsibilities

    iii. Identified areas of non-compliance and whether the non-compliance affects Member services or causes a quality of care concern

    iv. The scope and estimated impact of the non-compliance upon Members

    v. The known or estimated length of time that the subcontractor has been in non-compliance

vi. The Division's Corrective Action Plan (CAP) or strategies to bring the Administrative Services Subcontractor into compliance

vii. Sanction actions that may be taken because of the non-compliance

viii. The Division's activities that are occurring to bring the subcontractor into compliance.

C. ADMINISTRATIVE SERVICES SUBCONTRACTOR EVALUATION REPORT

1. The Division shall submit the annual Administrative Services Subcontractor Evaluation Report within 90 days of the start of the AHCCCS contract.
2. The Division shall ensure that the Administrative Services Subcontractor Evaluation Report includes the following:
   a. The name of the subcontractor
   b. The delegated duties and responsibilities
   c. The date of the most recent formal review of the duties, responsibilities, and financial position, as appropriate, of the subcontractor
   d. A comprehensive summary of the evaluation of the

operational and financial, as appropriate, performance of the subcontractor, including the type of review performed

e. The next scheduled formal review date

f. All identified areas of deficiency that:

   i. Affect Member services, or

   ii. Cause a quality of care concern

g. CAP Information, including:

   i. A detailed description of the reasons the subcontractor was placed on a CAP.

   ii. A description of the steps taken by the Subcontractor to address the CAP.

   iii. Date CAP reported to AHCCCS.

   iv. Current status and expected completion time of CAPs.

D. ADDITIONAL REQUIREMENTS

1. Before entering into an Administrative Services Subcontract, the Division shall evaluate the prospective Administrative Services Subcontractor's ability to perform the delegated duties.

2. The Division shall ensure that all Administrative Services

Subcontracts reference and with the Minimum Subcontract Provisions available on the AHCCCS website.

3. In the event of a modification to the AHCCCS Minimum Subcontract Provisions, the Division shall issue a notification and amend Administrative Services Subcontracts within 30 calendar days of the published change and ensure amendment of any affected subcontracts as needed.
4. The Division shall amend the affected Administrative Services Subcontracts on the regular renewal schedule or within six calendar months of the update, whichever comes first.
5. The Division shall ensure that all Administrative Services Subcontracts reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and State Medicaid Director Letter (SMDL) 09-001.
6. The Division shall ensure that the Administrative Services Subcontractors disclose to the Division and AHCCCS/Office of the Inspector General (OIG) the identity of any person excluded from the requirements outlined in subsection (5) of this section.

7. The Division shall ensure that all Administrative Services Subcontracts entered into by the Division are reviewed and approved by AHCCCS.
8. The Division shall ensure that all Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.
9. The Division shall maintain a fully executed original or electronic copy of all Administrative Services Subcontracts and make them accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.
10. The Division shall ensure that all Member communications related to the Medicaid line of business issued by the Administrative Services Subcontractor include the Division's name and comply with Member notification requirements specified in AdSS Operations Policy Manual, policy 404.
11. If the Division terminates the Administrative Services Subcontract, the Division shall ensure compliance with all aspects of the AHCCCS Contract notwithstanding the Administrative Services Subcontractor termination, including

availability of and access to all covered services and provision of covered services to Members within the required timeliness standards.

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: June 10, 2016
REFERENCES: 9 A.A.C. 22, Article 1; 42 CFR 438.207, 42 CFR 438.10(f) (4), 42 CFR 438.10(f) (5).

The Division ensures that performance and provider network standards are met to support a member's needs, as well as the needs of the membership as a whole. Changes to business operations or to the provider network are evaluated for the impact to members and providers.

Identifying A Provider Network and/or Business Operations Material Change

A. For changes impacting members and/or providers, the Division evaluates the impact of the change by geographical service area and as a whole using established criteria and/or methodology for determining the impact of the change.

B. Provider Network changes may include, but are not limited to:

1. Changes in services,
2. Geographic service areas, or
3. Payments.

C. Changes may also include the addition or change in:

1. Pharmacy Benefit Manager (PBM),
2. Dental Benefit Manager,
3. Acute Health Plan,
4. Provider Contracts (e.g. group homes, nursing facility), and
5. Any other delegated agreements.

D. Business Operations changes may include, but are not limited to:

1. Policy,
2. Process, and
3. Protocol, such as prior authorization or retrospective review.

E. Changes may also include the addition or change in:

1. Claims Processing system,

2. System changes and upgrades,

3. Member ID Card vendor,

4. Call center system,

5. Management Service Agreement (MSA), and

6. Any other Administrative Services Subcontract.

F. The Division will submit approval for a material change to AHCCCS, at least 60 days in advance of the material change.

G. Any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided will be communicated to affected providers at least 30 days in advance of the change as identified in Operations Policy Manual Chapter 60, Notification to Providers.

H. The Division will provide written notice to members within 15 days after receipt or issuance of a provider termination notice.

General Notifications

A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:

1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration.

2. For routine changes and updates to Division Guidelines, Policy/Provider Manual.

3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change.

4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.

B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.

C. Communication with Independent Providers is via US mail.

D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.

446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

REVISION DATE: 10/01/2021, 12/04/2019
EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Contractor Operations Manual (ACOM), Policy 446

This Policy applies to the Division of Developmental Disabilities and their subcontractors and outlines procedures related to grievances and investigations conducted by AHCCCS and the subcontractors under A.A.C. R9-21-402 et seq. concerning persons with a Serious Mental Illness (SMI).

A. This Policy applies to grievances or requests for investigation asserted by, or on behalf of, persons designated with a SMI to the extent the allegation asserts a violation relating to the right to receive services, supports and/or treatment that are state-funded and are no longer funded by the state.

   1. For persons designated as SMI, AHCCCS, the Division, and its subcontractor conduct investigations into allegations of physical abuse, sexual abuse, violations of SMI rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a member's death that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

      a. Refer to *AHCCCS Contractor Operations Manual, Chapter 400-Operations, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness* for full details and requirements of such grievance investigations.

   2. AHCCCS, or the Contractor before whom a grievance or request for investigation is pending, must immediately take whatever action may be reasonable to protect the health, safety, and security of any member, complainant, or witness.

B. Grievances involving an alleged rights violation, or a request for investigation involving an allegation where a condition requiring investigation exists, which occurred in an agency operated by a Division Subcontractor or one of its subcontracted providers and which does not involve a member's death or an allegation of physical or sexual abuse, must be filed with and investigated by the subcontractor.

C. The DDD Customer Service Center must refer any grievances or requests for investigation related to physical or sexual abuse or death to AHCCCS to begin the investigative process.

D. Support Coordinators must complete *DDD-2044A FORENG (11-19) Serious Mental Illness Grievance and Appeal Form* and send the form to DDD Customer Service Center (CSC) for the Division's internal use when a member with an SMI designation wants to file a grievance or appeal. This serves as the Division's notice of the grievance and appeal. The notice will allow the Division to effectively monitor the grievance or appeal and ensure it is resolved by the proper entity and within the

required timeframe.

E. Once notified, CSC will open a grievance in the Resolution System (RS) for violations related to member's rights.

1. The grievance procedure must follow the same procedure as other CSC grievances.

2. The purpose of this grievance policy is to ensure the subcontractor is investigating the matter properly and in a timely fashion, pursuant to the clauses outlined in the *AHCCCS Operations Manual, Chapter 400, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness.*

F. A grievant or the DDD member who is the subject of the grievance, who disagrees with the final decision of the subcontractor may file a request for an administrative appeal with AHCCCS within 30 days from the date of their receipt of the subcontractor's decision. The request for administrative appeal must specify the basis for disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the subcontractor decision.

G. When an administrative appeal is filed, the subcontractor must forward the full investigation case record, which includes all elements described in A.A.C. R9-21-409(D)(1), to AHCCCS. The failure of the subcontractor to forward a full investigation case record that supports the subcontractor's decision may result in a summary determination against the subcontractor. The subcontractor must prepare and send with the investigation case record, a memo which states:

1. Any objections the subcontractor has to the timeliness of the administrative appeal,

2. The subcontractor's response to any information provided in the administrative appeal that was not addressed in the investigation report, and

3. The subcontractor's understanding of the basis for the administrative appeal.

H. If an extension of any time frame related to the grievance process is needed, it must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:

1. The subcontractor investigator or any other subcontractor official responsible for responding to grievances must address the extension request to the subcontractor Director or designee.

2. The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address the extension request to the AHCCCS Deputy Director or designee.

3. A subcontractor request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance must be addressed to the AHCCCS Deputy Director or designee.

4. Requests for extension must be in writing, with copies to all parties.

5. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the member.

6. The request must explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.

7. Such request must be submitted to and acted upon prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed constitutes a denial of the request for an extension.

I Within 15 days of receipt of a timely filed administrative appeal, AHCCCS must review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and must prepare a written, dated decision.

1 A grievant or person who is the subject of the grievance who is dissatisfied with a decision of AHCCCS may request an administrative hearing before an administrative law judge within 30 days of the date of receipt of the decision.

II DDD Tribal Health Program (THP) who serve members that are diagnosed with an SMI diagnosis will follow the same grievance process as outlined above.

III In addition to a grievance or request for investigation which may be filed pursuant to this Policy and A.A.C. Title 9, Chapter 21, Article 4, a separate investigation into the death of a person receiving services must be conducted as described in AMPM Policy 960.

I Grievance Investigation Records: AHCCCS and the subcontractor will maintain records in the following manner:

1 All documentation received related to the grievance and investigation process will be date stamped on the day received.

2 A complete grievance investigation case record must be maintained for each case.

3 Copies of all information generated or obtained during the investigation.

4 All grievance and investigation files in a secure designated area and retain for at least five years.

5 A public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

6 Confidentiality and privacy of grievance and investigations records.

7 The complete grievance investigation case must include:

a The original grievance/investigation request letter and the AHCCCS Appeal or SMI Grievance Form, and

b Copies of all information generated or obtained during the

investigation.

8. The investigator's report that includes:

   a. A description of the grievance issue,

   b. Documentation of the investigative process,

   c. Names of all persons interviewed,

   d. Written documentation of the interviews,

   e. Summary of all documents reviewed,

   f. The investigator's findings.

   g. Conclusions and recommendations.

   h. A copy of:

      i. The acknowledgment letter,

      ii. Final decision letter,

      iii. Corrective action documentation, and

      iv. Any information/documentation generated by an appeal of the grievance decision.

449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

REVISION DATE: 6/29/2022

EFFECTIVE DATE: November 29, 2018

REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division). The purpose of this policy is to ensure the timely provision of behavioral health services to children eligible for Title XIX services who are residing with an out-of-home caregiver or children in out-of-home dependency with the Department of Child Safety (DCS), as specified throughout this policy, and to adopted children in accordance with A.R.S. § 8-512.01.

This policy delineates the Division's roles and responsibilities with respect to oversight of the Administrative Services Subcontractors (AdSS) and the Division's role with respect to support coordination.

DEFINITIONS

Adoptive Parent means any adult who is a resident of Arizona, whether married, unmarried, divorced or legally separated, who has adopted a child. For purposes of this policy, the adoptive parent is that of a child who is eligible under Title XIX of the Social Security Act.

Arizona Department of Child Safety (DCS) means the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.

2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.

3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.

4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Behavioral Health Out-of-Home Treatment means highly individualized treatment services and support interventions to meet the needs of each child and their family. 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. The primary goal of out-of-home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to his/her home and community settings.

Crisis means an acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

Crisis Services means services that are community based, recovery-oriented, and member focused that work to stabilize members as quickly as possible to assist them in returning to their baseline of functioning.

Member for purposes of this policy includes children residing with out-of-home caregivers, children in out-of-home dependency with DCS, and adopted children.

Out-of-Home Caregiver for purposes of this policy is where a child in DCS custody resides (i.e., kinship care, foster care, a shelter care provider, a receiving home, independent living program or group foster home).

Rapid Response is a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health needs and to refer the child for additional assessments through the behavioral health system.

POLICY

The Division delegates the responsibility to AdSS for the implementation of behavioral health services in alignment with this policy, and whose contract includes this requirement. The Division remains responsible for support coordination and oversight of the AdSS. (Refer to AdSS Operations Policy 449 for AdSS responsibilities.) The Division shall ensure timely provision of all behavioral health services for members enrolled with the AdSS. The Division shall ensure the AdSS provide coordinated care between the out-of-home caregiver or adoptive parent(s), all providers, and DCS, as appropriate.

A. GENERAL REQUIREMENTS

1. To meet the needs of members residing with an out-of-home caregiver, children in out-of-home dependency with DCS, and

adopted children, the Division shall:

a. Ensure services delivered through the AdSS are provided as specified in AdSS Operations Policy 417, and

b. Ensure the AdSS has availability of a telephone line, with designated staff, adequately trained on the provisions of this policy and the procedures in place to address calls.

B. REQUEST FOR BEHAVIORAL HEALTH OUT-OF-HOME TREATMENT

The Division shall ensure AdSS compliance with the following:

1. After a request is made to place a member in behavioral health out-of-home treatment, the AdSS shall issue a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include, but are not limited to, Behavioral Health Facilities as specified in A.A.C R9-10-101. If the AdSS determines there is insufficient information to make a determination, the AdSS shall document all substantive efforts to obtain required information within the 72-hour timeframe. If the request for behavioral health out-of-home treatment is denied, the AdSS shall ensure medically necessary alternative services are provided. BHRF denials by the AdSS shall be sent to the Division Utilization Management Unit for secondary review by the Division's Behavioral Health Medical Director. The Behavioral Health Medical Director shall review and may approve or overturn the denial from the AdSS.

2. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment, the AdSS shall coordinate with the hospital, Support Coordinator and Child and Family Team (CFT) to ensure an appropriate and safe discharge plan. The discharge plan shall include recommended follow-up services, including recommendations made by the CFT. For additional requirements regarding discharge planning refer to AMPM 1020.

3. The AdSS shall collaborate with DCS and the Support Coordinator to ensure an appropriate alternative for the member to be discharged when

    a. It is unsafe for the member to return to the out-of-home caregiver or adoptive parent(s), and/or

    b. It is unsafe for the out-of-home caregiver or adoptive parent(s) for the member to return.

4. The AdSS shall issue a Notice of Adverse Benefit Determination (NOA) as specified in AdSS Operations Policy 414 for any adverse action related to the request for any adverse action related to the request for behavioral health out-of-home treatment.

5. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria were not met but there was not a safe discharge plan in effect to meet the needs and safety of the member and the out-of-home caregiver or adoptive parents. In

these cases, the AdSS is responsible for payment regardless of principal diagnosis on the claim and may negotiate with the hospital for an appropriate rate.

C. BEHAVIORAL HEALTH APPOINTMENT STANDARD

The Division shall ensure AdSS compliance with the following:

1. Upon notification from an out-of-home caregiver or adoptive parent that a recommended behavioral health service is not provided to a member (as specified in AdSS Operations Policy 417), the AdSS shall:

    a. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to the Health Plan Customer Service (Mercy Care 800-624-3879 and United Healthcare 800-348-4058), as applicable;

    b. Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the AdSS;

    c. Obtain the name and contact information of the identified non-contracted provider of service, if applicable, to verify their AHCCCS registration; and

    d. Obtain information needed to determine medical necessity of requested services not received.

2. For services provided by a non-contracted provider, the AdSS shall:

a. Not deny claims submitted based solely on the billing provider being out of network, and

b. Reimburse clean claims at the lesser of 130% of the AHCCCS Fee-For-Service Rate or the provider's standard rate and as specified in AdSS Operations Policy 203.

c. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

D. EDUCATION

The Division shall ensure AdSS compliance with the following:

1. The AdSS is responsible for providing education to providers, Primary Care Physicians, members, families, CFT members and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to the following areas:

   a. Rights and responsibilities as delineated in A.R.S. §8-512.01,

   b. Trauma-informed care,

   c. Navigating the behavioral health system,

   d. Coordination of care as specified in this policy,

   e. Covered services,

   f. Referral process including Arizona Families First (Family in Recovery Succeeding Together; AFF),

g. The role of the AdSS,

h. The role of DCS as applicable, and

i. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

2. The AdSS shall provide training and education to primary care providers regarding the behavioral health referral process.

3. All AdSS member information shall meet the requirements of AdSS Operations Policy 404.

4. The Division reserves the right to verify education programs when performing oversight of the AdSS. AHCCCS reserves the right to verify education programs when performing a review of the Division.

E. REQUIREMENTS FOR CHILDREN IN THE CUSTODY OF DCS

In addition to the requirements above, the Division shall ensure the AdSS meets the requirements included in this section:

1. Telephone Line

a. Ensure the availability of a telephone line, with designated staff, that is responsible for handling incoming calls after business hours related to delivery of services, including failure of an assessment team to respond within two hours, and

b. Designated staff shall be adequately trained on the

provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There shall be processes in place for staff to:

i. Address barriers to care,

ii. Directly contact the crisis services vendor and/or provider,

iii. Track and report calls as specified throughout Policy, and

iv. Report the above information to the Children Services Liaison.

2. Continuity of Services

a. The AdSS is responsible for continuation and coordination of services the member is currently receiving.

b. If the member moves into a different county because of the location of the out-of-home caregiver, the AdSS must allow the member to continue any current treatment in the previous county and/or seek any new or additional treatment in the current county of residence regardless of the AdSS provider network.

3. Children Services Liaison

a. The AdSS shall designate an individual whose role is to serve as the member's single point of contact for accepting and responding to:

i. Inquiries from the out-of-home caregiver, adoptive parent, or providers,

ii. Issues and concerns related to the delivery of and access to behavioral health services for members,

iii. Collaborate with the out-of-home caregiver and adoptive parents to address barriers to services, including nonresponsive crisis providers, and

iv. Resolve concerns received in accordance with grievance system requirements.

b. The Children Services Liaison shall:

i. Provide the number for crisis services and after-hours telephone line in their outgoing voicemail message and email;

ii. Provide an expected timeframe for return calls in their outgoing voicemail message and email;

iii. Respond to all inquiries as indicated by need or safety but no later than one business day; and

iv. Follow up on all calls received by the after-hours telephone line.

c. The Division shall ensure the AdSS Children Services Liaison contact information is:

i. Provided to AHCCCS and DCS for distribution,

ii. Prominently placed on the member page of the AdSS' website, and

iii. Included in the Member Handbook.

d. The AdSS shall ensure calls received by the Children Services Liaison that meets the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

F. TRACKING AND REPORTING

1. The Division shall conduct ongoing oversight of the AdSS through a review of the following reporting to ensure compliance with this policy:

   a. Monitor, as specified in the AHCCCS Contract, an Access to Services Report using Attachment A to ACOM 449.

   b. Monitor and submit, as specified in the AHCCCS Contract, the number of calls and emails received by the AdSS Children Services Liaisons and the after-hours line related to children residing with out-of-home caregiver or children in out-of-home dependency with DCS specific to this policy (Attachment B to ACOM 449), and

   c. Monitor and submit, as specified in the AHCCCS Contract, a Rapid Response Reconciliation reporting all Rapid Response information for children in DCS custody (Attachment B). The Division shall ensure the AdSS perform a reconciliation of members placed in DCS custody

in contrast to those who have received a Rapid Response service. For any identified members in DCS custody who have not been engaged in behavioral health services, the AdSS shall ensure a Rapid Response service is delivered. For any identified members in DCS custody who are already receiving or otherwise are engaged in behavioral health services, the AdSS shall ensure an assigned service provider contacts the member and caregiver to conduct an assessment of the current status.

G. DIVISION OVERSIGHT OF AdSS:

The Division shall conduct oversight activities including, but not limited to the following methods to ensure compliance with this policy and policies referenced within this policy:

1. Annual Operational Review of related standards, including but not limited to:
    a. AdSS has policies and procedures in place and demonstrates compliance with them to ensure members in foster care receive behavioral health services in alignment with this policy and AdSS 417.
    b. AdSS demonstrates compliance with the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.
    c. AdSS provides evidence of training and education provided to primary care providers regarding the

behavioral health referral process.

d. AdSS monitors for evidence in the medical record and the member's individual service plan that medically necessary services were determined by a qualified behavioral health professional.

2. Receive and review deliverable reports to ensure compliance and address service gaps or non-compliance. Submit collated data received from the AdSS and submit reports as required by contract to AHCCCS.

3. Conduct a cadence of oversight meetings with each AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.

4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

1001-A RIGHTS AND RESPONSIBILITIES OF INDIVIDUALS SUPPORTED BY THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATE: 1/3/2024, 4/21/2023, 7/3/2015

REVIEW DATE: 6/23/2023

EFFECTIVE DATE: July 13, 1993

REFERENCES: A.R.S. § 36-551.01, A.R.S. § 41-3801, A.R.S. § 41-1492 et seq., A.R.S. § 41-1959; A.A.C. R9-21-211; A.A.C. R6-6-102; R6-6-104, R6-6-107, R6-6-108, R6-6-804, R6-6-901, R6-6-901-910 et seq., R6-6-1801 et seq., R6-6-1114

PURPOSE

To identify the rights and responsibilities that an individual has by virtue of being enrolled in programs operated or overseen by the Division of Developmental Disabilities (Division or DDD).

DEFINITIONS

1. "Individualized Family Service Plan" or "IFSP" means a written plan for providing early intervention services to an infant or toddler with a disability and the child's family that (a) is based on the evaluation and assessment; (b) includes parental

consent; c) is implemented as soon as possible once parental consent is obtained; and (d) is developed in accordance with IDEA Part C.

2. "Person-Centered Service Plan" or "PCSP" means a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

3. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important

to the Member in meeting the identified needs and preferences for the delivery of such services and supports.

4. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. MEMBER RIGHTS

1. The Division shall recognize that an individual with a developmental disability has the same rights, benefits, and privileges guaranteed by the constitutions and laws of the United States and the State of Arizona, including the:

   a. Right to exercise their rights as a citizen;

   b. Right to participate in social, religious, educational, cultural, and community activities;

   c. Right to own, rent, or lease property;

   d. Right to marry and have children;

   e. Right to be free from involuntary sterilization;

f. Right to express human sexuality and receive training as appropriate;

g. Right to consume alcoholic beverages if 21 years of age or older unless contraindicated by orders of their primary care provider or the court;

h. Right to the presumption of legal competency in guardianship proceedings;

i. Right to own and have free access to personal property;

j. Right to associate with persons of their own choosing;

k. Right to manage personal financial affairs and to be taught to do so;

l. Right to the least amount of physical assistance necessary to accomplish a task;

2. The Division shall recognize the following additional rights of an individual with a developmental disability receiving supports and services through the Division:

a. Right to be treated fairly regardless of race, ethnicity, culture, national origin, ancestry, religion, gender identity or expression, age, health, social origin or condition, creed, behavioral condition (intellectual) or physical disability, sexual orientation, genetic information, marital status, medical condition, or ability to pay;

b. Right to be treated with respect and with due consideration for their dignity and privacy by DDD staff and providers;

c. Right to a safe, clean, and humane physical environment;

d. Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

e. Right to protection from physical, verbal, sexual, psychological, or financial abuse, punishment, neglect, or exploitation;

f. Right to be free from overcorrection or the application of noxious stimuli as a negative consequence of a behavior;

g. Right to know who their Support Coordinator is and how to request a new Support Coordinator;

h. Right to an initial Person Centered Service Plan or Individualized Family Services Plan (PCSP or IFSP) planning document prior to receiving supports and services;

i. Right to participate and share in decision-making once approved and to receive a written PCSP or IFSP based upon relevant assessment results;

j. Right to participate in the PCSP or lFSP, periodic evaluations, and whenever possible, the opportunity to select among appropriate alternative supports and services;

k. Right to a periodic review of the PCSP or IFSP planning document;

l. Right to be supported by the organization to collaborate on decisions with their case manager;

m. Right to be informed of all case management services available, even if a service is not covered, and to discuss options with their case manager;

n. Right to be provided choices and to express individual preferences that will be respected and accepted;

o. Right to be given information in a way they can understand;

p. Right to have interpreter services or documents translated into their primary language;

q. Right to be given written notice of their rights in their primary language, in a manner that can be easily understood in the primary mode of communication, if possible;

r. Right to live in the least restrictive setting. A least restrictive setting refers to an environment in which a member strives to reach their full potential in accordance to the tenets of self-determination;

s. Right to equal employment opportunities based on the member's ability to meet qualifications;

t. Right to fair compensation for labor;

u. Right to be free from unnecessary and excessive medication. Medication shall not be used as punishment, for the convenience of the staff, as a substitute for a PCSP or IFSP, or in quantities that interfere with the member's PCSP or IFSP;

v. Right to be accorded privacy when receiving mail, during visits and telephone conversations;

w. Right to be accorded privacy during personal care, medical treatments, or personal discussions;

x. Right to confidentiality of information and medical records;

i. Have personally identifiable data and medical information kept confidential;

ii. Know what entities have access to their information;

iii. Know procedures used by DDD to ensure their security, privacy and confidentiality.

z. Right of a school-age member to receive publicly-supported educational services;

aa. Right of a child to receive appropriate supports and services, subject to available appropriations, which do not require the relinquishment or restriction of parental rights or custody, except as prescribed in A.R.S. § 8-533, which describes the grounds needed to justify the termination of the parent-child relationship;

bb. Right to withdraw from programs, supports and services, unless the member was assigned to the Department of Child Safety by the juvenile court or placed in a secure facility by the guardian and court;

cc. Right to file a grievance against the Division.

dd. Get help understanding the appeal process including how to appeal when a benefit is denied;

ee. Right to access information about the Division, its staff, its contractors, and staff qualifications.

ff. Right to refuse interviews related to crimes committed against them;

gg. Right to consent to or withhold consent from participation in a research project approved by the Division management team or any other research project: right to knowledge regarding the nature of the research, potential effects of a treatment procedure as part of a research project, right to confidentiality, and the right to withdraw from the research project at any time.

hh. Right to petition the Superior Court for redress when they believe that their rights have been violated, unless other remedies exist under federal or State laws;

ii. Right to contact the Independent Oversight Committee;

3. The Division shall recognize the following additional rights of an individual with a developmental disability who is eligible for the Arizona Long Term Care System (ALTCS):

   a. Right to know about providers who speak languages other than English;

   b. Right to receive services in the community at the same level as others not receiving Medicaid home and community based services;

   c. Right to select where services are provided based on individual needs, preferences and resources;

   d. Right to make life choices, including daily activities, physical environment, with whom they interact, and who provides services and supports;

   e. Right to have personal care needs provided, except for cases of emergency, by a direct care staff of the gender chosen by the responsible person; this choice shall be specified in the Planning Document;

f. Right to make decisions about their care, including refusing care or getting details about what could happen if they do or do not get care;

g. Right to get a second opinion from a qualified physical or behavioral health care professional at no cost within their health plan network or outside the network if there is no in-network option;

h. Right to get information about their treatment options and alternatives in a way that is understandable;

i. Right to develop a contingency plan with their provider agency to decide what they want to do if a caregiver is late or does not show up for each of their assessed services;

j. Right to request information about the structure and operation of their health plan, including their contract with the Division of Developmental Disabilities;

k. Right to know how their health plan pays providers, controls costs, and uses services;

l. Right to see their health care records at any time and to request they be changed or corrected;

m. Right to request a copy of their health care records at no cost every year and to receive a response to that request within 30 days of making the request;

n. Right to receive emergency care at any hospital or other setting without prior approval from their doctor or health plan;

o. Right to create advance directives that protect their right to refuse unwanted health care or to request wanted care if they are too ill to make decisions;

p. Right to file a grievance not only with the Division but also with their health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);

q. Right to get information on beneficiary and plan information;

r. Right to information regarding the supports and services available through a provider and about related charges, including any fees for supports and services not covered by a third-party payor;

s. Right to an administrative review, if in disagreement with a decision made by the Division, by filing a verbal or written request for such with the DDD Office of Compliance and Review, and the right to appeal the decision;

4. The Division shall recognize the following additional rights of an individual with a Serious Mental Illness designation:

a. Right to receive the right kind of mental health services based on individual need;

b. Right to Participate in all areas of mental health treatment, including individual service or treatment plan meetings;

c. Right to have a discharge plan before leaving the hospital;

d. Right to consent or say Yes or No to treatment (except in an emergency or by court order);

e. Right to have treatment or medical help in a similar area as others or in the least restrictive area to meet the individual needs;

f. Right to be free from unnecessary seclusion or restraint;

g. Right to not be physically, sexually, or verbally abused;

h. Right to privacy (mail, visits, telephone conversations);

i. Right to file an appeal or grievance when unhappy with services, something is not working, or feel treated unfairly;

j. Right to choose a designated representative(s) to assist during service or treatment planning meetings and in filing grievances;

k. Right to a case manager to work with you to get the services or help needed;

l. Right to a written behavioral health service or treatment plan that sets forth the services you will receive;

m. Right to associate with others;

n. Right to confidentiality of psychiatric records;

o. Right to get copies of psychiatric records (unless it would not be in the best interest to have them);

p. Right to appeal a court-ordered involuntary commitment and to consult with an attorney and to request judicial review of court-ordered commitment every 60 days; and

q. Right to not be discriminated against in employment or housing.

5. The Division shall recognize the following additional rights of individuals living in Community Residential Settings:

a. Right to be treated with dignity and respect by DDD staff and providers;

b. Right to impartial access to treatment or accommodations;

c. Right to a safe, humane, and clean physical environment;

d. Right to make decisions about their care, including refusing care or getting details about what could happen if they do

or do not get care and communicate directly with those responsible to provide care;

e. Right to choose their personal care provider;

f. Right to be informed of their medical condition, of any technical procedures which may be performed, of the identity of the persons who will perform the procedures, attendant risks of treatment and the right to refuse treatment;

g. Right to be free from unnecessary drugs and physical restraints, except as authorized in writing by a physician for a specified time period and in accordance with the Division rules regarding behavior supports;

h. Right to a physical examination and prompt medical attention;

i. Right to refuse to talk with or see someone;

j. Right to participate in social, religious, and community group activities;

k. Right to manage their own financial affairs and be taught to do so to the extent of their capabilities;

l. Right to refuse to perform services for the home, but if they do provide services, right to be compensated at prevailing wages commensurate within state and federal laws and as prescribed by the Industrial Commission;

m. Right to file an incident report;

n. Right to file a grievance not only with the Division but also with their health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);

o. Right to the least amount of physical assistance necessary to accomplish a task;

p. Right to have care for personal needs provided, except in cases of emergency, by a direct care staff of the gender chosen by the responsible person and to have the choice specified in the PCSP or IFSP planning document;

q. Right to use available resources to select the home in the community in which they live;

r. Right to have a written residency agreement in place;

s. Right to have keys to their home and bedroom doors, or alternatives in place, to support the free entry and exit from their home;

t. Right to physically access their home and areas within their home;

u. Right to have choices over whom they live with, and only share a bedroom if they choose to do so;

v. Right to decide how to furnish and decorate their home;

w. Right to decide how to use outdoor spaces;

x. Right to have access to privacy within their homes including privacy with regard to written correspondence, telephone communication, and visitors;

y. Right to make informed choices about how they spend their time in and outside of their homes;

z. Right to have access to food and supplies within their home;

aa. Right to have visitors when they want to;

bb. Right to own and have free access to personal property.

B. MEMBER RESPONSIBILITIES

1. The Division shall notify all individuals supported by the Division of Developmental Disabilities that they have the responsibility to:

   a. Be as active a participant as possible in their person-centered service plan (PCSP) meetings;

   b. Notify their Support Coordinator in advance if they are unable to attend their scheduled person-centered service planning meetings;

c. Follow the mutually agreed-on person-centered service plan or notify their Support Coordinator if they cannot follow the plan;

d. Notify their Support Coordinator and their usual care provider(s) if they disenroll from DDD;

e. Provide DDD with accurate and timely information necessary to deliver services;

f. Participate in the DDD redetermination process at ages 6 and 18 or at any time deemed appropriate by the Division's Assistant Director.

2. The Division shall notify all individuals supported by the Division of Developmental Disabilities who are also eligible for the Arizona Long Term Care System (ALTCS) that they have the responsibility to:

a. Participate in the Arizona Long Term Care System (ALTCS) eligibility process, including providing documentation when requested;

b. Keep scheduled doctors and therapy appointments or cancel them at least 24 hours ahead of time;

c. Go to your doctor during office hours if possible instead of using urgent care or the emergency room;

d. Provide accurate and honest information to health care providers;

e. Notify the Division of changes in private/commercial health insurance coverage, including Medicare or Tricare, or other qualifying life event;

f. Follow instructions provided by health care providers and ask questions if they do not understand the instructions.

1001-B RESPONSIBILITIES OF INDIVIDUALS APPLYING FOR AND/OR RECEIVING SUPPORTS AND SERVICES

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

Applying for and/or receiving supports and services individuals with developmental disabilities are to be supported in exercising the same rights and choices and afforded the same opportunities enjoyed by other citizens. The Division provides this support by following the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life shall be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, preferences, strengths and needs. For individuals receiving services through the Division, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support. The Division offers many options for a member wanting to make more choices about services and supports, such as:

A. Selecting a Support Coordinator;

B. Selecting and directing their planning process, either an Individual Support Plan and/or a Person-Centered Plan;

C. Selecting service providers, both qualified vendors and individual independent providers;

D. Hiring, managing, and firing service providers;

E. Using a fiscal intermediary to manage the financial aspects of having a service provider who is his/her employee; and,

F. Having the spouse serve as his/her provider.

1002 VOTER REGISTRATION

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

All support coordination staff must comply with the Arizona Department of Economic Security Policy DES 1-01-24, regarding the National Voter Registration Act of 1993, and applicable state statutes, by offering individuals applying for services the opportunity to register to vote.

Staff will accept the verification of U.S. Citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. Citizenship document.

Staff will sign the acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by new employees within 60 days of hire. The signed copy is maintained in the Supervisor's file.

1003 DISTRICT INDEPENDENT OVERSIGHT COMMITTEES

REVISION DATE: 01/18/2023, 07/10/19, 07/13/15

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 41-3801; A.R.S. § 41-3804

PURPOSE

This policy outlines duties and membership body requirements for Independent Oversight Committees, which are established to promote rights of clients who are receiving developmental disabilities services.

POLICY

A. INDEPENDENT OVERSIGHT COMMITTEE DUTIES

The Division of Developmental Disabilities (Division) shall establish Independent Oversight Committees within specific Division districts**:** Central, East, North, West, and South. Each Independent Oversight Committee shall:

1. Meet at least quarterly each calendar year, or as often as necessary as determined by the chairperson, in accordance with the bylaws of the committee.
2. Provide independent oversight to ensure the rights of members are protected, including but not limited to:

a. Incidents of possible abuse, neglect, or denial of an individual's rights.

b. Administration of medication that changes recipient's behavior directly or as a side effect.

c. Aversive or intrusive programs.

d. Research proposals in the field of developmental disabilities that directly involve individuals receiving supports and services.

3. Submit, in writing, to the Arizona Department of Administration (ADOA) Director, any objections it has to specific concerns, actions by employees of the Division, or actions by employees of service providers.

4. Issue an annual report summarizing its activities and making recommendations of changes it believes the Division should consider implementing.

5. Additional information for specific DDD Independent Oversight Committees are available on the DDD ADOA website.

B. INDEPENDENT OVERSIGHT COMMITTEE MEMBERSHIP

1. Each committee shall be comprised of at least seven and not more than15 persons with expertise in one or more of the following areas:
    a. Psychology
    b. Law
    c. Medicine
    d. Education
    e. Special education
    f. Social Work
    g. Criminal Justice
2. Each committee shall include at least two parents of developmentally disabled members who receive services from the Division.
3. Employees of the Department of Economic Security, and subject-matter experts may serve on a committee only as non voting members whose presence is not counted for the purpose of determining a quorum
4. When there is a vacancy in an existing committee's membership, the committee shall review nominees presented by advocacy

groups, local advisory councils, committee members, and the ADOA director.

1004-A INFORMED CONSENT

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-551 (15) and 36-561.

As one means of protecting the rights of consumers, the Division requires written consent from the individual/responsible person for release of confidential information. Consents may also be required for participation in events, medical treatments, and activities. A.R.S. § 36-551 (15) defines consent as voluntary informed consent. Consent is voluntary if not given as the result of coercion or undue influence.

Consent is informed if the person giving the consent has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of the alternatives to the procedure; and, has been informed and comprehends that withholding or withdrawal of consent will not prejudice the future provision of care and supports and services to the individual. In case of unusual or hazardous treatment procedures performed pursuant to A.R.S. § 36-561, subsection A, experimental research, organ transplantation and non-therapeutic surgery, consent is informed if, in addition to the foregoing, the individual/responsible person giving the consent has been informed of and comprehends the method to be used in the proposed procedure.

All consents must be time or event-limited. Consent may be withdrawn at any time by giving written notification to the individual's Support Coordinator.

Consumer's Competency Questioned

When a consumer's ability to make decisions about medical treatment/ procedures is questioned, the matter must be forwarded to the Division's Medical Director for consideration.

1005-A GUARDIANSHIP AND CONSERVATORSHIP OR SURROGATE PARENT

REVISION DATE: 9/30/2016, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 15-761, 15-763, et seq.; 36-551 (01)(H), 36-551(17), 36-564(D), 14.5101, et seq.; 14-5105, 14-5311, 14-5303-5304, 14-5310; 14-5401, 14-5312; 14-5408(C); 14-5315; A.A.C. R6-6-1401. Public Law 105-17.

REFERENCES: A.R.S. §§

Guardianship is a legal method that is used to insure that a person who is unable to make reasoned decisions has someone specifically assigned to make decisions on his/her behalf. A guardian must be appointed by a court. A conservator refers to a person appointed by a court to manage the estate of a protected person. A person may have a guardian, a conservator or both appointed by the court.

Guardianship or conservatorship for persons with developmental disabilities shall be:

A. Utilized only as is necessary to promote the well-being of the individual;

B. Designed to encourage the development of maximum self- reliance and independence in the individual; and,

C. Ordered only to the extent necessitated by the individual's actual mental, physical and adaptive limitations.

Appointment of a Guardian or Conservator

Only a court can determine that someone needs a guardian. Neither the family nor a Support Coordinator can unilaterally or jointly make that determination. However, the individual himself/herself, a family member, or any person interested in his/her welfare may petition the court (file a request for a hearing in a State court) for a finding of incapacity and the consequent appointment of a guardian. The court will appoint an attorney to represent the allegedly incapacitated person in the hearing unless the individual has his/her own attorney.

It should be noted that under Arizona law, a person with a developmental disability is presumed legally competent in guardianship proceedings until the court makes a determination to the contrary.

The person alleged to be incapacitated shall be interviewed by a person appointed by the court (called a court visitor) and examined by a court appointed physician, psychologist, or a registered nurse who will submit written reports to the court. In addition, the court visitor shall interview the person seeking appointment as guardian, and visit the home of both the individual and the proposed guardian.

During the hearing, the individual who is the subject of the hearing, has the right to be represented by an attorney, to be present at the hearing, to see or hear all evidence, to present evidence, to cross-examine witnesses, and to trial by jury. If the individual alleged to be incapacitated or his/her counsel requests, the issue may be determined at a closed

hearing.

Before a guardian can be appointed, the court must be satisfied "by clear and convincing evidence" that the appointment of a guardian or conservator is necessary to provide for the demonstrated needs of the individual.

In case of an emergency situation, the court can appoint a temporary guardian and/or a temporary conservator.

If the appointment of a guardian or conservator is required for a American Indian who is a member of an Indian Tribe and who has significant contacts with that tribe, but who is not an Indian child within the scope of federal law, the Arizona Administrative Code requires that the appointment of a guardian or conservator shall first be requested through the appropriate tribal court, if any, unless the request through the tribal court is not in the recipient's best interests as determined by the Individual Support Plan (ISP) team.

Who May be Guardian

Any competent person may be appointed guardian by the Court. Persons who are not disqualified have priority for appointment as guardian in the following order:

A. Spouse;

B. Individual or corporation nominated by the person, if in the opinion of the court, the person has sufficient mental capacity to make an intelligent choice for guardian;

C. An adult child;

D. A parent, including a person nominated by will or other writing signed by a deceased parent;

E. A relative with whom the individual has resided for more than six months prior to the filing of the petition;

F. The nominee of a person who is caring for the person or paying benefits to him/her; or,

G. A public or private fiduciary, professional guardian, conservator.

The court may give preference for the appointment of a family member unless this is contrary to the expressed wishes of the individual or is not in his/her best interest as determined by the court.
Persons who wish to be considered for appointment as a temporary or permanent guardian or conservator must provide the court with all required information. Specifically, the proposed guardian must disclose any interest in any enterprise providing health care or comfort care services to any individual.

Duties of a Guardian

A guardian's duties include, but are not limited to:

A. Encouraging the individual to develop maximum self-reliance and independence;

B. Working toward limiting or terminating the guardianship and seeking alternatives to guardianship;

C. Finding the most appropriate and least restrictive setting for the individual consistent with his/her needs, capabilities and financial ability;

D. Making reasonable efforts to secure medical, psychological, and social services for the individual;

E. Making reasonable efforts to secure appropriate training, education, and social and vocational opportunities for the individual;

F. Taking care of his/her ward's clothing, furniture, vehicles, and other personal effects;

G. Giving consents or approvals for medical or other professional care that may be necessary; and,

H. Completing all reports required by the court.

To encourage the self-reliance and independence of the individual (the ward), the court may grant him/her the right to handle part of his/her money or property without the consent or supervision of a conservator. This may include allowing the individual to maintain appropriate accounts in a bank or other financial institution.

Procedures

As part of the annual review, the ISP team shall evaluate the possible need for a guardian and/or conservator for an individual receiving services through DES/DDD. This information must be noted on the ISP form DD-217 - 2 (Team Assessment Summary, cont) under guardianship status.

When there is serious doubt regarding the ability of the individual applying for services or receiving services to make or communicate responsible decisions, every effort must be made to have a judicial determination made regarding the need for guardianship and/or conservatorship.

In the case of minor child where there is no parent or interested party who is willing and able to serve as guardian, the Support Coordinator should refer the child to Department of Child Safety (DCS).

If an individual is 18 years of age or older, the parents are not the guardians unless they have been so appointed by the court. Thus, parents cannot continue to sign medical consent forms, etc. for their children who have become of legal age. The parents may wish to pursue guardianship status.

If the Support Coordinator and/or the ISP team believes that a determination of legal competency should be pursued, the Support Coordinator should:

A. Explain the need to the individual and/or family;

B. Work with the individual/and or family to help them understand the process necessary for obtaining a guardian and/or a conservator;

C. Refer the individual and/or family for help, if it is needed, in securing an attorney to handle the proceedings; (referrals, for example, to: Arizona Center for Law in the Public Interest, Community Legal Services, The Arc);

D. If the individual/family is unwilling or unable to seek guardianship, the Support Coordinator must pursue guardianship by:

1. Writing a letter to the county public fiduciary where the individual receives services explaining the situation; and/or

2. Contacting Adult Protective Service (APS) for assistance.

Surrogate Parent

Parental involvement in the planning of a child's Individual Education Plan (IEP) is a federal requirement. For a child who is without a parent willing/able to participate in the child's educational process, federal and State laws provide for the appointment, by the court, of a surrogate parent to represent a child in decisions regarding special education.

A petition for a surrogate parent for a child with disabilities may be made if any of the three following conditions have been met:

A. No parent can be identified;

B. A public agency cannot determine the whereabouts of a parent after having made three reasonable attempts; or,

C. The child is a ward of the State and the biological parent is unwilling or unable to consent to special education placement.

A person who is an employee of a State agency which is involved in the education or care of the child is not eligible to be a surrogate parent. Thus, a Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) Support Coordinator cannot be a surrogate parent. Moreover, a DES/DDD Support Coordinator cannot sign an authorization for a special education evaluation or an authorization for services for a child who has a developmental disability.

Procedures

If a child who is receiving services through DES/DDD has a surrogate parent, this information must be noted on the Individual Support Plan (ISP) form *DD-217 - 2 Team*

Assessment Summary, continued under guardianship status and reviewed annually. In addition, the surrogate parent must be part of the ISP team.

A foster parent who wants to be a surrogate parent should work with the Support Coordinator in making a request to the courts. While a foster parent may petition the court to receive an appointment as a surrogate parent, the court is responsible for determining whether a particular individual is able to act as a foster parent, and also represent the best interest of the child as a surrogate parent.

If the Support Coordinator believes a surrogate parent is necessary, e.g., the natural parents have relinquished their rights, the Support Coordinator should seek to have a surrogate parent appointed so that decisions regarding the child's education can be made in a timely manner.

The Arizona Department of Education (ADE) has information regarding surrogate parents and usually has a list of persons who have volunteered to be surrogate parents and have already received the required training.

1005-C AUTHORIZED REPRESENTATIVE FOR ALTCS BENEFITS

REVISION DATES: 10/28/2020, 9/01/2014
EFFECTIVE DATE: July 31, 1993

If there is a legal representative, that person must file the application for Arizona Long Term Care Service (ALTCS) benefits or authorize someone else to be the authorized representative. This is a person who is authorized in writing by an applicant or legal representative to represent him/her in the application process.

The authorized representative signs an affirmation to having knowledge of the applicant's circumstances, has been informed and understands the responsibilities which include:

1. Providing complete and accurate information, to the best of his/her knowledge, regarding the applicant's income, resources, household composition, citizenship, residency, and medical insurance coverage;

2. Providing all documents needed to determine eligibility;

3. Notifying the local ALTCS office of any change in the applicant's circumstances within 10 working days of the occurrence;

4. Signing all forms necessary for completing the application and verifying eligibility; and

5. Identifying and filing insurance claims and assigning insurance benefits to AHCCCS.

NOTE: Generally, a family member or a legally appointed guardian assumes the responsibility of being an authorized representative for an individual applicant. The Support Coordinator may assist in the process of making application.

1005-D REPRESENTATIVE PAYEE

REVISION DATE: 11/16/2022, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: 20 C.F.R. 404.2001-404.2065; 20 C.F.R. 416.601-416.665; A.R.S. § 36-557(O); Division Operations Policy 4004-A

PURPOSE

This policy outlines the responsibilities for the Division when a Member needs or has a Representative Payee.

DEFINITIONS

1. "Fee for Service Representative Payee" means an organization that is approved by the Social Security Administration (SSA) to perform the role of Representative Payee and to collect a monthly fee from a member's benefit payment to perform the service.
2. "Member" means an individual enrolled with the Division.
3. "Representative Payee" means an individual or organization appointed by the Social Security Administration (SSA), Railroad Retirement, Veteran's Benefits, and Civil Service to receive and manage benefits.

4. "Social Security Benefits - Social Security (SSA, Title II)" means a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner.
5. "Supplemental Security Income (SSI), Title XVI" means a federal income maintenance program for the aged, blind, and disabled persons with few or no resources.

POLICY

A. DIVISION REQUIREMENTS

1. The Division shall serve as Representative Payee for adult Members that meet all of the following criteria:
   a. The Member receives SSA, SSI, Railroad Retirement, Veteran's Benefits, Civil Service, or other benefits.
   b. The Member or guardian requests the Division to serve as Representative Payee.
   c. The Member does not have natural supports who are willing or able to manage his or her funds.
   d. The Member cannot afford a Fee for Service Representative Payee.

e. The Support Coordinator and Planning Team requests the Division to serve as Representative Payee.

f. The Member does not have an outside bank, credit union or other account established on their behalf.

2. The Division shall serve as Representative Payee if the Member is a child and meets all the following criteria:

a. The Member is eligible for SSA and/or SSI;

b. The Member is under the care and custody of the Department of Child Safety; or

c. The Member is under the care and custody of the tribal social service agency; and

d. The Member's placement is provided and paid by the Division.

3. The Division shall request approval from the organization providing the Member's benefits to serve as Representative Payee if the Member meets the criteria in A.1. or A.2. above.

4. The Division shall manage a Member's employment earnings upon the Member's request and if the Division is providing the member Representative Payee services.

B. DIVISION REPRESENTATIVE PAYEE RESPONSIBILITIES

1. The Division, as Representative Payee, shall use the funds they manage for the exclusive use and benefit and in the member's best interest.
2. When managing the Member's funds, the Division shall:
   a. Establish an individual account for the Member;
   b. Distribute the Member's funds in accordance with the requirements of the entity providing the benefits to the Member;
   c. Keep an accounting of the funds received and distributed; and
   d. Safeguard and secure the Member's funds.
3. The Division, as Representative Payee, shall report annually to the organization providing benefits to the Member the following information:
   a. How the Member's benefits were used;

b. The amount of the Member's benefits saved;

c. Any changes in the Member's living arrangements; and

d. Other information as required or requested by the organization providing benefits to the Member.

4. The Division shall, if necessary documents are made available by the Member, report a Member's employment earnings as required by SSA, if the Division:

a. Is Representative Payee for a Member receiving SSA/SSI benefits; and

b. Is managing the Member's employment earnings.

C. SUPPORT COORDINATION RESPONSIBILITIES

1. The assigned Support Coordinator shall complete and submit a DDD-1822A Request for DES/DDD to Become Representative Payee-Adult form to Member Funds if a Member meets the requirements in A.1. above and requests Representative Payee services from the Division.

2. The Support Coordinator shall complete and submit a DDD-1831A Request for Division of Developmental Disabilities to

become Representative Payee-Child form to Member Funds if the Member is a child and meets the criteria in A.2. above.

3. If the Member requires a Representative Payee, but does not meet the criteria in A. to receive Representative Payee services from the Division, the Support Coordinator shall:
    a. Refer to the Member to the SSA website or local SSA office; and
    b. Coordinate with the Member and Planning Team in finding natural or community supports for Representative Payee services.
4. The Support Coordinator shall document if a Member has a Representative Payee, whether through the Division, community, or a natural support, in the Person-Centered Service Plan.
5. The Support Coordinator shall, if agreed to by the Member, include the Member's the Representative Payee in Planning Team meetings.
6. The Support Coordinator shall complete the DDD-0221A Spending Plan form within the Member's monthly budget as part

of the Person-Centered Service Plan for Members for whom the Division is Representative Payee.

7. The Support Coordinator shall only authorize up to $499.00 for Member funds disbursement requests.
8. The Support Coordinator's Supervisor or Designee shall approve or deny Member funds disbursement requests over $500.00.

1007 SUPPORTING SEPARATED OR DIVORCED FAMILIES

EFFECTIVE DATE: December 7, 2022

REFERENCES: A.R.S. § 25-403.06

PURPOSE

This policy sets forth guidance on working with parents or guardians of Division of Developmental Disabilities (DDD) Members, when the parents or guardians are separated or divorced, in order to ensure continuity of communication for planning and implementing Member services.

DEFINITIONS

1. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).
2. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551

POLICY

A. DOCUMENTATION

1. When the Support Coordinator becomes aware that a Member's parents or guardians are separated or divorced, the Support Coordinator shall request a copy of the court ordered custody

agreement or Parenting Plan to be placed in the Member's file.

2. The Support Coordinator may initiate services or implement changes in the Member's services, including change of providers, prior to the requested custody agreement or Parenting Plan being received when:
   a. Both parents or guardians are involved in the planning process, and
   b. Both parents or guardians agree with the proposed changes.
3. When the Support Coordinator becomes aware that any court-approved changes have occurred to the custody agreement or Parenting Plan, the Support Coordinator shall request a copy to be placed in the Member's file.
4. When the Support Coordinator becomes aware of any updates to any informal agreements, after finalizing the custody agreement or Parenting Plan, the Support Coordinator shall request a notarized copy of this information be placed in writing by both parties, and placed in the Member's file.

B. COMMUNICATION

1. Division staff shall send information to both parties equally, in the same manner whenever possible, when both parties have joint legal custody.
2. When Division staff respond to communication from one party, staff shall document the discussion in an email to both parties to confirm the conversation.

C. PLANNING MEETINGS

1. The Support Coordinator shall include both parties and the Member in service planning meetings, at mutually agreeable times and locations, unless both parties agree that one person shall be the representative decision maker.
2. The Support Coordinator is not responsible for scheduling two separate meetings when parents or guardians do not wish to interactively participate in the same planning meeting.
3. The Division may grant separate meetings if one party has a Protective Order against the other party. If the Division is aware of a Protective Order, the Support Coordinator shall obtain a

copy of the Protective Order file in the Legal section of the Member's file.

4. The Support Coordinator shall first attempt to schedule meetings in the Member's home, however, meetings can be held at a neutral location such as a Division office.

5. If a required meeting cannot be scheduled because of the failure of the parties to reach agreement on time or location, please see Section E.

D. ASSESSING SERVICES

1. When parents share joint legal custody, the Division shall provide services in the parents' homes or in the community in the same percentage of time outlined in the custody agreement or Parenting Plan, unless otherwise agreed to by both parties.

2. Division staff shall support goals for skill development as mutually agreed upon by the planning team. If more than one Qualified Vendor or Independent Provider is in place for a teaching/Habilitative service, Division staff shall assist the

planning team with coordinating the teaching strategies within both parties' homes as skills are more likely to be generally applied to other settings.

3. The Division may complete home modifications in the home where the Member spends the majority of their time to meet the Member's accessibility needs, as determined medically necessary by the home modification assessment. When the Member also lives part-time with the other party, home modifications may also be provided in the other party's home, at the time the other party chooses to have an assessment to determine medically necessary home modifications to meet the Member's accessibility needs at that home environment.

E. CONFLICT RESOLUTION

When parents with joint legal custody cannot agree, despite facilitation by Support Coordination staff, the Division shall not initiate new services or implement changes in the Member's services, including change of providers.

3001 FAMILY MEMBERS AS PAID PROVIDERS

REVISION DATE: 2/26/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

A. Natural Child;

B. Natural Sibling;

C. Adoptive Child;

D. Adoptive Sibling;

E. Stepchild or Stepsibling;

F. Father-in-Law, Mother-in-Law, Son-in-Law, Daughter-in-Law, Sister-in-Law, Brother-in-Law;

G. Grandparent or Grandchild; and, or,

H. Spouse of Grandparent or Grandchild.

Immediate relatives not permitted to provide services for children under age 18 include:

A. Natural Parent;

B. Adoptive Parent ; and,

C. Step Parent.

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services;

B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse (See Attendant Care section for exception);

C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources;

D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or Habilitation (skilled care includes, but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers, or suctioning tracheostomy care) (See Appendix D – Skilled Nursing Matrix);

E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service;

F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws, and rules;

G. Primary caregivers/parents may not be paid to provide Respite;

H. Services shall not replace care provided by the person's natural support system;

I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division;

J. Qualified family members may become certified home and community based service providers by meeting the certification requirements, as applicable; and,

K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

3003 SELECTION OF PROVIDERS

REVISION DATES: 3/02/22, 3/22/21, 2/05/18, 6/10/16
EFFECTIVE DATE: 10/04/14
REFERENCES: A.A.C. R6-6-2101 thru R6-6-2115

PURPOSE

To provide a person-centered approach for the Division of Developmental Disabilities (Division) members to select providers in a fair and equitable manner. The Division does not discriminate against Qualified Vendors/Independent Providers who serve high-risk populations or who specialize in conditions that result in costly treatment due to Division members selecting their own providers.

Division staff are not permitted to show favoritism toward any specific Qualified Vendor/ Independent Provider. If staff are asked to make a recommendation regarding a Qualified Vendor/Independent Provider, staff must explain to the member/responsible person that they cannot make a specific recommendation. Staff will then review the methods that are available for the member to select a Qualified Vendor/Independent Provider. The Division may assist the member/responsible person to identify the criteria needed to make a selection based on the member's needs.

I. POLICY

A. IDENTIFYING THE NEED FOR SELECTING A QUALIFIED VENDOR

1. The selection of a Qualified Vendor is needed when:
    a. A new service is approved by the Division, or
    b. A member/responsible person requests a change of Qualified Vendor.
2. If the member/responsible person requests a new Qualified Vendor at the time of the annual planning meeting:
    a. The request will be documented in the Planning Document.
    b. The Division will accommodate the requests to the extent appropriate and practical.
3. If the member/responsible person requests a new Qualified Vendor outside of an annual planning meeting:
    a. The request must be in writing or reported directly to the Division for incorporation into the member's record and include:
        i. The rationale for changing Qualified Vendors, and
        ii. A description of the opportunities given to the current Qualified Vendor to address the member's concerns.

4. If there is team agreement to make the change, the Division will accommodate the requests to the extent appropriate and practical.

5. If there is no team agreement, the Division shall schedule and convene a resolution meeting as soon as possible, document steps to resolve the concern(s), and monitor the plan for the following 21 days to determine if the concerns have been resolved. If the concerns have not been resolved, the Division will accommodate the requests to the extent appropriate and practical.

II. NON-RESIDENTIAL SERVICES

A. METHODS FOR SELECTING A QUALIFIED VENDOR - NON-RESIDENTIAL SERVICES

1. When a non-residential service is approved by the Division, or a change of Qualified Vendor for a non-residential service is needed, the member/responsible person may identify a Qualified Vendor in the following ways:

   a. The member may identify a Qualified Vendor or contracted Independent Provider without assistance from the Division. The Division will issue a vendor call concurrently to ensure that services are put in place.

   b. If requested by the member/responsible person, the Division may provide an electronic or printed copy of the Qualified Vendor or Independent Provider Directory, or direct the member/responsible person to use the online Provider Search option available on the Division's webpage, "Assistance for Individuals or Families."

   c. The member/responsible person will confirm the potential Qualified Vendor's availability with the Division.

2. The member may select a Qualified Vendor through the use of a vendor call issued by the Division. A vendor call for non-residential services is a notice from the Division inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific member or specific group of members, based on the requirements defined in the member's Planning Document.

B. SELECTING A QUALIFIED VENDOR USING A NON-RESIDENTIAL VENDOR CALL

1. Vendor calls for non-residential services remain open and/or continuous until the service is assigned.

2. The Division provides the member/responsible person with responses that meet the criteria of the vendor call as they are received.

3. After receiving the first response to the vendor call from the Division, the member/responsible person must select a Qualified Vendor from the responses received within seven calendar days.

4. If a member/responsible person is not willing to, is unable to, or does or does not select a vendor, a Qualified Vendor may be auto assigned on their behalf by the Division. The member/responsible person will be notified of the auto-assignment.

5. The selection will be documented in the member's file and progress notes.

C. QUALIFIED VENDOR NOT IDENTIFIED – NON-RESIDENTIAL VENDOR CALLS

1. When a non-residential vendor call does not receive any Qualified Vendor responses, the Division will use direct referral to individually contact one or more of the Qualified Vendors who provide services in the geographic area of the member. If necessary, the Division may extend the search to proximal areas or statewide.

2. Negotiated rate considerations and/or out-of-network providers may be utilized by the Division if a Qualified Vendor is not identified using the vendor call and direct referral process.

3. Alternative services will be offered, assessed, and documented in the member's file by the Division while a Qualified Vendor is being identified.

III. RESIDENTIAL SERVICES

A. METHODS FOR SELECTING A QUALIFIED VENDOR - RESIDENTIAL SERVICES

1. When a residential service is approved by the Division, or a change of Qualified Vendor for a residential service is needed, the member/ responsible person may identify a Qualified Vendor in the following ways:

   a. The member/responsible person may identify a currently contracted Qualified Vendor on their own; however, the Division must confirm that the selected Qualified Vendor has an existing/current funded capacity that can meet the member's needs prior to the authorization of services.

   b. The member/responsible person may select a Qualified Vendor through the use of a vendor call issued by the Division. A vendor call for residential services is an invitation to Qualified Vendors to provide services for a specific member, based on the member's individual needs.

B. SELECTING A QUALIFIED VENDOR USING A RESIDENTIAL VENDOR CALL

1. Vendor calls for residential services close after five calendar days.

2. When Qualified Vendor responses to residential vendor calls are received, the Division provides the member/responsible person with the responses that met the criteria in the vendor call after it closes.

    a. The member/responsible person must select a Qualified Vendor from the responses within five calendar days of receiving the response list from the Division. The member/ responsible person may request an additional five calendar days to select a Qualified Vendor, if needed.

    b. If a member/responsible person is not willing to, unable to, or does not select a vendor within the allotted time frame, a Qualified Vendor may be auto assigned on their behalf by the Division. The member/responsible person will be notified of the auto-assignment.

3. The selection will be documented in the member's file and progress notes.

C. QUALIFIED VENDOR NOT IDENTIFIED - RESIDENTIAL VENDOR CALLS

1. When a residential vendor call does not receive any responses, the Division will determine if the parameters of the vendor call need to be adjusted.

2. If the parameters of the vendor call are adjusted, a new vendor call will be issued.

3. If the parameters of the vendor call cannot be adjusted, the Division will use direct referral to individually contact one or more of the Qualified Vendors who provide services in the preferred geographic area of the member.

4. The Division may identify the need to expand the Network when there are no responses to vendor calls/direct referrals for two or more members.

5. Negotiated rate considerations may be utilized at the discretion of the Division.

6. Alternative services may be offered, assessed, and documented in the member’s file by the Division while a Qualified Vendor is being identified.

7. Under rare circumstances the Division may consider the use of an out-of-network provider for emergent needs.

IV. INDEPENDENT PROVIDERS

A. SELECTING INDEPENDENT PROVIDERS

1. Members may select to receive services from an existing independent provider who has an Independent Provider Agreement with the Division. Beginning in 2019, the Division stopped expanding the Independent Provider Program. Exceptions may be considered on a case-by-case basis and only if there is no network sufficiency to meet a specific member's needs.

2. A member/responsible person may change Independent Providers at any time.

3. Independent Providers are paid a rate based on member assessment.

4. The Division requires the use of a fiscal intermediary to manage the tax responsibilities and other employer obligations related to Independent Provider selection.

5. The fiscal intermediary is responsible for:

    a. Paying claims submitted by Independent Providers, including tax obligations;

    b. Tracking authorized service hours; and

    c. Working with the member/responsible person and the Division to resolve any financial concerns.

B. REQUIREMENTS FOR MEMBERS USING INDEPENDENT PROVIDERS

1. When a member/responsible person selects an existing Independent Provider to provide the service, the member/responsible person shall:

    a. Hire, orient, and train each Independent Provider to deliver the support as authorized in the Planning Documents;

    b. Review and approve each Independent Provider timesheet;

    c. Track the hours of service used compared to the hours of service authorized by the Division; and

    d. Report any concerns about the Independent Provider or the Independent Provider program to the Division and work with the fiscal intermediary and Division staff toward resolution.

3004 RESERVED

3005 RESERVED

3006 SHORT TERM EMERGENCY SITUATIONS (RESIDENTIAL AND DAY PROGRAMS)

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.A.C. R6-6-2110

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include, but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee *and* the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, or e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen ([15]) calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.
Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

A. The change in behavior or condition that precipitated an emergency situation;

B. The actions being taken to assist member (e.g., medical or psychiatric appointment, arranging for positive behavioral support, grief counseling);

C. The projected date of completion for each step; and,

D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within (21) calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV's request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.

3007 SERVICE PROVIDER INFORMATION, AUTHORITY, AND NOTIFICATION

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 3, 1993

The Division shall disclose to a service provider in the Planning Document, and in all meetings resulting from a response to a Vendor Call for Services, any historical and behavioral information necessary for the provider to anticipate the member's future behaviors and needs. This includes summary information from the Program Review Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and Behavioral Health Treatment Plans. The Division shall redact the member's identification from this information.

Service providers are authorized to engage in the following activities in accordance with the member's Planning Document:

A. Administer medications, including assisting the member's self-administration of medications;

B. Log, store, and dispose of medications; and,

C. Maintain medications and protocols for direct care.

The Division may establish procedures for items "A" through "C" listed above.
To protect the health and safety of a member, a provider must notify the Division within 24 hours if an emergency situation exists in which the provider is unable to meet the health or safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15 days after notification to recommend any changes, including whether there is a need for temporary additional staffing to provide appropriate care for a member, and shall develop a plan within 30 days after notification to resolve the situation.

<u>Other Safety Considerations for Placements</u>

Prior to any out-of-home respite or residential placement (including emergencies), the *Pre-Service Provider Information*, *Residential Transfer Checklist* , and any other pertinent forms shall be completed to gather general care information and identify potential safety concerns to prevent risk to the member, other residents, staff, and the public.

The Planning Team shall complete the *Case Transfer* form as part of the pre-placement meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with potential safety risks including, but not limited to training, inoculations, and staffing as needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the Department of Child Safety (DCS), or other members/agencies as appropriate, will identify

planned responses to known problems prior to placement, and document them on the *Risk Assessment*.

3008 ELECTRONIC MONITORING

REVIEW DATE:
EFFECTIVE DATE: December 27, 2023
REFERENCES: 45 CFR Part 164, A.R.S. §12-2297, A.R.S. §36-551.01, A.R.S. §36.568

PURPOSE

This policy outlines the Division's oversight and monitoring of Qualified Vendors and the use of Electronic Monitoring Devices in service sites funded by the Division.

DEFINITIONS

1. "Common Area" means areas inside and outside the home designed for use by multiple individuals, including residents. Bedrooms, toileting areas, and bathing areas are excluded from this definition, regardless of the number of individuals for which the area is designed.

2. "Electronic Monitoring Device" means the same as defined in A.R.S. § 36-568(E).

3. "Health Insurance Portability and Accountability Act (HIPAA)" means the Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21,

1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

POLICY

A. ELECTRONIC MONITORING DEVICES INSTALLED BY QUALIFIED VENDORS

1. The Division shall review and approve the Qualified Vendor's policies, procedures, and notices prior to the installation of the Electronic Monitoring Devices in the Common Areas of a group home, nursing supported group home, day treatment, or employment service site or a vehicle used for transportation.
2. The Division shall ensure Qualified Vendors only install Electronic Monitoring Devices in Common Areas.

3. Prior to installing or using Electronic Monitoring Devices in either a service site or a vehicle used for transportation, the Division shall ensure the Qualified Vendor:
    a. Notifies the Division of the intent to install devices.
    b. Complies with federal regulations for the Security and Privacy of Protected Health Information found at 45 CFR Part 164 (HIPAA) and other applicable state and federal law addressing confidentiality;
    c. Specifies in policy how Electronic Monitoring Device recordings, regardless of format, are secured to protect the confidentiality of the Members;
    d. Obtains written consent from each Responsible Person for Members who receive services at the service site;
    e. Determines in what circumstances access to the Electronic Monitoring Device recordings may be allowed;
    f. Determines which personnel may have access to the Electronic Monitoring Device recordings;
    g. Provides training to staff members who will have access to the Electronic Monitoring Devices; and

h. Posts signs at each service site entrance and in a conspicuous place in the common area and in the vehicle that is being monitored which indicates the days and hours of monitoring.

4. When the Division has approved the Qualified Vendor to use Electronic Monitoring Devices in either a service site or a vehicle used for transportation, the Division shall ensure the Qualified Vendor:

a. Maintains records created by Electronic Monitoring Devices in accordance with A.R.S. §12.2297 that can be produced upon request of the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law unless otherwise restricted.

b. Retains and has accessible any Electronic Monitoring Device recordings, regardless of format, generated by the Electronic Monitoring Devices installed and monitored by the Qualified Vendor for a minimum of 30 calendar days.

c. Evaluates all Electronic Monitoring Devices at least quarterly to ensure the Electronic Monitoring Devices are functioning properly, secure from access by unauthorized

personnel, and are being used in compliance with this Policy.

d. Monitors adherence to policies and promptly addresses non-compliance.

e. Maintains a log of all monitoring of Electronic Monitoring Devices.

f. Makes policies, training records, training acknowledgments, evaluations, and monitoring logs available to the Division as requested

5. The Division shall ensure the Qualified Vendor takes action when a Responsible Person notifies the Qualified Vendor they are no longer in agreement with the use of the Electronic Monitoring Devices by requiring the Qualified Vendor to:

a. Immediately turn off the Electronic Monitoring Devices;

b. Notify all Responsible Persons of the discontinuation of electronic monitoring in the setting;

c. Remove the Electronic Monitoring Devices within two business days.

6. The Division shall ensure that Members, living in a group home or nursing supported group home, are informed that a Qualified Vendor may allow the Responsible Persons to share in the costs of the installation, oversight, and monitoring of Electronic Monitoring Devices maintained by the Qualified Vendor when the Responsible Person agrees to the arrangement.

B. RESPONSIBLE PERSON INSTALLATION

1. The Division shall ensure Qualified Vendors permit installation of Electronic Monitoring Devices, at the expense of the Responsible Person, in Common Areas of a group home, nursing supported group home, or a vehicle used for transportation after all of the Responsible Persons consent to the use of Electronic Monitoring Devices.

2. The Division shall not permit Qualified Vendors to:

   a. Turn off or on the Electronic Monitoring Device;

   b. Cover up or in any way obscure the ability of the Electronic Monitoring Device to have full view of the area chosen by the Responsible Person;

c. Move the Electronic Monitoring Device;

d. In any other way assist or hamper the operation of and use of the Electronic Monitoring Device.

3. The Division shall ensure the Qualified Vendor takes action when a Responsible Person notifies the Division or the Qualified Vendor that they are no longer in agreement with the use of Electronic Monitoring Devices by requiring the Qualified Vendor to:

a. Immediately Stop using the Electronic Monitoring Devices;

b. Notify all Responsible Persons and the Division in writing of the discontinuation of Electronic Monitoring in the setting;

c. Ensure the Responsible Person removes the Electronic Monitoring Devices within two business days, and

d. Make any necessary repairs, at the time of removal, caused by the installation and removal of the Electronic Monitoring Devices.

C. ELECTRONIC MONITORING DEVICES IN PRIVATE SPACES INSTALLED BY THE RESPONSIBLE PERSONS

1. The Division shall ensure Electronic Monitoring Devices installed by the Responsible Person are only installed in the Member's private spaces.
2. The Division shall ensure Qualified Vendors do not prohibit the Responsible Person from installing Electronic Monitoring Devices in a Member's private bedroom, toileting area, and bathing area in a group home or nursing supported group home.
3. The Division shall not be responsible or make a Qualified Vendor be responsible to monitor the data collected from the Electronic Monitoring Devices including when the Responsible Person shares the data from the Electronic Monitoring Devices access with a third party..
4. The Division shall ensure the Qualified Vendor follows HIPAA as outlined in 45 CFR Part 164 and other compliance requirements when the Responsible Person shares the data from the Electronic Monitoring Devices with the Qualified Vendor.
5. The Division shall ensure the Qualified Vendor takes action when a Member moves out of the group home or nursing supported group home by requiring the Qualified Vendor to:

a. Ensure the Responsible Person removes the Electronic Monitoring Devices from the Member's private spaces within two business days, and

b. Makes any necessary repairs, at the time of removal, caused by the installation and removal of the Electronic Monitoring Devices.

4001 THIRD PARTY LIABILITY

REVISION DATE: 4/24/2019, 9/1/2014
EFFECTIVE DATE: January 1, 1996

Third party liability (TPL) is any funding source other than the Division of Developmental Disabilities (the Division). It includes medical insurance, for example, Medicare, CHAMPUS, TriCARE, or Blue Cross/Blue Shield. It also includes any benefits or settlements a person has as the result of an accident. It may also include eligibility for other programs such as Children's Rehabilitative Services (CRS), Arizona Health Care Cost Containment System (AHCCCS), or county funded services.

Policy

The Division is required to bill any third party for all covered services for all individuals eligible for services through the Division. A member/responsible person is required to provide third party insurance information when requested.

Retroactive Recoveries Involving Commercial Insurance Payor Sources

For two years from the date of service, the Division engages in retroactive third-party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment.

If a commercial insurance payor source is identified, the Division seeks recovery from the commercial insurance. The Division is prohibited from recouping related payments from providers, requiring providers to act, or requiring the involvement of providers in any way, unless the provider was paid in full from both the Division and the commercial insurance.

Other Third-Party Liability Recoveries

A. The Division will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The Division does not pursue recovery in the following circumstances, unless the case has been referred to the Division by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tortfeasors
- Restitution Recoveries
- Worker's Compensation Cases.

B. Upon identification of a potentially liable third party for any of the above situations, the Division reports the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case within 10 business days.

The Division may refer mass tort or total plan cases to the Division's authorized contractor. The Division will cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Cases

A. In total plan cases, the Division performs all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916 for cases pursued by the Division. The Division may retain up to 100% of its recovery collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the Division's financial liability for the member

2. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (e.g. lien filing).

3. Such recovery is not prohibited by state or federal law.

B. Prior to negotiating a settlement on a total plan case, the Division notifies AHCCCS or AHCCCS' authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. The Division must report settlement information to AHCCCS by the 10th day of each month on an AHCCCS-approved monthly file.

Joint and Mass Tort Cases

AHCCCS' authorized representative performs all research, investigation, and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Division.

In joint and mass tort cases, AHCCCS' authorized representative is also negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Division will be responsible for their prorated share of the contingency fee. The Division's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Division.

Other Reporting Requirements

A. All TPL reporting requirements are subject to validation through periodic audits and/or Operational Reviews that may include the Division's submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include but are not limited to:

- The member's first and last name
- AHCCCS ID
- Date of incident
- Claimed amount
- Paid/recovered amount
- Case status.

4002 CLIENT BILLING

REVISION DATE: 5/10/2023, 11/17/2021, 11/20/2019, 3/20/2019, 9/1/2014
EFFECTIVE DATE: January 1, 1996
REFERENCES: 20 C.F.R. § 416.1205; A.R.S. § 36-551; A.A.C. R6-6-1801; A.A.C. R6-6-2201; A.A.C. Chapter 6, Article 12, Cost of Care Portion

PURPOSE

The purpose of this policy is to outline the requirements for Members to financially contribute to the cost of services provided by the Division.

DEFINITIONS

1. "Administrative Review" means an informal review of a decision made by the Division.
2. "Cost of Care Portion" means the percentage of the cost of a Member's care that a Responsible Person or Representative Payee may be required to pay to the Division to offset the cost of the Member's care. The percentage of the cost of care is calculated based on the Member's income and based on 200% of the federal poverty guidelines.
3. "Home and Community Based Services" or "HCBS" means one or more of the following services provided to clients: attendant care, day treatment and training for children or adults, habilitation, home health

aide, home health nurse, hospice care, housekeeping-chore or homemaker, non-emergency transportation, occupational therapy, personal care, physical therapy, respiratory therapy, respite services, speech therapy, supported employment, and other comparable services as approved by the AHCCCS Director.

4. "Maximum Allowable Limit" means the highest amount of an individual's income or assets permitted by the Social Security Administration for Supplemental Security Income eligibility. This amount is also used by the Division to determine the Member's Cost of Care Portion.
5. "Member" means the same as "Client" as prescribed in A.R.S. § 36-551.
6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.

7. "Representative Payee" means an individual or organization appointed by the Social Security Administration, Railroad Retirement, Veteran's Benefits, and Civil Service to receive and manage benefits.
8. "Residential Services" or "Room and Board" means a living arrangement operated by the Division or by a Service Provider, in which Members live with varied degrees of appropriate supervision.
9. "Special Needs Trust" means a legal arrangement that enables a person with a disability to hold assets and maintain his or her eligibility for public assistance benefits.

POLICY

A. FINANCIAL CONTRIBUTION

1. The Division shall require Members receiving services from the Division to make a financial contribution to the cost of their care based on their eligibility:
    a. ALTCS Members shall only pay for the Cost of Care Portion for Residential Services.
    b. Non-ALTCS Members shall pay for the Cost of Care Portion for all program services including Residential Services.

2. The Division shall bill Members receiving state-funded services who have a trust, annuity, estate, or assets exceeding the Maximum Allowable Limit of $2,000, including Special Needs Trusts set up outside the State of Arizona, to their Cost of Care Portion for all programs and services provided by the Division.
3. The Division shall not bill Members receiving state-funded services who have a Special Needs Trust set up within the State of Arizona.

B. FINANCIAL CONTRIBUTIONS AND BILLING FOR RESIDENTIAL SERVICES (COST OF CARE PORTION)

1. The Division shall calculate the Member's Cost of Care Portion based on the amount of income or benefits the Member receives, including Social Security, Veteran's, and Railroad Retirement benefits.
2. The Division shall use the Federal Poverty Guidelines on the Health and Human Services Website to calculate a Member's Cost of Care.

3. The Division shall base the Cost of Care Portion for a Member receiving Residential Services on the total amount of income and monthly benefits the Member receives as follows:
    a. The required financial contribution is a maximum of 70% of the Member’s income and monthly benefits the Member receives, but must not exceed the actual cost of Residential Services.
    b. The Division shall, when the Member's personal savings exceeds the Maximum Allowable Limit of $2000 of the monthly federal benefits, calculate the billing amount as follows:
        i. For the ALTCS Member, the actual cost of Residential Services until the Member’s personal savings drops below the Maximum Allowable Limit of $2,000.
        ii. For the non-ALTCS Member, the actual cost of all services, including Residential Services, until the Member’s personal savings drops below the Maximum Allowable Limit of $2,000.

4. The Office of Accounts Receivable and Collections shall notify the Responsible Person or Representative Payee of the amount the Member must pay each month for Residential Services.
5. The Responsible Person or Representative Payee may contact the Division to request one or more of the following based on financial hardship of the Member:
    a. A financial review;
    b. An Administrative Review; or
    c. A reduction in the amount billed.
6. The Division shall require the Responsible Person or Representative Payee to report any lump sum of past due benefit payments from the benefit source to the Division and shall bill against the lump sum amount.

C. FINANCIAL REVIEW

1. The Responsible Person or Representative Payee may request a financial review of the Member's Cost of Care Portion payment amount, by requesting in writing any of the following:
    a. An informal business review.

i. The Division's Business office shall conduct an informal business review when requested by the Responsible Person or Representative Payeeat any time.

ii. The Responsible Person or Representative Payee shall submit the request via email to dddrevenuedesk@azdes.gov and include recent tax forms.

iii. The Division shall respond to the Responsible Person or Representative Payee within 10 business days from receipt of the request.

b. An Administrative Review as prescribed by A.A.C. R6-6-1801 et seq with appeal rights as prescribed by A.A.C. R6-6-2201.

i. The Responsible Person or Representative Payee, shall, at any time within 30 days of the date payment for the Cost of Care Portion is due, submit a request to the Division's Office of Administrative Review at dddofficeofcompliance@azdes.gov.

2. The Responsible Person or Representative Payee may request an Administrative Review without requesting an informal business review.

D. HARDSHIP REDUCTION REQUEST

1. The Responsible Person or Representative Payee may request a hardship reduction of the Cost of Care Portion by submitting a DDD-1532A Hardship Reduction Request form with documentation of expenses to the Division at DDDCORRBHSBilling@azdes.gov.
2. The Division shall review hardship reduction requests for any of the following expenses:
    a. Medicare Part D prescription drug co-payments, when submitted with proof of out-of-pocket expenses.
    b. Amounts ordered by a court for restitution, child or spousal support, when documentation of the order is submitted.
    c. Amounts paid for services provided by and items prescribed by a licensed healthcare professional, when documentation of the expenses supporting the request

and denial(s) from third party payers, or other potential sources of assistance are submitted.

d. Expenses for an extraordinary circumstance that affects the Member's health and safety when documentation of the amount of the expense, and the effect on the Member's health and safety if the expense is not incurred is submitted.

e. Cost of a prepaid burial or cremation plan when supported by documentation of the cost and the length of the payment period.

3. The Division shall review hardship reduction requests that include current documentation of the expenses supporting the request and shall issue a written determination within 30 business days that:

a. Approves a temporary reduction of the Cost of Care Portion billing amount for up to 12 months, or

b. Denies the request.

4. The Responsible Person or Representative Payee may, if they disagree with the Division's hardship reduction request

determination, submit a request for an Administrative Review no later than 30 days following the date of the notice as per A.A.C. R6-6-2201.

5. Upon request by the Division, the Responsible Person or Representative Payee shall provide verification that the expense for which a hardship reduction request was granted has been paid.
6. The Responsible Person or Representative Payee may submit a hardship reduction request at any time as long as the incurred cost is not older than six months.

4003 ADMINISTRATIVE REVIEW / APPEAL AND HEARING RIGHTS

REVISION DATE: 9/1/2014
EFFECTIVE DATE: January 1, 1996
REFERENCES: A.A.C. 6-6-22 (R6-6-2201 et seq.).

A. The Division will issue a written decision within thirty (30) calendar days from receipt of the request for Administrative Review. Appeal of this decision is available as prescribed by A.A.C. Title 6, Chapter 6, Article 22 (R6-6-2201 et seq.).

B. If Administrative review is based on notice of an increase in the monthly billing amount, the billing amount shall not increase until the Department has issued its final decision.

C. If the Administrative Review decision or an appeal of an Administrative Review decision results in affirmation of the original order in whole or in part, the monthly billing liability shall be retroactively effective from the date of the original notice of the billing amount. The person liable for the cost of care shall pay all amounts as stated in the original notice, as adjusted (if any adjustment in the amount is made by Administrative Review or the appeal). The Department's final decision on the billing amount will be retroactively effective beginning with the month in which the request for Administrative Review was made. Failure to pay the amounts owed may result in termination of services.

4004 OVERVIEW

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

This chapter explains Department of Economic Security (DES) policies for safeguarding, using, and investing funds for members in the Division of Developmental Disabilities (DDD).

4004-A MEMBER FUNDS - DEFINITIONS

REVISION DATE: 09/30/2020, 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 36-557(O), A.A.C. R6-6-1204, A.R.S. §36-2901, Supplemental Security Income (SSI), Title XVI, A.A.C. R6-6-1204.

A. Member Funds System – A system used by the Division of Developmental Disabilities (the Division), to maintain and track member funds.

B. Fiduciary Capacity – The capacity in which a person will properly and faithfully account for all member funds received by him/her. A person who is trusted to handle member funds is acting in a fiduciary capacity. Fiduciaries may include any employee of the State of Arizona or a private provider under contract.

C. Individual Service Plan (ISP) Spending Plan - The Planning Team is required to complete the following form, *ISP Spending Plan (DD-221-FF),* to set the expectation for how the member's money will be spent in the upcoming year.

The Division Support Coordinator and the Division Member Funds Unit are responsible for managing the funds to maintain Arizona Long Term Care Services (ALTCS) and SSI program eligibility. All members for whom the Division is the Representative Payee, and all members living in licensed residential settings, are required to complete a *DD-221-FF* form each year.

D. Legal Guardian or Conservator – An individual appointed by the court of law responsible for a minor or an incompetent adult. The Social Security Administration (SSA) does not automatically select a legal guardian or conservator as payee for a beneficiary. Instead, SSA will make independent judgments in every case to determine who will best serve the beneficiary as payee. This may or may not be a legal guardian/conservator.

E. Member Funds - Funds entrusted to an individual or agency for safeguarding and investment. The requirements for this are found in the instrument establishing such funds, and by Division Policy and Internal Instruction Manuals. The source of funds may include any of the following:

- Cash
- Checks
- Money orders
- Petty cash funds
- Change funds
- Bank accounts
- Savings accounts and investments

- ACH/Electronic

F. Planning Document – The general term for the Individual Support Plan (ISP), Individualized Family Services Plan, or Person-Centered Plan. The Planning Document includes an ISP - Spending Plan, as appropriate.

G. Personal Spending Money – The discretionary funds and allowances provided to members.

H. Provider - A provider is any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. Qualified Vendors are Providers.

I. Railroad Retirement Annuities and Pensions – The comprehensive benefit program created in the 1930s, for railroad employees who retired and included their families and survivors. For more information on this benefit, contact the Railroad Retirement Board and request form: *IB-2*.

J. Representative Payee - Individual or organization appointed by Social Security to receive and manage the social security or SSI benefits of another person. A representative payee must use the funds they manage for the exclusive use and benefit and in the member's best interest.

Requirements for a Division Representative Payee:

1. When no one is willing or able to perform the Representative Payee duties, or a member cannot afford the monthly fee to pay for this service, the Division may request that the Social Security Administration appoint them to become the representative for the member. When the Division is the Representative Payee, the Support Coordinator and Member Funds are responsible for managing member funds.

2. Pursuant to Arizona Revised Statutes (A.R.S.) § 36-557(O), a service provider may serve as a representative payee if requested by the member or the member's guardian and approved by the payer.

K. Residential Services – the services that include Room and Board, and daily Habilitation may be provided in one of the following settings: Group Home; Developmental Home; Nursing Supported Group Home.

Residential Room and Board is not a reimbursable service under ALTCS; therefore, it is the only residential service that is billable under the Arizona Administrative Code (A.A.C.) R6-6-1204.

L. Social Security Benefits - Social Security (SSA, Title II) is a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner. A worker's spouse or children may become eligible for Social Security upon the worker's attainment of a certain retirement age, disability or death, if the worker becomes disabled or dies. The amount someone receives depends upon the age of the wage earner, the length of time worked

and the amount they earned from which Federal Insurance Contributions Act (FICA) taxes were withheld.

For more information regarding Social Security, visit the Social Security website at www.ssa.gov.

Supplemental Security Income (SSI), Title XVI, is a federal income maintenance program for the aged, blind, and disabled persons with few or no resources. The person must be blind, or disabled, or 65 or older, have limited income, and cannot have over $2,000 in allowable resources.

M. Veterans Benefits – Benefits payable to surviving spouses and dependents of military personnel who die while in active military service and to survivors of veterans who died after active service.

4004-B MEMBER FUNDS SYSTEM

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: DDD Operations Policy, 1005-D Representative Payee

When the Division of Developmental Disabilities (the Division) is approved by the Social Security Administration (SSA) to become the Representative Payee for a member (reference *DDD Operations Policy 1005-D Representative Payee*), Member Funds will establish a collective saving and checking account.

The collective saving and checking accounts and are comprised of:

A. Social Security Benefits (RSDI or SSA)

B. Social Security Income (SSI)

C. Wages earned by the member

D. Railroad Retirement (RR)

E. Veterans Benefits (VA)

F. Revenue from personal trust funds and estates

G. Monetary gifts

H. Earned interest

I. Other Sources.

J. Stipends

K. Civil Service

The Division will serve as the Representative Payee of last resort, when a member has no one else willing, or able, to manage his or her funds and cannot afford a Fee for Service Representative Payee.

The Division will not serve as Representative Payee when any outside bank, credit union, and other accounts have been established or opened on member's behalf. Separate accounts make it impossible to assure that the member's financial eligibility level for benefits or Arizona Long Term Care System Service (ALTCS) is not exceeded, including Achieving a Better Life Experience (ABLE) Accounts.

A member who can establish an ABLE account or other account has identified a "party" willing to manage his or her funds and can afford a Fee for Service Payee. Upon request to transfer monies from a Member Fund account into an ABLE account, the member's Support Coordinator, the member, and Social Security will be given a three – month notice of intent for the Division to discontinue as the Representative Payee. Failure to identify a new Representative Payee by the end of the 90-day notice period may result in Social Security suspending the member's benefits.

Division employees are prohibited from offering assistance or help an individual complete income tax forms unless they are the legal guardians for the members.

A. For the Division to become a Representative Payee for a member, the Support Coordinator must submit one of the following forms via email to the DDD DS Client Fund (DDDDSClientFund@azdes.gov): The DS stands for District South, DS is the only district that has a client funds unit we are statewide unit

1. For children, complete this form: *Request for DES/DDD to Become Representative Payee-Child (DDD-1831A).*

2. For adults, complete this form *Request for DDD to Become the Representative Payee (DDD-1822A*).

4004-D RESPONSIBILITIES

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. Support Coordination District Program Administrators and Managers are ultimately responsible for the proper use of the member funds.

B. The Division of Developmental Disabilities Business Operations and Client Funds will:

1. Ensure training, assistance, and technical guidance is provided to all employees responsible for member funds.

2. Exercise good judgment and due diligence in the administration of member funds.

3. Audit and provide administrative assistance to review activity related to member funds.

C. Confidentiality will be maintained in accordance with *Chapter 6001-A Confidentiality* of the Operations Policy Manual.

D. No Division employee shall offer assistance or in any way help an individual complete income tax forms, unless they are the legal guardians for the member.

4004-E SAFEGUARDING MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

Purpose

This policy establishes the Division of Development Disabilities (the Division, DDD) responsibilities as the Representative Payee Management of Accounts.

Separate Accounts

A. A separate accounting must be maintained for each member. The accounting must show all funds received or disbursed, and remaining balances.

B. Transactions posted to a member's Client Funds account must be traceable to an original source document, such as a *Request for Client Funds (DDD-1833A)*, a receipt, invoice, or bill, etc.

C. Electronic transfers to withdraw funds from member accounts are not allowed. An electronic transfers to deposit funds from the member's earned income source(s) must have prior authorization from the Client Fund Unit

Fund Transactions

A. All funds received must be documented through the Client Fund System.

B. Checks and other negotiable instruments received must be logged on a daily basis and endorsed with the restrictive statement, as follows:

- AZ DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF DEVELOPMENTAL DISABILITIES
- ACCOUNT NUMBER
- FOR DEPOSIT ONLY

C. Funds received must be deposited in the designated bank account in a timely manner. Appropriate safeguards must be present while funds are transported between the Division's facility and the bank.

D. The same person must not handle a transaction from beginning to end. If personnel and other resources permit, deposits, cash/check logging, client funds duties, and administrative functions will be separated.

E. The Client Fund System Manager acts in a fiduciary capacity, which includes responsibility to account for all funds in the Client Fund System.

Insurance purchased for members in the Client Fund System such as life or burial insurance must not list as beneficiary any of the following: any of the following as a beneficiary:

1. The Division
2. An employee of the Division
3. A paid contracted provider
4. An employee of a provider.

However, a family member who is also an employee of the Division or a provider may be listed as a beneficiary. Additionally:

- Any policy purchased must be of no cash value.
- Any policy purchased must show that the member is the sole owner of the policy.

F. All transactions and record keeping must be done confidentially. Only those who have been approved by the Division are allowed to review and to work with member records.

G. The Client Funds Unit will only release information directly to DDD Support Coordination, Social Security, Revenue Desk, ALTCS, and Office of Inspector General.

4004-F MEMBER FUNDS SECURITY

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Member funds will be kept in a secure safe or locked location until deposited. When the Fund Manager leaves the work area, the safe or other location shall be locked.

Funds shall not be stored in desks, unlocked files, purses, or other places that are not secure.

Computer access to member information shall be restricted by secure passwords. No one other than the fund manager and/or designee shall have knowledge of the safe key/combination or the password to secure files.

The District Business Operations Manager or designee shall reconcile member accounts monthly. The administrator of business operations must approve any exceptions.

4004-G DISBURSING MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. All disbursements will be by pre-numbered checks.

B. All disbursements, except by authority of the Support Coordination District Program Manager/Lieutenant Program Manager (DPM/LPM), must be authorized in the Individual Spending Plan.

C. All disbursements require the following:

1. Disbursements shall be documented by written requests for funds.

2. Any request over $500 must be approved by the Support Coordination Supervisor or a designee of equal to or higher ranking.

3. Documentation of the amount of each ongoing deduction for any billings including but not limited to residential.

4. Excess funds are not to be used for non-approved purchases. If disbursed funds exceed the cost of the approved purchase, these excess funds shall be returned to the member's account with a reconciliation statement accounting for purchases.

   The person processing an expenditure cannot be the payee of the check. Nor will the person maintaining accounting records or preparing checks also sign the checks.

D. All pre-numbered checks will be accounted for monthly in the following categories to aid in the bank reconciliation process:

1. Paid by bank (cancelled)

2. Void

3. Outstanding

4. Suspense File: Cash or checks in the hands of third parties for the purchase of goods and services for members will be signed for and a suspense file established pending paid receipts. Suspense files will be cleared within thirty days after full payment for goods and services.

E. It is the policy of the Social Security Administration that individuals shall be provided at least $30 monthly for their personal needs.

1. Member personal spending paid directly to the member does not require receipts.

2. However, any personal spending money not paid directly to the member requires supporting documentation verifying the use of these funds. Those entities required to account for members funds will maintain a log of all

expenditures for each member.

F. All non-personal spending money disbursed from the member's account for any good(s) or service(s) will be verified within 30 days, by an itemized receipt. The receipt must show:

1. The merchant name(s)
2. Receipt Date
3. Receipt amount
4. A description of the item(s) purchased, or services delivered.

G. Until the properly supported receipt form is submitted, no further requests for that vendor or individual will be processed unless specifically approved by the Support Coordination District Program Administrator or Manager or designee.

H. It is permissible for a request to designate that several disbursements be made in the name of a member over a period. Examples include monthly personal allowances or rent subsidy. Such requests remain in effect until the Support Coordinator submits paperwork to change or cancel the request.

I. A disbursement request charging a member's account will not be honored unless that account has sufficient funds to pay the entire amount requested. The requesting party will be so notified, and a modified request can be submitted.

J. All requests will be processed by the payment deadline set by the district business office or designated member fund system personnel.

4004 – H MEMBER FUNDS – PROVIDER RESPONSIBILITIES

REVISION DATE: 12/16/2020, 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: Operations Policy Manual, 4004-I, Ledgers Maintained by Providers

Provider Responsibility for Member Funds

Qualified Vendor, Independent Provider, or Individual/Guardian must:

A. Provide services and care for a member, may request to receive and maintain funds from the Division of Developmental Disabilities (DDD, the Division) on behalf of the member, for personal spending and other uses. These funds must be recorded in a ledger (Refer to the *Operations Policy Manual, Chapter 4004-I Ledgers Maintained by Providers)* maintained in the member's residence or at the provider or agency's business office.

1. When there is an opportunity to request a one-time allocation of funds for the member to be used for a specific purchase or activity, this funding is in addition to the member's ongoing monthly spending funds and must be requested *from DDD Support Coordinator* and pre-approved.

2. For a reimbursement submission, use the *Expenditure Reconciliation (DDD-1832A)* form for all special funding requests for a one-time purchase or expense.

B. Provide a record of all member-designated funds received and proof of how they were spent to be fully approved and advanced by the Division.

C. Provide services and care for a member may request to receive and maintain funds from the Division of Developmental Disabilities (DDD, the Division), on behalf of the member, for personal spending and other uses. These funds must be recorded in a ledger (Refer to *Operations Policy Manual, Chapter 4004-I*) maintained in the member's residence or at the provider or agency's business office.

When there is an opportunity to request a one-time allocation of funds for the member to be used for a specific purchase or activity, this funding is in addition to the member's ongoing monthly spending funds and must be requested from the Division and pre-approved. A special funding request for a one-time purchase or expense must be submitted for reimbursement using the *Expenditure Reconciliation (DDD-1832A)* form.

D. Provide a record of all member-designated funds received and proof of how they were spent, to be fully approved and advanced by the Division.

Proper Use of Member Funds

A. Member special funds requests are for **member use only unless** written approval has been granted by the Social Security Administration (SSA). The use of member funds to pay the expenses of another person(s) to assist in a specific task, i.e., accompany the member to a destination for an activity where they will require care

and supervision but will be able to participate. If SSA has given their approval, it will be noted on the *Expenditure Reconciliation (DDD-1832A)* form.

B. Monthly ongoing spending funds do NOT have SSA approval and should never be used to pay for another person's expenses.

Valid Receipts

A. A legible receipt of the expense is required. The receipt must not be altered in any way; all the information on the receipt must be printed and legible.

B. Detailed notes of the expense are required, including merchant name, date, total expense, and a description of the items purchased or a reason for the expense.

Limitations

The following Member special fund disbursements are prohibited from the following:

A. To loan, borrow, give, or provide to any person, for any reason, other than the reason described in the original request, this includes to other members, provider staff, relatives, or friends.

B. Purchase anything that is ordinarily required to be supplied by the Qualified Vendor, Independent Provider, Individual/Guardian, or the Division.

C. For unauthorized purchases, the Division requires the Support Coordinator to provide written approval for amendments to the currently authorized expenditure.

D. To exceed the amount advanced of funds. The Division requires the Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

The Qualified Vendor, Independent Provider, or Individual/Guardian are prohibited from the following:

A. Establishing, assist in the application process, be included in the application process, or otherwise obtaining a credit card in the member's name.

B. Establishing, assist in the application process, be included in the application process, or otherwise obtaining a bank account or joint bank account for a member

- Exception: The following is required when opening a bank account as a habilitation goal for the member to become his or her own payee:
    - An outline of the goal, with a timeline in the member's planning document.
    - A review of monthly bank statements submitted to DES/DDD Member Funds Systems office.

- Close supervision of the member's bank account and funds in the DES/DDD account to ensure that the funds in, if combined, do not create an overpayment of resources.

C. Allows the member any direct access to the special funds received and maintained on behalf of the member.

D. Altered receipts will not be accepted, and the amount of the altered receipt will be refunded back to the member's DES/DDD member account. The provider will not be reimbursed for the expense.

Reporting the Use of All Funds Advanced by the Division

Upon receiving a special funds disbursement, advanced by the Division, the Qualified Vendor, Independent Provider, or Individual/Guardian must submit the required documentation to the Member Funds Systems office, within 30 days from the issue date of the check, as follows:

A. Purchases that were made on-line will contain the following:

1. The confirmation order shows merchant names, items purchased, item amount, date ordered, and total amount paid.

2. The confirmation form is showing the delivered date.

   Note: If a gift card was purchased with a special fund's disbursement, and the gift card was used to purchase items on-line, also provide a legible receipt for the gift card's purchase.

3. *Expenditure Reconciliation (DDD 1832A)* form

4. All excess funds must be returned to member funds in the form of a cashier's check, money order, or Qualified Vendor business check and submitted to the DES/DDD Member Funds Systems office.

B. Purchases that were not made on-line will contain the following:

1. Legible receipts that show merchant name, items purchased, item amount, date ordered, and total amount paid.

   Note: If a gift card was purchased with a special fund's disbursement, also provide the receipt for the purchase of the gift card.

2. *Expenditure Reconciliation (DDD 1832A)* form.

3. All excess funds must be returned to member funds in the form of a cashier's check, money order, or Qualified Vendor business check and submitted to the DES/DDD Member Funds Systems office.

Reimbursement for Expenditures in Excess of Advanced Funds

To request reimbursement for expenditures not covered by the original advanced funds, submit the following documentation to the Member Funds Systems office:

A. Purchases that were made on-line will contain the following:

1. The confirmation page or receipt of the order showing merchant name, items purchased, item amount, date ordered, and total amount paid.

2. The confirmation page is showing the delivered date.

   Note: If a gift card was used to purchase items on-line, also provide a legible receipt for the purchase of the gift card.

3. *Expenditure Reconciliation (DDD 1832A)* form

4. Written approval from the Support Coordinator.

   Note: Member funds are only used for authorized expenditures. The Division requires the Division Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

B. Purchases that were not made on-line will contain the following:

1. Legible receipts that show merchant name, items purchased, item amount, date purchased, and total amount paid

   Note: If a gift card was purchased with the funds, also provide original receipts for the purchase of the gift card.

2. *Expenditure Reconciliation (DDD 1832A* form).

3. Written approval from the Support Coordinator.

   Note: Member funds are only used for authorized expenditures. The Division requires the Division Support Coordinator to provide written approval for any amendment to the currently authorized expenditure.

Gift Card Purchases

A. The purchase of a gift card requires the same accounting practices and oversight as a cash purchase. Original receipts for the purchase of the gift card and detailed receipts showing the use of the gift card are required. The Individual or Qualified Vendor must submit the required documentation to the Member Funds Systems office within 30 days from the date on which the Division issued the check, per the reporting requirement.

   A gift card has been purchased for a family/friend, only the original receipt for the purchase of the gift card is required.

B. The purchase of a gift card for use by the member requires the same accounting practices and oversight as a cash purchase. The Qualified Vendor, Independent Provider, or Individual/Guardian must submit the required documentation to the Member Funds Systems office within 30 days from the issue date of the check, per the reporting requirement. If the gift card is not used within the 30-day timeframe, then the gift card should be returned to the Division and the funds refunded to the member's account. A new gift card can be requested and used at a later date, within a new 30-day timeframe.

C. If a gift card has been purchased for a family member or friend, only the original receipt for the purchase of the gift card is required to be reported to the Division. The family member or friend is not required to use the gift card within a specific timeframe and is not required to produce a receipt to verify how they spent the gift card.

4004-I LEDGERS MAINTAINED BY PROVIDERS

REVISION DATE: 2/24/2021, 12/2/2020, 8/30/2013

EFFECTIVE DATE: January 15, 1996

REFERENCES: A.R.S. § 41-1345, SSA Guide for Organizational Representative Payees, Publication No. 17-013

Purpose

The purpose of this policy is to establish the requirements for maintaining ledgers of funds for Division of Developmental Disabilities (the Division) members.

A Qualified Vendor, Independent Provider, or Individual/Guardian who receives funds from the Division of Developmental Disabilities (the Division), family, employment, or other sources, on behalf of the member, is required to open and maintain a separate ledger for each member receiving these funds. The ledger is a financial record, composed of a separate sub-ledger recording all the transactions with a daily balance. The monthly ending balance must not exceed $200.00 for each member. The Qualified Vendor, Independent Provider, or Individual/Guardian is required to return funds in excess of $200.00 to the DES/DDD Member Funds Systems office for depositing back into the member's account.

The Division recommends using the following form – *Member Funds Monthly Ledger (DDD-2036A),* refer to the *Documents Center* in the Division's intranet.

Ledgers

A. The Qualified Vendor, Independent Provider, or Individual/Guardian must account for **all** funds received and spent in the ledger. The format of the ledger must include:

   1. The member's full name
   2. The reporting month and year
   3. The name of the Qualified Vendor, Independent Provider, or Individual/Guardian submitting the ledger.
   4. The beginning or rolled over balance from the previous month; (a "running All balance").
   5. The merchants name
   6. All funds received: Source(s) of the fund(s) and the date(s) received
   7. Expenditures: Memos on what was purchased, date(s), and receipt(s).
   8. Receipts must be legible and include the merchant's name, date of purchase, the total amount of purchase, and description of items purchased. If receipts are not available, the cost must be identified on the monthly ledger and may be subject to additional scrutiny based on the amount and circumstances.

B. Ledgers should not have negative amounts listed.

C. Ledgers must be maintained for a minimum of six years. The Qualified Vendor, Independent Provider, or Individual/Guardian must:

1. Submit a **monthly ledger,** receipts, and excess funds to the DES/DDD Member Funds Systems office by the 15th of each following month.

   Note: The member's monthly spending funds will be *suspended* if the monthly ledgers, receipts, and excess funds are not submitted by the 15th of each following month. (Refer to Calendar.)

Calendar	
At the end of the month:	Submit the ledger by:
January	February 15th
February	March 15th
March	April 16th
April	May 15th
May	June 15th
June	July 15th
July	August 15th
August	September 15th
September	October 15th
October	November 15th
November	December 15th
December	January 15th

2. Provide the ledger for review at each Planning Meeting or as requested by the Division, the member, or the responsible person.

3. Ensure that the member's monthly spending funds are used to meet acceptable day-to-day personal needs as agreed in the planning documents, including recreation and miscellaneous expenses as required by the Social Security Administration.

4. Ensure that the member's funds are not used to purchase items required to be supplied by the Qualified Vendor, Independent Provider, Individual/Guardian, or the Division.

a. Transportation for daily activities, including but not limited to day treatment, employment preparedness, and training, employment, medical appointments, visits with family and/or friends, and community activities.

Room and Board, including three meals daily and snacks and/or as per service specification, for residential services including group homes and developmental homes.

5. Keep member funds in a secure locked location.

6. Not allow the member to have direct access to funds.

7. Ensure that the monthly ledgers are closed, the receipts and unspent funds are returned, and any required documentation is submitted to the DES/DDD Member Funds Systems office within 15 days from the date a member returns home, is no longer receiving services, or is deceased.

D. The Support Coordinator will adjust the spending plan to ensure that the member funds maintained by the Qualified Vendor, Independent Provider, or Individual/Guardian do not exceed the balances outlined above. Any excess funds must be returned to the Member Funds System for deposit into the member's account.

Missing Funds

A. If any funds are discovered stolen or missing from the member's ledger or personal cash, the Qualified Vendor, Independent Provider, or Individual/Guardian must:

1. Report to the Division:

a. By the close of the next business day following the discovery of the loss or theft.

b. Member funds, balances, and ledgers are subject to audit. Any audit exceptions are the responsibility of the service provider for resolution and/or repayment.

2. Replace the funds within ten (10) working days of the discovery of the theft or missing funds.

B. The Statewide Member Fund Manager and/or District Program Manager will determine whether it is appropriate to refer issues to the Department of Economic Security (DES), Office of Special Investigations (OSI), and the Social Security Administration (SSA).

Missing Ledgers

A. If a ledger is discovered missing, the funds issued for that month including, any rolled over funds recorded from the previous month, must be returned within 15 days of discovery.

4004-J BANK RECONCILIATION

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Bank and checkbook balances shall be reconciled monthly. The duties of reconciling the bank and Member Fund System balances and maintaining the accounting records will be separated. Bank, petty cash, and change fund balances shall be reconciled in member accounts monthly.

The Member Funds System Manager or designee shall send Monthly Member Fund reconciliation reports to the Division of Business and Finance, Accounting Office.

Summaries of these reports are to be sent to the Business Operations Administrator.

A report on the number of Title XIX eligible individuals shall be sent monthly to local Arizona Health Care Cost Containment System (AHCCCS) office:

A. Those with balances over $1,500; and,

B. Those with balances over $2,000.

A report including all accounts with balances over $2,000 shall be sent to the District Program Administrator/Manager. This report shall be reviewed by management staff to ensure that District staff are working towards a spend down plan.

4004-K ADMINISTRATION OF MEMBER FUNDS

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-1204; DDD Operations Policy 4004-O

The Division of Developmental Disabilities (The Division, DDD) administers member funds in accordance with the intent of the individual or entity providing the funds.

A. For the economy and efficiency of administration, member funds are pooled into one bank account. Separate records are maintained that identify each member's funds. Separate records are maintained which identify all transactions and balances for each member's individual Member funds account.

B. Funds in the pooled bank account in excess of current requirements must be invested following the provisions of the Division's Policy Manuals.

C. Unless allowed by law, member funds, including interest earnings, are not used to pay the cost of administration, supplies, equipment, or services. However, bank and investment institution service charges for administering pooled checking and investment accounts may be offset against interest earnings.

D. Member funds must not be loaned to other members, state employees, or any other agency or person.

E. Member funds that are advanced by the Division must be reconciled against receipts for all expenditures

F. Member One Time Special Funds that are advanced by the Division must be submitted with original receipts within 30 days from the check's issue date.

G. Any expenditure in excess of the original funds advanced must be evidenced by an original receipt and written prior approval from the DDD Support Coordinator to be eligible for reimbursement.

H. Member funds are only used for authorized expenditures. DDD Support Coordinator written approval is required for any amendment to the currently authorized expenditure.

I. All unspent member funds that have been advanced to a third party for purchases or allowances will be returned to the Client Fund System office, deposited into the bank, and credited to the appropriate member's account.

J. Money is paid out of the Division-administered member accounts only under the supervision of the DDD Support Coordinator. Supervisory approval is required for dollar amounts over $500.00. Client Fund System disbursements require a completed *Request for Funds (DDD-1833A)* submitted to the Member funds Unit

K. The use of a credit card must not be approved.

L. The purchase of gift cards requires the same accounting practices, oversight, and original receipts turned within 30 days of issuance of funds just as if issued by check.

M. Upon Social Security's approval (via a *Social Security Appraisal/Request for Funds (DDD-1823A*)form, member funds may be used to pay for the extraordinary expenses of an escort or attendant when the member is traveling, on vacation, or participating in community activities.

1. These expenses may include the cost of transportation, admission fees, meals, and lodging.

2. Non Covered Expenses are Snacks, alcoholic beverages, and souvenirs, or other personal purchases for the escort or attendant.

Prior to any disbursement of funds, a *Social Security Appraisal/Request for Funds (DDD-1823A)* is completed by the Support Coordinator and submitted to the Client Fund System office for Social Security approval. Upon Social Security's approval (via a *Social Security Appraisal/Request for Funds (DDD-1823A*)) form, member funds may be used to pay for an escort/attendant's extraordinary expenses member is traveling, on vacation, or participating in community activities.

Covered expenses may include

- The cost of transportation, admission fees, meals, and/or lodging
- Tipping is permitted with meals. The tip amount must be included on the receipt and come to no more than 20% of the bill. If the member is splitting the cost of a group meal, then the contribution to the tip should be divided equally among the number of persons sharing the meal. The total tip must be no more than 20% of the bill.
- Non-Covered expenses may include snacks, alcoholic beverages, and souvenirs, or other personal purchases for the escort or attendant.

N. Funds belonging to members who no longer require financial management from the Division must be disposed of as noted in *the Division's Operations Policy 4004-O, Termination of a Member's Account*.

4004 - M CHANGES IN MEMBER STATUS

REVISION DATE: 09/30/2020; 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. If a member, whose funds are managed by the Division of Developmental Disabilities (the Division), experiences any change in status, the Support Coordinator (SC) or the designee notifies Member Funds staff, who reports all changes to Social Security directly.

1. Changes in status include:

a. The member passes away

b. The member moves

c. The member marries

d. The member starts or stops working, even if the earnings are small.

e. A member's condition improves

f. The member starts receiving another government benefit or the amount of that benefit changes.

g. The member plans to leave the United States for 30 days or more

h. The member is imprisoned for a crime that carries a sentence of over one month.

i. The member is committed to an institution by court order for a crime committed because of mental impairment.

j. Custody of a child changes or a child is adopted

k. A child’s parent’s divorce

l. The Representative Payee can no longer serve as the Representative Payee, or; the member no longer needs a Representative Payee.

B. Additional events which must be reported by the SC to the Member Funds Systems Office for Supplemental Security Income (SSI) beneficiaries include:

1. The member moves in to or is released from a hospital, nursing home, or other institution; or is relocated from one location to another.

2. A married member separates from his or her spouse, or they begin living together after a separation.

3. Somebody moves into, or out of, the member's household.

4. The member has any change in income or resources (a child's SSI benefit check may change if there are any changes in the family income or resources).

4004-N INVESTING MEMBER FUNDS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Interest earnings, minus any bank charges on Member funds that are invested in the State Treasurer's Office, will be apportioned to member's accounts quarterly based on account period ending balances.

4004-O TERMINATION OF A MEMBER'S ACCOUNT OR CHANGE IN REPRESENTATIVE PAYEE

REVISION DATE: 09/30/2020, 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887

Member Funds and the Death of a Member

When the Division of Developmental Disabilities (the Division) is notified that a member is deceased:

A. Benefits not payable must be returned to Social Security.

1. Social Security benefits are paid each month, representing payment for the previous month. When a person who receives social security benefits dies, no payment is due for the month of death, even if he or she dies on the last day of the month.

   Example: May 3rd SSA benefits are received April benefits, not May. If the member passes away in April, the benefit for April received in May must be returned to Social Security. The member is not entitled to a payment for the month of death.

2. Supplement Security Income (SSI) benefits are for the month in which they are paid. Therefore, the SSI benefit is paid for the month of death. SSI benefits received for months after the month of death must be returned.

   Example: May 1st SSI benefit is received, and the member died May 25 the SSI is retained. Suppose an SSI payment is received on June 1st that must be returned to Social Security.

B. All outstanding debts will be paid as the fund balance allows, including residential billing in accordance with the applicable rule and law.

C. Burial expenses may be paid as the fund balance allows.

D. Remaining fund balances are returned to the legal representative of a member's estate for disposition under state law.

   When there is no entity to receive money from the member's account, and there is no family, guardian, custodian, executor, or beneficiary, the following Arizona Revised Statutes will apply in the disbursement of the account: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887.

Social Security Selected a New Representative Payee

When the designated Representative Payee changes from the Division to another entity, all debts incurred while the Division was the Representative Payee must be paid, and all member funds identified as Social Security Benefits must be returned to the SSA. The

new Representative Payee may then request these funds from the SSA. The funds are not to be transferred directly from the Division to the new Representative Payee.

Inactive Accounts

Accounts determined to be inactive (having no transactions for a year or more) will be terminated after reasonable efforts to dispense the funds have failed. The account will be closed, and funds sent to the Arizona State Revenue after five (5) years, if unclaimed. (Unclaimed Property – Arizona Department of Revenue, Unclaimed Property Unit.)

5000 REINSURANCE POLICY

REVISION DATE: 11/8/2023
EFFECTIVE DATE: 8/11/2021
REFERENCES: 42 U.S.C. § 1396b (i); 42 U.S.C. § 1396d(r)(5); 42 C.F.R. § 441.35; 42 C.F.R. § 433.135 et seq.; A.R.S. § 36-2903; A.R.S. § 8-512; Title XIX/XXI; A.A.C. R9-22-1001; A.A.C. R9-22-720; AHCCCS Reinsurance Manual; AHCCCS Contract; ISA DD-THP; ACOM 414; AMPM 1620-I; AMPM 310-DD; AMPM 300-2A; AdSS Operations Manual, Policy 414; DDD Operations Policy Manual 414; AdSS Medical Policy Manual 310-DD; DDD Medical Policy Manual 310-DD

PURPOSE

The purpose of this policy is to outline the requirements the Division must meet to request Reinsurance reimbursement from the Arizona Health Care Cost Containment System (AHCCCS).

DEFINITIONS

1. "Adjudicated Claim" means a claim that has been received and processed by the AdSS which resulted in payment or denial of payment.
2. "Behavioral Health Services" or "BHS" means physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue.

3. "Biologic Drugs" means products produced by biotechnology. These drugs are referred to as biologicals, biologic drugs, biological drugs, or biopharmaceuticals.
4. "Case" means a record for a Member that is composed of one or more Adjudicated Encounters.
5. "Case Type" means a description of the type of Reinsurance being paid to the Division based on the Member's medical condition and eligibility. Case Types include, but are not limited to DES, Hemophilia, von Willebrand Disease, Gaucher's Disease, Biologic or high cost specialty drugs, transplants, and High Cost Behavioral Health Services.
6. "Catastrophic Reinsurance" means reimbursement, full or partial, depending on the Case Type, from AHCCCS to the Division for the cost of care associated with certain medical conditions and specific drugs described in the Contract, AMPM, and DDD policy.
7. "Clean Claim Status" or "Clean Encounter" means a claim or Encounter that may be processed in the AHCCCS Prepaid Medical Management Information System (PMMIS) without obtaining additional information from the Contractor of service or from a third party; and has passed all of the Encounter and Reinsurance edits within the 15-month timely

filing deadline. This does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

8. "Coinsurance" means the percentage rate, established each Contract Year by AHCCCS, at which AHCCCS will reimburse the Division for covered services incurred above the Deductible.
9. "Contract" means, for the purposes of this policy, the legal written agreement that the Division has with AHCCCS for providing health care coverage to Members who are eligible for ALTCS. This coverage includes physical health services and Behavioral Health Services.
10. "Contractor" or "Division" for the purposes of this policy, means an organization or entity that has a prepaid capitated Contract with AHCCCS to provide goods and services to Members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and Federal law, and regulations.
11. "Contract Year" means the twelve-month period beginning on October 1st through and including September 30th for Reinsurance. The Contract Year may not correspond with the term of a Contract as specified in Section A of an entity's Contract with AHCCCS.

12. "Deductible" means the annual amount, established each Contract Year by AHCCCS, of Reinsurance covered services that must be paid and encountered by the Division for each individual Member before the Division receives Reinsurance payments from AHCCCS.
13. "DES Case Type" means certain covered inpatient facility services as described in the Contract, AMPM, and this policy that may qualify for Reinsurance reimbursement.
14. "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" means covered services for Members under 21 to correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act (Federal Law Subsection 42 USC 1396d (a)). Services are covered under EPSDT even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.
15. "Encounter" means a record of health care related service that is a mirror image of a claim and is rendered by a provider or providers

registered with AHCCCS to a Member who is enrolled with the Division on the date of service.

16. "Gaucher's Disease" means an inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
17. "Hemophilia" means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of Hemophilia - A, B, and C. The severity of Hemophilia is related to the amount of clotting factor in the blood.
18. "High Cost Behavioral Health" or "BEH" means specialized mental health services for ALTCS Members that were discontinued under Catastrophic Reinsurance, unless the Member was approved prior to October 1, 2007 and was active on September 30, 2007.
19. "Member" means the same as "client" as defined in A.R.S. § 36-551.
20. "Prepaid Medical Management Information System" or "PMMIS" means the AHCCCS mainframe pricing system of record that the Division uses for accessing the Reinsurance System.

21. "Prior Period Coverage" or "PPC" means the period of time prior to the Member's enrollment, during which a Member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a Member is enrolled with the Division.
22. "Prospective Coverage" means the period of time from when the AdSS receives notification the Member has been assigned to their plan and is expected to be capitated for the Member.
23. "Regular Reinsurance" means a partial reimbursement from AHCCCS to the Division for covered inpatient facility services (DES Case Type) as described in the Contract, AMPM, and DDD policy.
24. "Reinsurance" or "RI" means a stop-loss program provided by AHCCCS to the Division for the partial reimbursement of covered medical services incurred for a Member beyond an annual Deductible level.
25. "Reinsurance Payment Cycle" means the monthly updating of Reinsurance files in PMMIS for payment processing starting the first Wednesday of the month from 5:00 p.m. until the following Wednesday morning.
26. "Reinsurance System" means the PMMIS application for accessing Reinsurance Case data.

27. "Skilled Nursing Facility" or "SNF" means a nursing facility for those Members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.
28. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for AHCCCS benefits.
29. "Von Willebrand Disease" means an inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

POLICY

A. GENERAL REINSURANCE REIMBURSEMENT REQUIREMENTS FOR ALL CASE TYPES

1. The Division shall comply with the terms and conditions of the Contract with AHCCCS.
2. The Division shall require the Administrative Services Subcontractors (AdSS) to be responsible for the annual Deductible levels as determined by AHCCCS for covered medical services for each Member for the Contract Year.

3. The Division shall submit Reinsurance reimbursement requests from the AdSS to AHCCCS for Reinsurance covered services incurred for a Member beyond the annual Deductible level.
4. The Division shall require Encounters from the AdSS to meet the following criteria to qualify for Reinsurance reimbursement:
    a. The Encounter is approved and adjudicated within required time frames per the AHCCCS Contract and this policy;
    b. The Encounter associates to a Reinsurance Case;
    c. The Encounter is medically necessary;
    d. The service is non-experimental;
    e. The service is cost effective; and
    f. The service does not exceed an established cost threshold.
5. Upon receiving the Reinsurance funds from AHCCCS, the Division shall reimburse the AdSS the established AdSS Contract Coinsurance rate for Encounters that associate to a Reinsurance Case.
6. The Division shall not reimburse the AdSS for final Reinsurance claims which cross over Contract Years.

7. The Division shall base reimbursement of all covered Reinsurance Encounters on the following, unless costs are paid under a sub-capitated arrangement as outlined in subsection (8):
    a. Costs paid by the AdSS;
    b. Net of interest;
    c. Penalties;
    d. Discounts;
    e. AHCCCS Coinsurance rates;
    f. Medicare payment; and
    h. Third Party Liability (TPL) payment.
8. The Division shall base reimbursement of Reinsurance Encounters for costs paid under a sub-capitated arrangement on the following:
    a. The lower of the AHCCCS allowed amount;
    b. Reported AdSS paid amount;
    c. Net of interest;
    d. Penalties;
    e. Discounts;

f. AHCCCS Coinsurance rates;

g. Medicare payment; and

h. TPL payment.

9. The Division shall refer to the Reinsurance page on the AHCCCS website for current:

a. Deductible levels;

b. Coinsurance rates;

c. Eligibility requirements;

d. Documentation requirements;

e. Covered high cost or Biologic drugs;

f. Required time frames for submitting documentation and requests;

g. Reinsurance forms;

h. AHCCCS Reinsurance policy;

i. Transplant rates and Contracts; and

j. Reinsurance processing training manual and instructions.

10. The Division and the AdSS shall coordinate benefits with first party, Medicare, and TPL payers as required by Division Operations Policy Chapter 4001 and by the AHCCCS Contract.

11. The Division shall submit requests for Reinsurance reimbursement to AHCCCS by 5:00 p.m. if the due date lands on a business day; or by 5:00 p.m. the next business day, if the due date lands on a weekend or State-recognized holiday.
12. The Division may perform medical audits on Reinsurance Cases with advance notice to the AdSS.

B. REGULAR REINSURANCE (DES CASE TYPE) REQUIREMENTS

1. The Division shall request from AHCCCS partial reimbursement for the following Regular Reinsurance covered inpatient hospital services provided to Members:
    a. Acute care hospitals (provider type 02);
    b. Specialty per diem hospitals (provider type C4);
    c. Accredited psychiatric hospitals (provider type 71);
    d. Per diem rates for Skilled Nursing Facility (SNF) services provided within 30 days following an acute inpatient hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any Contract Year when:

i. The SNF stay is the first continuous SNF stay post inpatient discharge; or

ii. The second SNF admission follows an additional inpatient stay.

e. Services specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".

2. The Division shall not request Regular Reinsurance from AHCCCS for the following inpatient provider service types that are not covered by AHCCCS:

a. Same day admit-and-discharge services;

b. Mental health residential treatment centers;

c. Subacute facilities; and

d. Services that are not specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".

3. The Division shall pay Regular Reinsurance for the Member's Prospective Coverage and Prior Period Coverage (PPC) enrollment periods.

4. The Division shall reimburse the AdSS for Regular Reinsurance benefits once per month, subject to the availability of funds.

5. The Division shall follow the same requirements in this section for requesting Regular Reinsurance for Tribal Health Program (THP) claims.
6. The Division shall not pay Regular Reinsurance on the following types of claims:
    a. Final claims that cross over Contract Years; and
    b. Interim claims.
7. The Division shall request Regular Reinsurance consideration from AHCCCS for the final claim associated with the full length of a Member's hospital stay as long as the days of the hospital stay do not cross Contract Years.

C. GENERAL CATASTROPHIC REINSURANCE REQUIREMENTS

1. The Division shall request from AHCCCS partial reimbursement of Catastrophic Reinsurance for medically necessary covered services provided to Members for the following Case Types:
    a. Hemophilia;
    b. Von Willebrand Disease;
    c. Gaucher’s Disease;
    d. Biologic or high-cost specialty drugs;

e. High Cost Behavioral Health; and

f. Case Types other than transplants exceeding $1 million.

2. The Division shall not require Deductibles for Catastrophic Reinsurance Cases.

3. The Division shall request a new Catastrophic Reinsurance Case by submitting the following documents received from the AdSS to the AHCCCS Division of Health Care Management (DHCM) Medical Management Department (MM) within 30 days of the Member's initial diagnosis or enrollment with the Division:

   a. The Request for Catastrophic Reinsurance form; and

   b. Supporting clinical documentation.

4. The Division Health Care Services (HCS) shall review medical documentation submitted by the AdSS to confirm the Member's medical condition meets the criteria in Sections D, E, and F of this policy prior to submitting a request for a new Catastrophic Reinsurance Case to the AHCCCS MM.

5. The Division shall submit the following documentation received from the AdSS to the AHCCCS MM within 30 days of the start of

the Contract Year for continuation of previously approved Catastrophic Reinsurance Cases:

a. The Request for Catastrophic Reinsurance form; and

b. The Non-Transplant Catastrophic Reinsurance Member List form.

6. The Division may require supporting clinical documentation from the AdSS for previously approved Catastrophic Reinsurance.

7. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Catastrophic Reinsurance forms to the AdSS that submitted the request.

8. The Division shall utilize the AHCCCS Contract for Hemophilia factor and blood disorders as the authorizing payor.

9. The Division shall reimburse the AdSS for all medically necessary services provided during the Contract Year:

a. The current Coinsurance Rate for Catastrophic Cases; or

b. The AdSS’s paid amount, whichever is lower, depending on the subcap/CN1 code on the Encounter.

10. The Division shall reimburse the AdSS Catastrophic Reinsurance retroactively for a maximum of 30 days from the date the request is received by the AHCCCS MM.
11. The Division shall delegate prior authorization and care coordination to the AdSS for all components covered under the Contract for their Members.
12. The Division shall pay Reinsurance on catastrophic claims that contain any PPC and Prospective Coverage.

D. CATASTROPHIC REINSURANCE COVERAGE FOR BLOOD DISORDERS

1. The Division shall ensure Catastrophic Reinsurance coverage is available for all Members diagnosed with Hemophilia.
2. The Division shall base Catastrophic Reinsurance coverage for von Willebrand Disease on the following criteria:
    a. Type 1 and Type 2A that do not respond to desmopressin (DDAVP);
    b. Type 2B, Type 2M, and Type 2N based on diagnosis only; and
    c. Type 3 based on diagnosis only.

3. The Division shall base Catastrophic Reinsurance coverage for all Members diagnosed with Gaucher's Disease Type I.
4. The Division shall not request Catastrophic Reinsurance for Gaucher's Disease Type 2 and Type 3.

E. CATASTROPHIC REINSURANCE COVERAGE FOR BIOLOGIC OR HIGH-COST SPECIALTY DRUGS

1. The Division shall request Catastrophic Reinsurance from AHCCCS to cover the cost of medically necessary Biologic and high-cost specialty drugs for Members.
2. The Division shall request Catastrophic Reinsurance for the covered Biologic and high cost specialty drugs listed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website.
3. The Division shall reimburse Catastrophic Reinsurance to the AdSS as follows when a biosimilar or generic equivalent of a Biologic Drug is available, and is more cost effective than the brand-name product:
    a. The current Catastrophic Coinsurance rate of the lesser of the Biologic or high-cost or its biosimilar equivalent for

Reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific Member.

b. The current Catastrophic Coinsurance rate of the paid amount of the branded Biologic Drug if the AHCCCS Pharmacy and Therapeutics Committee mandates the utilization of only the brand name Biologic or high-cost specialty drug rather than the biosimilar.

4. The Division shall, in the instances in which AHCCCS has specialty Contracts, or when legislation and policy limits the allowable reimbursement, shall reimburse the Catastrophic Coinsurance rate of the lesser of:
   a. The AHCCCS contracted or mandated amount; or
   b. The AdSS's paid amount.
5. The Division may submit requests for new biological drugs or high-cost specialty drugs to the AHCCCS Reinsurance Unit for consideration for Reinsurance purposes.
6. The Division shall require the AdSS to encounter all Biologic or high-cost specialty drugs on a Form C pharmacy claim to be eligible for Reinsurance.

F. CATASTROPHIC REINSURANCE COVERAGE FOR HIGH COST BEHAVIORAL HEALTH

1. The Division shall request Catastrophic Reinsurance reimbursement from AHCCCS for medically necessary covered services provided during the Contract Year for Members enrolled in the High Cost Behavioral Health (BEH) Program prior to October 1, 2007.
2. The Division shall submit the following to the AHCCCS MM no later than 10 business days prior to the expiration of the current approval to request continuation of BEH Reinsurance Reimbursement:
    a. The High Cost Behavioral Health Reinsurance form, located in the AHCCCS website reauthorization request; and
    b. Supporting medical documentation as required in AMPM 1620-I.
3. The Division shall use Adjudicated Encounters for covered services provided to enrolled BEH Members to determine Reinsurance reimbursement.

4. The Division shall base Reinsurance coverage on documentation substantiating the Member's treatment is provided in the least restrictive treatment setting.

G. HIGH DOLLAR CATASTROPHIC REINSURANCE COVERAGE - $1,000,000+

1. The Division shall reimburse the AdSS 100% for all medically necessary Reinsurance covered expenses provided in a Contract Year for Case Types other than transplants, after the Reinsurance Case total value meets or exceeds $1 million, which is comprised of:
   a. The total AdSS paid amount; and
   b. The Deductible.
2. The Division shall require the AdSS to notify the Division once a Reinsurance Case total value reaches $1 million.
3. The Division, upon notification from the AdSS that a Reinsurance Case total value has reached $1 million, shall submit to AHCCCS:
   a. A Reinsurance Action Request form via the SFTP;
   b. A Catastrophic Case CRN Transfer Request form via the SFTP;

c. A request via email to the AHCCCS Reinsurance Supervisor and Reinsurance Analyst to create Case for the specific Case Type.

4. The Division shall disqualify the AdSS from receiving 100% reimbursement for Catastrophic Cases and related Encounters exceeding $1 million when the AdSS fails to do the following within 15 months of the end date of service:

a. Notify the Division of a Reinsurance Case reaching $1 million; or

b. Notify the AHCCCS Reinsurance Unit of Encounters that should be transferred; or

c. Adjudicate related Encounters.

H. CATASTROPHIC REINSURANCE COVERAGE FOR THP MEMBERS

1. The Division shall request Catastrophic Reinsurance reimbursement from AHCCCS for THP Members for the following Case Types:

a. Hemophilia;

b. Von Willebrand Disease;

c. Gaucher’s Disease;

d. Biologic or high-cost specialty drugs;

e. High Cost Behavioral Health; and

f. Case Types other than transplants exceeding $1 million.

2. The Division shall identify THP Cases eligible for Catastrophic Reinsurance reimbursement by data mining Encounters and claims information received weekly from AHCCCS and the AHCCCS pharmacy benefit manager.

3. The Division shall adhere to the general Catastrophic Reinsurance requirements listed in Section C of this policy for THP Members.

4. The Division shall use the same Case Type criteria for coverage of the medical conditions in Sections D, E, F, and G of this policy for THP Members.

J. TRANSPLANT REINSURANCE OVERVIEW

1. The Division shall request transplant Reinsurance from AHCCCS to partially reimburse the AdSS for the cost of care for enrolled Members:

a. Age 21 years and older who meet transplant Reinsurance coverage criteria for the specific transplant types listed AMPM 310-DD and the AHCCCS State Plan.

b. Under age 21, who under the EPSDT Program, are covered for all non-experimental transplants necessary to correct or ameliorate defects, illnesses, and physical conditions whether or not the particular non-experimental transplant is covered by the AHCCCS State Plan or listed in AMPM 310-DD.

2. The Division shall comply with the terms and conditions of the AHCCCS transplant specialty Contract.

3. The Division shall not require Deductibles for Transplant Reinsurance Cases.

4. The Division shall reimburse the AdSS the AHCCCS contracted Coinsurance rate for transplant services that qualify for Reinsurance.

5. The Division shall reimburse the AdSS the current AHCCCS contracted rates for the following transplant components:

a. Outpatient transplant evaluation;

b. Donor search and harvesting of the donor cells for stem cell transplants;

c. Preparation and transplant; and

d. Post-transplant care (Days 1 – 30 and Days 31 – 60).

6. The Division shall require the AdSS to notify the Division and AHCCCS when a Member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant.

7. The Division shall oversee the following responsibilities of the AdSS when the AHCCCS transplant specialty Contract is used:

a. Prior authorization; and

b. Care coordination.

K. TRANSPLANT CASE CREATION REQUIREMENTS

1. The Division shall require the AdSS to submit the Request for Transplant Reinsurance form to the Division within 30 days of the Member's first component of the transplant.

2. The Division HCS shall review all Requests for Transplant Reinsurance forms, supporting clinical documentation, and relevant AdSS policy received from the AdSS to confirm whether the transplant is:

a. Medically necessary;

b. Covered by AHCCCS;

c. Considered the standard of care; and

d. Not considered experimental.

3. The Division, upon determining the criteria are met in item 2 of this section, shall submit the Request for Transplant Reinsurance form received from the AdSS to the AHCCCS MM within 30 days of the Member's first component of the transplant to request approval and activation of the transplant Case in the PMMIS system for Reinsurance reimbursement.

4. If the Division receives a request for transplant Reinsurance that is outside the criteria in J(1)(a) of this policy, the Division may consult an independent review organization regarding whether a request for transplant Reinsurance is considered the standard of care and medically necessary.

5. If the Division determines the transplant should be authorized after receiving consultation from an independent review organization, the Division shall notify the AHCCCS MM of the

pending decision and submit the Request for Transplant Reinsurance form as required in item 1 of this section.

6. The Division shall submit to AHCCCS MM the Transplant Reinsurance Crossover Member List received from the AdSS for Members requiring continuation of previously approved transplant Reinsurance.
7. The Division shall refer to the Reinsurance Transplant Case Key Entry Instructions Manual on the AHCCCS website for transplant case management in the PMMIS system.
8. The Division may deny Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean Reinsurance claims; or
    b. Failure to submit the Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.
9. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Transplant Reinsurance forms to the AdSS that submitted the request.

L. REQUIRED TRANSPLANT CASE COMMUNICATION

1. The Division shall communicate the Division's transplant activity by submitting Quarterly Transplant Log form located on the AHCCCS website to the AHCCCS MM no later than 15 days after the end of each quarter as instructed in the AHCCCS Reinsurance Processing Manual.
2. The Division shall not alter or password protect the Quarterly Transplant Log format prior to submission to AHCCCS.
3. The Division shall submit the Quarterly Transplant Log with all the transplant activity from the previous Contract Year on or before October 15th of each year.
4. The Division shall remove all non-active Members from the Quarterly Transplant Log that is submitted for the new Contract Year on or prior to January 15th.
5. The Division shall only include transplant components that are reinsurable by AHCCCS on the Quarterly Transplant Log for the new Contract Year.

M. TRANSPLANT CLAIM REINSURANCE REIMBURSEMENT

1. The Division shall not reimburse the AdSS Regular Reinsurance if AHCCCS determines that a transplant is not eligible for transplant Reinsurance coverage.
2. The Division shall not reimburse the AdSS for the following transplants that are not eligible for transplant Reinsurance coverage:
    a. Bone graft transplants;
    b. Corneal transplants; and
    c. Kidney transplants.
3. The Division may submit to AHCCCS for consideration a request for Regular Reinsurance for transplants that do not qualify for transplant Reinsurance.
4. The Division shall not reimburse transplant Reinsurance for Members who have TPL including:
    a. Medicare Part A; or
    b. Medicare Parts A and B.

5. The Division may reimburse transplant Reinsurance, less any payments received from Medicare, for Members with Medicare coverage under the below circumstances:
    a. If the Member has Medicare Part A and has exhausted their Medicare Part A benefit including lifetime reserve days during a transplant stage, only that stage and subsequent stages may qualify for Reinsurance.
        i. If the Member chooses not to use their available lifetime reserve days, the transplant stages will not qualify for transplant Reinsurance.
    b. If the Member has Medicare Part B only.
    c. If the Member qualifies for partial transplant coverage, an explanation of benefits (EOB) with Medicare payments must:
        i. Balance with the Medicare payments in PMMIS; and
        ii. State that the Member has exhausted Medicare Part A.
6. The Division shall pay transplant Reinsurance reimbursement if Medicare does not cover a transplant type based on the

Member's diagnoses and the transplant type is an AHCCCS covered benefit.

7. The Division shall not apply quick pay discounts or interest to transplant Reinsurance reimbursements.
8. The Division shall retroactively reimburse transplant Reinsurance to the AdSS a maximum of 30 days from the date the Request for Transplant Reinsurance form was received and approved by AHCCCS.
9. The Division shall require the AdSS to submit clean Reinsurance claims to AHCCCS no later than 15 months from the end date of service for each transplant component in order to receive transplant Reinsurance reimbursement.
10. The Division shall recognize the submission date of Reinsurance claims to AHCCCS as the date of receipt by the AHCCCS Administration, DHCM Reinsurance Unit.
11. The Division may deny transplant Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean transplant Reinsurance claims; or

b. Failure to submit the Request for Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

12. The Division shall require the AdSS to file transplant Encounters with a CN1 code of 09 in order for the Encounter to associate to the transplant Case.

13. The Division shall require the AdSS to void and replace an incorrectly coded transplant Encounter with the correct CN1 code if there is more than 45 days before the 15-month timely filing deadline.

14. If there is less than 45 days before the 15-month timely transplant claim filing deadline, the Division may require the AdSS to:

    a. Submit a request to the AHCCCS Reinsurance analyst to manually associate transplant Encounters to the transplant Case; and

    b. Submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15-month timely filing deadline.

15. The Division shall only reimburse transplant Reinsurance for adjudicated Encounters that are associated with the transplant Case.
16. The Division shall reimburse Reinsurance for transplant stages when billed amounts and health plan paid amounts for adjudicated Encounters agree with supporting transplant claim and invoice amounts on the PMMIS RI115 screen.
17. The Division shall apply prorated calculations based on the number of days used in the stage only when:
    a. Tandem transplants occur; or
    b. A Member changes Health Plans, in the middle of a transplant stage.
18. The Division shall submit the following documentation received from the AdSS to the AHCCCS Reinsurance SFTP folder to request Reinsurance reimbursement for transplant stages:
    a. The Transplant Stage Invoice Cover Sheet; and
    b. The transplant checklist documentation requirements from the AHCCCS Reinsurance Processing Manual.

19. The Division shall calculate timeliness for each transplant stage payment based on the latest adjudication date for the complete set of Encounters related to the stage.
20. The Division shall notify AHCCCS by email that the information in item 18 a. - b. has been posted to the AHCCCS Reinsurance SFTP folder.

N. REQUIREMENTS FOR TRANSPLANTS THAT SPAN CONTRACT YEARS

1. The Division shall base the transplant stage Reimbursement rate on the end date of the stage.
2. The Division shall require the AdSS to split a transplant stage spanning two Contract Years based on the actual dates within the two Contract Years.
3. The Division shall not require the AdSS to split transplant Encounters spanning two Contract Years unless a transplant component exceeding 60 days exists.
4. The Division shall submit the Reinsurance Action Request Form received from the AdSS to the AHCCCS DHCM Reinsurance Unit

to request the transfer of transplant Encounter(s) spanning Contract Years to the Case based on the end date of the stage.

O. OUTLIER THRESHOLD COVERAGE FOR TRANSPLANTS

1. The Division shall pay the AdSS transplant outlier coverage upon AHCCCS approval of the AdSS's request for outlier coverage of a transplant Case.
2. The Division shall submit the following documentation received from the AdSS to the AHCCCS DHCM Reinsurance Unit to request consideration for transplant outlier coverage:
    a. Transplant Outlier Template form located on the AHCCCS website; and
    b. The documentation listed in the outlier checklist from the AHCCCS Reinsurance Processing Manual.

P. CLAIM ENCOUNTER DOCUMENTATION AND TIMEFRAMES FOR TRANSPLANT CONTRACTS

1. The Division shall submit adjudicated transplant claims for each stage of the solid organ transplantation or hematopoietic cellular therapy received from the AdSS to the AHCCCS DHCM

Reinsurance Unit no later than 15 months from the end date of service.

2. The Division shall consider adjudicated and payable transplant Encounters for the particular transplant stage completed on or before the 15-month timeframe, as a Clean Claim.
3. The Division shall require the AdSS to submit outlier claim components to the Division no later than 15 months from the end date of the last completed stage.
4. The Division shall submit the transplant Encounter file received from the AdSS to the AHCCCS DHCM Reinsurance Unit at least 45 days prior to the 15-month deadline to ensure that the adjudication meets the 15-month timeframe.
5. If the Division submits the Encounter file to AHCCCS less than 45 days before the 15-month timeframe and the adjudication has not been completed by the 15-month deadline, then the claim will be denied for not having achieved Clean Claim status within the required timeframe.

6. The Division shall base timeliness of the claim submission for each stage of the transplant on the submission date for the complete set of Encounters related to the stage.
7. The Division shall base timeliness for each transplant stage payment on the latest adjudication date for the complete set of Encounters related to the transplant stage.

Q. POST TRANSPLANT INPATIENT STAYS EXCEEDING 11 OR 61 DAYS

1. The Division shall apply the following requirements for continuous post-transplant inpatient care from the date of the prep and transplant component from day 11+ and for kidney transplants from day 61+ for all other Case Types:
   a. The Division shall reimburse the claim or Encounter for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other Case types for all Members at 75% of the transplant per diem rate less the Deductible.
   b. The Division shall pay outlier reimbursement when the cost threshold of the claim or Encounter for the continuous

inpatient stay for day 11+ for kidney transplants and day 61+ for all other Case Types is met or exceeded.

c. The Division shall ensure all day 11+ and day 61+ Encounters are received by AHCCCS prior to adjudication.

d. The Division shall split Encounters submitted for a day 11+ and day 61+ stage that spans Contract Years.

e. The Division shall refer to the AHCCCS website to access the Day 11+ or 61+ Transplant Component Worksheet and Instructions form.

2. The Division, using the Day 11+ or 61+ Outlier Worksheet and Instructions from the AHCCCS website, shall request from AHCCCS outlier reimbursement for transplant days 11+ and 61+ paid at the per diem rate pursuant to the AHCCCS transplant specialty Contract at an established cost threshold.

R. TRANSPLANT TRANSPORTATION AND LODGING REINSURANCE REIMBURSEMENT REQUIREMENTS

1. The Division shall reimburse Reinsurance for transportation, room, and board to the AdSS at the AHCCCS allowable rates for

the transplant candidate or recipient, potential donor or donor and, if needed, one adult caregiver.

2. The Division shall require the AdSS to submit a request to AHCCCS Reinsurance Finance using the Transplant Transportation Lodging form found on the AHCCCS website.

S. MULTI-ORGAN TRANSPLANTS THAT ARE NOT COVERED IN THE AHCCCS SPECIALTY CONTRACTS

1. The Division may request authorization from AHCCCS MM for transplant Cases that overlap when a second transplant component is started within the timeframe of an established component.
2. If a Member requires a multi-organ transplant, the Division shall request Reinsurance for the following:
   a. The preparation and transplant components for each organ when performed separately; and
   b. The post-transplant component that provides the AdSS with the highest reimbursement and covers the longest period of time.

c. The surgical component of the second transplant, if a second covered organ transplant is performed during the post-transplant periods of the first transplant.

3. If approved by AHCCCS, the Division shall reimburse prorated Reinsurance for the first transplant component and provide Reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1-30 post-transplant component and the day 31- 60 post-transplant component.

4. The Division shall follow all applicable notification and claims filing requirements when requesting authorization for Reinsurance reimbursement for multi-organ transplants that are not covered by AHCCCS.

T. MULTI-SEQUENCE TRANSPLANTS

1. The Division shall request authorization from AHCCCS MM for a transplant Case that requires an additional transplant for the same transplant type and an additional transplant sequence is started within the timeframe of an established component.

2. If a Member requires a second sequence transplant, the Division shall request Reinsurance for the initial transplant until the prep and transplant of the additional sequence occurs.
3. If an additional sequence is performed during the post-transplant periods of the previous transplant, the Division, upon approval from AHCCCS, shall reimburse the AdSS the prorated transplant component that coincides with the prep and transplant of the following sequence.
4. The Division shall follow all applicable AHCCCS notification and claims filing requirements when requesting Reinsurance reimbursement for multi-sequence transplants.

U. OUT OF STATE OR NON-CONTRACTED FACILITIES AND NON-CONTRACTED TRANSPLANTS

1. The Division shall, prior to the Member receiving out of state transplant services, require the AdSS to request approval for Reinsurance from AHCCCS if the transplant services are:
   a. At non-contracted transplant facilities; or
   b. At out-of-state contracted facilities for non-contracted transplant types.

2. The Division shall require the AdSS to obtain prior approval from the AHCCCS Medical Director for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service.
3. The AdSS shall, if prior approval is not obtained for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service:
    a. Incur costs for transplant services at the out of state facility;
    b. Be ineligible for either transplant or Regular Reinsurance; and
    c. Be ineligible for costs to be excluded from any applicable reconciliation calculations.
4. The Division shall, for an AHCCCS approved transplant performed out of state at a non-contracted facility, reimburse at 85% of the lesser of:
    a. The AHCCCS transplant contracted rate for the same organ or tissue, if available; or
    b. The AdSS paid amount.

5. The Division shall reimburse transplant Reinsurance depending on the unique circumstances of each AHCCCS approved non-contracted transplant, at 85% of the AdSS's paid amount for comparable Case or component rates.

V. SPLIT STAGES WHEN CONTRACTOR ENROLLMENT CHANGES

1. The Division shall require the AdSS to notify the Division when a Member changes AdSS during a transplant stage.
2. The Division shall edit the transplant stages in PMMIS for the dates of service each AdSS provided to the Member, when transplant stages are split between two AdSSs.

W. TRANSPLANT REINSURANCE REQUIREMENTS FOR THP MEMBERS

1. The Division shall submit the Request for Transplant Reinsurance form to the AHCCCS MM to create the transplant Case.
2. If the Request for Transplant Reinsurance is made by any entity other than the Division, the DDD Transplant Coordinator and DDD Reinsurance shall receive notification from AHCCCS MM.
3. The Division shall coordinate Transplant Reinsurance payment of claims and reimbursement with AHCCCS.

X. ENCOUNTER SUBMISSION REQUIREMENTS

1. The Division shall reimburse the AdSS for Reinsurance claims that correspond to Encounters that associate to a Reinsurance Case.
2. The Division shall require the following Reinsurance-associated Encounters except as provided for claim disputes, to reach an adjudicated status within 15 months from the end date of service, or date of eligibility posting, whichever is later to be considered as timely filed:
    a. Replacements;
    b. Voids; and
    c. New day Encounters
3. The AdSS shall not manually replace or void Encounters during the Reinsurance Payment Cycle.
4. The Division shall require the AdSS to void Encounters that are recouped in full.

Y. TIME LIMITS FOR FILING REINSURANCE CLAIMS

1. The Division shall pay the AdSS's Reinsurance claims for Regular Reinsurance Cases that are created automatically by PMMIS once

the Encounter reaches an adjudicated status through the Encounter System.

2. The Division shall require the AdSS to submit written requests for Reinsurance consideration for all other Reinsurance claims to the Division, except for Regular Reinsurance, using the required forms as described in this policy.
3. The Division shall require the AdSS to submit Encounters for Reinsurance that have attained a clean status no later than 15 months from the end date of service.
4. The Division shall require the AdSS to submit retro-eligibility Encounters that have attained a Clean Claim status no later than 15 months from the date of eligibility posting.
5. For Encounters undergoing Member appeal, provider claim dispute, grievance or other legal action, including an informal resolution originating from a request for a formal claim dispute or Member appeal, the Division shall consider the claim timely if:
    a. The decision letter is received by AHCCCS no later than 90 days from the date of the final decision in that action; and

b. The Encounters reach adjudicated status no later than 90 calendar days from the date of the final decision in that action, even if the 15-month deadline for attaining Clean Claim status has expired.

6. The Division shall not reimburse the AdSS Reinsurance if the AdSS fails to submit the adjudicated Encounter and the decision documentation within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director's decision, or other legal action, whichever is applicable.

Z. ADMINISTRATIVE DISPUTE REQUIREMENTS

The Division shall require the AdSS to follow the administrative dispute process as instructed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website, if the AdSS has exhausted Reinsurance refiling or reconsideration processes and still disagrees with an action taken regarding a Reinsurance claim.

AA. DIVISION OVERSIGHT

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:

a. Annual Operational Review of each AdSS,

b. Review and analyze deliverable reports submitted by the AdSS, and

c. Conduct oversight meetings with the AdSS for the purpose of:

i. Reviewing compliance,

ii. Addressing concerns with access to care or other quality of care concerns,

iii. Discussing systemic issues, and

iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

A. ENCOUNTER VOIDS AND REPLACEMENTS

1. When a void Encounter is submitted for a previously paid associated Reinsurance Encounter, the Reinsurance payment related to the voided Encounter will be recouped by AHCCCS.
2. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is less than the original AdSS paid amount, the difference will be recouped by AHCCCS.

3. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, the additional amount will be paid if the replacement Encounter was adjudicated and reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.
4. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, but the replacement Encounter was not adjudicated and did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same Encounter cycle, then the original AdSS paid amount will be recouped AHCCCS.
5. When a replacement Encounter is not submitted timely, and does not adjudicate to Encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of

eligibility posting, whichever is later, within the same Encounter cycle it was submitted, and any of the following scenarios occur:

a. The original Encounter was never associated to a Reinsurance Case; or

b. The original Encounter was never associated to a Reinsurance Case; or

c. The original Encounter associated with a Reinsurance Case but never reached pay status (PY); or

d. The original Encounter has a previous Reinsurance paid amount of zero ($0.00):

i. The replacement Encounter is then subject to the Reinsurance timely filing limit edits:

1) H583 Reinsurance claim received more than 15 months after end date of service; or

2) H584 Reinsurance claim received more than 15 months after eligibility posting.

6. When a Replacement Encounter is subject to the following scenarios:

a. Not submitted timely; and

b. Replacement Encounter did not adjudicate; and

c. Replacement Encounter did not reach approved status (CLM STAT 31); and

d. Within the same Encounter Cycle same Encounter cycle; and

e. Original Encounter (Encounter identified on the 837 & NCPDP) Reinsurance paid amount > $0:

i. The original AdSS paid amount will be recouped by AHCCCS.

7. The replacement Encounter consists of a two-step process:

a. The original AdSS paid amount will be recouped by AHCCCS.

b. The replacement Encounter transaction or process.

B. THIRD PARTY LIABILITY

1. Failure to comply with the TPL notification requirements may result in those sanctions specified in the AHCCCS Contract.

2. Should AHCCCS or its authorized representative identify TPL recovery payments received by the Contractors that do not

comply with the notification requirements in this section the following actions shall occur:

a. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.

b. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor's contingency fee schedule shall be added to the billing.

3. In addition, the Medicare Allowed, Medicare Paid, TPL Payments and Value Code fields, as applicable, must be completed when the Encounter is submitted for Reinsurance consideration.

C. MEDICARE

1. Medicare Calculations

a. The Reinsurance system does not calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data

is populated and mapped from the fields in the Encounter system.

b. If there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter, then the Contractor must address these issues with the AHCCCS Encounter Unit.

2. PMMIS' view of Medicare

a. The Encounter System categorizes Medicare as the type of Medicare appropriate for the stay. Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Part A dollars.

b. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Part B dollars.

c. Scenario Examples:

i. If the Member has only Medicare Part B and the Encounter is for an inpatient stay, then on the Encounter the Medicare Part B dollars should be placed under Other Coverage.

ii. If the Member has only Medicare Part B and the Encounter is for a doctor visit, then on the Encounter the Medicare Part B dollars should be placed under Medicare Coverage.

Form Type	Type of Medicare	Field on Encounter
I	Medicare Part A	Medicare
	Medicare Part B	Other Insurance
A	Medicare Part A	Does Not Apply
	Medicare Part B	Medicare
O	Medicare Part A	Other Insurance
	Medicare Part B	Does Not Apply

3. Medicare Lesser of Logic

   a. The Medicare copay, Coinsurance, or Deductible; or

   b. The difference between the Contractor's contracted rate and the Medicare paid amount.

4. Edit A510

   a. Medicare Deductible and Coinsurance Exceeds Allowed Amount

      i. Reinsurance Internal Pend

b. Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.

Summary of Reinsurance Coverage

Case Type	Deductible	Co-Ins
RAC-Acute Contractors	$75,000	75%
RAC-DCS/CHP Contractor	$75,000	75%
Catastrophic–Biologics/High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High$	n/a	100%
Hemophilia	n/a	85%
Von-Willebrand's	n/a	85%
Gaucher's	n/a	85%
State Only Termination	n/a	100%
High Cost Behavioral Health	n/a	75%
DES-DDD	$75,000	75%
RAC-ALTCS – EPD MC PT.A 0-1,999	$75,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	$75,000	75%
RAC-ALTCS – EPD No PT.A	$75,000	75%

0-1,999		
RAC-ALTCS – EPD No PT.A 2,000+	$75,000	75%

Reinsurance Contract Year	Contract Year Ending
YR 38	10/1/19 – 9/30/20
YR 39	10/1/20 – 9/30/21
YR 40	10/1/21 – 9/30/22
YR 41	10/1/22 – 9/30/23
YR 42	10/1/23 – 9/30/24
YR 43	10/1/24 – 9/30/25
YR 44	10/1/25 – 9/30/26

6001-A CONFIDENTIALITY

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-568(01), 36-551(07), 41-1346, 41-1959, 36-568(01), and, 36-551(01); A.A.C. R6-6-102, et seq., and, R6-6-102.

Confidential Information

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, Social Security Number (SSN), ASSISTS or Arizona Health Care Costs Containment System (AHCCCS) I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

A. The right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;

B. The right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;

C. The right to receive one copy of their medical record free of charge annually;

D. The right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;

E. The right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;

F. The right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;

G. Subpoenas are not court orders. Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F;

H. The right to file complaints;

I. The right to seek correction of records; and

J. Should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.

6001-B RELEASE OF INFORMATION

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-104; 42 CFR 483.410(c) (3).

An authorized list of persons or titles, who may have access to personally identifiable information, shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

A. Obtained from the member or responsible person in writing and dated); and,

B. Maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.

6001-C ACCESS TO PERSONALLY IDENTIFIABLE INFORMATION

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R6-6-103.

A *Record of Access* documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a *Record of Access* is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with ALL personally identifying information deleted.

While Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) do not require a standardized *Record of Access*, all *Record of Access* documents shall include:

A. Requestor's name;

B. Date information copied/sent;

C. Purpose for request;

D. Specific information released;

E. Where information was sent; and

F. Verification of consent.

A *Record of Access* is not required for the following:

A. Member/responsible person or their written designee;

B. Federally authorized members including AHCCCS and DHS staff; or

C. Direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must maintain a Log Book which documents the names of persons, other than Support Coordinators, or supervisors reviewing the case record and date/time of the review is maintained. The *Record of Access* is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the *Record of Access* (See Master Folder Access Log).

6001-D PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

REVISION DATES: 11/9/22, 9/01/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: 45 CFR 160.103(5), A.R.S. §§ 36-568(01), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191

PURPOSE

This policy applies to all Division staff and covered entities authorized to use and disclose Protected Health Information. This policy sets forth the lawful use of disclosing Protected Health Information without written consent from the individual whose health information is being disclosed.

DEFINITIONS

1. "Protected Health Information" means individually identifiable health information, as specified in 45 CFR 160.103(5), about an individual that is transmitted or maintained in any medium where the information is:
    a. Created or received by a health care provider, health plan, employer, or health care clearinghouse.
    b. Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an

individual.

2. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult, or a developmentally disabled adult who is a member or an applicant for whom no guardian has been appointed.

POLICY

A. PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1. The Division shall treat information obtained and records prepared during the course of providing any services to Division members as confidential and privileged matter.
2. The Division shall disclose those records only as authorized by state or federal law, including the Health Insurance Portability and Accountability Act, or pursuant to the following:
    a. When the responsible person designates in writing persons to whom records or information may be disclosed.
    b. For treatment, payment, and health care operations activities.
    c. To the extent necessary to make claims on behalf of a member for aid, insurance, or medical assistance to which the member may be entitled.

d. Pursuant to a court order.

e. In communications between professional persons in providing services or appropriate referrals.

f. When such a disclosure is necessary to protect against a clear and substantial risk of imminent serious injury.

g. To the superior court when a petition to establish guardianship for the member is filed pursuant to A.R.S. Title 14, Chapter 5.

h. To public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability, and to public health or other government authorities authorized to receive reports of child abuse and neglect.

i. To appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

j. To health oversight agencies for purposes of legally authorized health oversight activities such as audits and investigations necessary for oversight of the healthcare system.

k. To other state agencies or bodies for official purposes.

i. The Information shall be disclosed without the

designation of the name of the member unless the name is required for the official purposes of state agencies or bodies requesting such information.

ii. Information received by a state agency or body shall be maintained as confidential unless a consent to release has been given as provided in this section.

l. To a law enforcement agency or a county medical examiner in the performance of official duties, unless the records requested relate to a person who is the subject of a criminal investigation, in which case the records may only be released pursuant to a court order or grand jury subpoena.

B. ACCOUNTING OF DISCLOSURES

The Division shall provide an accounting of disclosures upon written request from the responsible person.

C. CONFIDENTIAL COMMUNICATIONS REQUIREMENTS

The Division shall provide an alternative means or location for receiving communications of protected health information upon written request from the responsible person.

6001-E VIOLATIONS AND PENALTIES

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-204

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE'S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.

6001-F CASE RECORDS

REVISION DATE: /2 /201 , 5/29/2019, 2/17/2017, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: 42 CFR 483.410(c)(1)(6)

Central Case Records

The Division of Developmental Disabilities (Division) maintains a central case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to a member and is kept in a location designated by the local Confidentiality Officer/designee, but it is usually in the Support Coordinator/Qualified Intellectual Disabilities Professional's (QIDP's) office.

Central case records are available to the member or responsible person upon written request to:

Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301301
Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

The Support Coordinator makes sure that all information generated regarding services to the member is documented in the central case record.

A. Central case records must contain the following:

1. Birth Certificate
2. Guardianship records, if applicable
3. Adoption records, if applicable
4. Divorce Decree, and/or Custody Orders, if applicable
5. Court Orders [including Orders of Protection], if applicable
6. Arizona Confidentiality Program (ACP) records, if applicable
7. A copy of the member's Planning Documents/Individualized Education Program (IEP)
8. Program data and progress notes
9. The member's identifying information and a brief social history
10. Pertinent health/medical information
11. Current evaluative data/assessments
12. Authorization for emergency care, if appropriate

13. Visitation records, if appropriate
14. Record of financial disbursements, if appropriate
15. Active treatment schedule (ICF/IID)
16. Resident fact sheet, if appropriate
17. Periodic dental records, if appropriate
18. ICAP, if appropriate
19. Documentation regarding the protection of member rights, including records authorizing the release of educational and protected health information.
20. An accepted diagnosis/diagnostic scheme
21. Documentation of an evaluation that identifies the member's specific needs
22. Reviews/modifications to the Planning Documents and IEP
23. Communication among persons involved with the member and his/her program, including emails
24. Documentation of protection of the legal rights of each person served including records of all actions that may significantly affect these rights
25. Documentation to furnish a basis of review, study and evaluation of overall programs provided by the Division
26. Member primary data from FOCUS
27. For members residing in a Nursing Facility (NF) placed on termination status:
    a. A Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs
    b. Documentation of the member's choice of placement
    c. The reason for non-placement in a NF placed on termination status for a new placement.

B. Case records, where applicable, must contain the following additional documentation:

1. Arizona Long Term Care System (ALTCS) eligibility
2. Utilization review report
3. Current photograph of the member, if needed
4. Physician statements of medical necessity
5. Pre-Admission Screening
6. Psychological evaluations/social history

7. Medication history
8. Immunization record
9. Incident, injury, illness, and treatment reports including hospital stays
10. Seizure reports
11. Records of contacts/referrals
12. An accounting ledger
13. Authorization for emergency care
14. Behavioral health records as described in this Policy Manual
15. Other pertinent information.

Program/Service Records

Occasionally, the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records; this includes overflow files. The Confidentiality Officer, Support Coordinator, or QIDP assures:

- Files are available at each site where the member receives services, as appropriate
- The Support Coordinator/QIDP has access to such files
- A summary of information contained in such records is entered into the member's Central record.

These files must contain:

A. The name, address and phone number of the physician or health facility providing medical care

B. Reports of accidents, illness, and treatments

C. Reports of significant behavioral incidents, if applicable

D. Current medication treatment plan, if applicable

E. A description of the member's specialized needs

F. A copy of the Planning Documents/IEP

G. Program data/progress notes

H. Identifying information/social summary

I. Pertinent health/medical information

J. Current evaluative data/assessments

K. Authorization for emergency care

L. Visitation records

M. Records of financial disbursements

N. Active treatment schedule (ICF/IID)

O. Resident fact sheet; and where applicable

P. Periodic dental reports.

6001-H RECORDS STORAGE AND SECURITY

REVISION DATE: 2/17/2017, 12/11/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297, *Records Reference Request* (J-240)

Internal Storage (Active Case Records)

The Division of Developmental Disabilities (Division) considers case records for members currently eligible for services to be active records. Active files may contain too much information to be confined to one case record. The Division may establish and use overflow files to store non-essential, outdated information.

Once established, overflow records can contain progress notes, educational records, Planning Documents, correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, Qualified Intellectual Disabilities Professional (QIDP) notes in the most current active record that there is an overflow(s) file and indicate where it is stored.

The overflow record is maintained within the Division in a place designated by the District for an unspecified period of time.

External Storage (Closed/Terminated Case Records)

The Records Center is the Department of Economic Security (DES) official depository for closed/terminated case records. The Records Center provides storage, retrieval, and re-file services for DES.

To transfer closed/terminated files for storage/retention, Division staff:

A. Review the records retention schedule to determine that the records are appropriate for retention at this time.

B. Pack records into standard boxes 15” L X 12” W X 10” H, leaving a minimum of two inches of space to permit retrieval.

C. Electronically complete a *DES Records Storage Request* (J-239) through the Records Center Management System (RCMS).

D. Assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up.

E. Upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, Division staff electronically complete a *Records Reference Request* (J-240) through RCMS.

Destruction of Records

Records are destroyed in accordance with the records retention schedule, in compliance with A.R.S. § 12-2297.

6001-I MANAGEMENT AND MAINTENANCE OF RECORDS

REVISION DATE: 12/22/2021, 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297,42 CFR 438.3(U)

POLICY

The Division of Developmental Disabilities (Division) must maintain all records for a period of five years from the date of final payment under contract with Arizona Health Care Cost Containment System (AHCCCS) unless a longer period of time is required by law.

For retention of the member's medical records, the Division must ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider must retain the member's medical records according to the following:

A. If the member is an adult, the Division must retain the member's medical records for at least six years after the last date the adult member received medical or health care services from the Division.

B. If the member is under 18 years of age, the Division must maintain the member's medical records either for at least three years after the child's 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division must comply with the record retention periods specified in HIPAA Privacy Rule and regulations.

If the Division's contract with AHCCCS is completely or partially terminated, the records relating to the work terminated must be preserved and made available for a period of five years from the date of any such termination.

Records that relate to grievances, disputes, litigation, or the settlement of claims arising out of the performance of the Division's contract with AHCCCS, or costs and expenses of the Division's contract with AHCCCS to which exception has been taken by AHCCCS, must be retained by the Division for a period of ten years after the date of final disposition or resolution thereof. [See 42 CFR 438.3(U)].

6001-J RECORDS MANAGEMENT LITIGATION HOLD

EFFECTIVE DATE: February 28, 2024

REFERENCES: A.R.S. § 38-421, A.R.S. § 39-121-.01, A.R.S. § 41-151.12, A.R.S. § 41-151.13, A.R.S. § 41-151.14, A.R.S. § 41-151.15, A.R.S. § 41-151.16, A.R.S. § 41-151, A.R.S. § 41-151.18, Arizona State Library, Archives and Public Records Schedule Numbers: DES-CS-1125 - 35132, 35131, 53310, and 53311

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. The purpose of this policy is to outline staff responsibility when there is a litigation hold Notice to Preserve.

DEFINITIONS

1. "Custodian of Records" or "Custodian" means any Division employee who manages records at the office level and is the base for implementing records management policies and procedures by applying a records-retention schedule.
2. "Disposition Schedule" or "Retention Schedule" means a list of record series titles that indicates the minimum length of time to

maintain each series and what should happen once the retention period has been met.

3. "Employee Tracking List" means a comprehensive list of Division employees who are or were associated with the coordination of care for a Member related to a litigation hold notice to preserve.
4. "Litigation Hold" means an internal process that an organization undergoes to preserve all data that might relate to a legal action involving the organization.
5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Notice to Preserve" means a letter or other notice informing an employee of actual or reasonably anticipated litigation, otherwise known as a pre-claim, and directing the employee or group of employees to identify, collect, and preserve relevant information.
7. "Records" means all hardcopy and electronic books, paper, emails, maps, photographs, drafts, markups, or other documentary materials, regardless of physical form or characteristics, including prints or copies of such items produced or reproduced on film or electronic media pursuant to A.R.S. §

41-151.16; made or received by any governmental agency in pursuance of law or in connection with the transaction of public business and preserved or appropriate for preservation by the agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the government, or because of the informational and historical value of the data contained therein, and includes records that are made confidential by statute. Library or museum material made or acquired solely for reference or exhibition purposes, extra copies of documents preserved only for convenience of reference and stocks of publications or documents intended for sale or distribution to interested persons are not included within the definition of records. All records media are included in this definition from the traditional paper forms to electronic types in use (i.e., email, social media), and/or forms of records not yet invented.

8. "Records Management Center" or "RMC" means the facility where DCS records are stored, retrieved, and eventually destroyed according to record retention schedules.

9. "Records Management Unit" or "RMU" means the Division's records department that maintains and oversees the management of Member records.

POLICY

A. The Division shall retain any record upon Notice to Preserve relevant to litigation as follows:

1. The Division shall retain relevant records:
    a. For six years after the prospect of litigation ends or according to the record disposition schedule for DES-CS-1125, whichever is later; and
    b. If there is no court action until the expiration of all time periods within which legal action may be taken.
2. Division employees having access to any records outlined in a Litigation Hold shall preserve all records in their original forms.
3. The Division shall prevent the destruction, alteration, or deletion of relevant information and records.
4. The Division shall preserve the following types of items for a Litigation hold:
    a. Emails;

b. Contact lists;

c. Text/chat messages;

d. Spreadsheets;

e. Presentations;

f. Databases, or other data stored;

g. Video, transcripts and audio recordings;

h. Medical documentation; and

i. Documentation of services, and anything else that can be electronically stored and is related to the litigation subject.

B. The RMU shall:

1. Gather all records related to the actual or anticipated litigation, including paper and electronically stored records, and
2. Review documents to identify Division staff names for the given time period outlined in the litigation hold;

C. The RMU shall preserve, catalog, and retain the related files within the Records Management Center:

1. The Custodian shall not remove, transfer, or destroy preserved records while the Litigation Hold is in place.

2. After the notice to preserve has been lifted, RMU staff shall adhere to the appropriate retention period ends.

6002-D MEMBERS AT RISK IF MISSING

REVISION DATE: 8/2/23, 3/16/22, 11/29/17, 5/20/16, 3/2/15 EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 46-451(A)(10), A.R.S. § 14-1501, A.R.S. §36-551, A.A.C. R6-6-805, Division Medical Policy 966

PURPOSE

To set forth the requirements of vendors and the Division of Developmental Disabilities' (Division) staff when a Member is missing and the subsequent review or revision of the Planning Document by the Planning Team.

DEFINITIONS

1. "Immediate Jeopardy" means a situation in which the vendor's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a Member(s). An Immediate Jeopardy situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm. See Division Medical Policy 966.

2. "Medallion Program" means Members enrolled in this program receive a medallion that can be worn as a bracelet or shoe tag. This medallion provides identification that helps first responders in case of an emergency or if a Division Member becomes lost in the community. Each identification tag includes the Member's Focus ID number and a 24-hour phone number for first response emergency personnel to contact.

3. "Media" means any type of electronic, digital, or print communication including newspapers, TV, radio, flyers, newsletters. or other internet-based forms of electronic communication such as websites for social networking, blogs.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Planning Document" means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP) or Person Centered Service Plan (PCSP).

6. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed as cited in A.R.S § 36- 551.

8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. MISSING MEMBERS

1. If a Member without planned alone time, while receiving Division-authorized services, is missing or at is risk of harm, or when a Member with alone time as defined in the Planning Document is missing longer than the plan provides, including a Member missing from a licensed Behavioral Health Inpatient Facility (BHIF), Behavioral Health Residential Facility (BHRF), Division Group Home, Assisted Living Facility (ALF), Skilled Nursing Facility (SNF), Intermediate Care Facility, Adult Behavioral Health Therapeutic Home (ABHTH), or Therapeutic Foster Care (TFC), the vendor shall:

a. Conduct a search of the immediate area.

b. Notify the program supervisor or other staff to assist with the search if the Member is not located within 15 minutes.

c. Contact local hospitals, shelters, jails, and bus stations during the search.

d. If the Member is not located within 30 minutes the vendor shall notify law enforcement agencies in the immediate and surrounding communities and provide all relevant information, including medical conditions, medication, behavioral and communication needs.

3. The vendor shall immediately notify the following entities, document who was contacted, date and time, and send a confirmation email after notification is made:

a. The Division by calling the District specific Quality Assurance phone number, emailing the Incident Report Inbox, or calling the after-hours reporting system on evenings and weekends at 602-375-1403.

i. If a situation is determined to likely cause serious

injury, harm, impairment, or death to a Member(s), and an immediate need to be corrected to avoid further or future serious harm, indicate in the report that the situation may require an Immediate Jeopardy response.

b. Support Coordination during regular business hours or by calling the District after hours reporting system on evenings and weekends at (602) 375-1403 or provide the information in an email to the District specific Incident Report Inbox.

c. The guardian(s), if applicable.

4. The vendor shall report and submit a written incident report to the Division as soon as possible but no later than the next business day after the incident. The vendor may submit the incident report to the Division via fax or email using the District contact information.

5. The vendor shall include the following information in the incident report:

a. Age of Member

b. General description of the person

c. Time and location of disappearance

d. Effort to locate Member(s)

e. Vulnerability

f. Means of communication

g. Medical or special needs

h. Precursors to disappearance

i. Time police and parents or guardian notified

j. Time and person or method of Division notification

k. Other entities contacted

l. Legal status (e.g., foster care, probation).

6. The Support Coordinator shall, if the Member has prescribed medication, contact the physician or pharmacist to determine whether a potential medical risk may arise if the Member goes without prescribed medication for any length of time.

B. DIVISION RESPONSIBILITIES

1. The Support Coordinator shall convene the Planning Team within 30 days, or sooner as designated in the Planning Document, of

the date the Member was reported missing to:

a. Review the current Planning Document and Risk Assessment,

b. Modify the Planning Document as appropriate, and

c. Complete or update form DDD 1569A if the Member resides in a group home licensed by Arizona Department of Health Services consistent with A.A.C. R6-6-805.

C. MEDIA INVOLVEMENT

1. If law enforcement elects to contact the Media to assist in locating the Member, the vendor shall:

   a. Cooperate with law enforcement officials by providing essential information about the Member to be released to the Media,

   b. Notify the designated District Quality Assurance staff,

   c. Notify the designated support coordinator, and.

   d. Notify the parent(s) or guardian(s), if applicable.

2. The Division District Quality Assurance staff shall notify Executive Leadership via the Division's Executive Leadership

Notifications mailbox upon notification of Media involvement by the vendor.

Signature of Chief Medical Officer:

SUPPLEMENTAL INFORMATIONAL

1. Members who enroll in the Medallion Program agree to the disclosure of certain protected health information to rescuers in order to provide the Member with assistance in an emergency or if they are lost in the community.

2. The QMU staff answers the Medallion hotline during regular business hours and the Arizona Training Program at Coolidge staff answers the hotline calls after hours.

3. Upon receipt of a call, staff verifies that the caller obtained the phone number from the Medallion identification tag of the Member. Information may be disclosed to the caller, generally expected to be law enforcement, emergency medical providers, or individuals attempting to assist the Member, in the event the Member becomes ill, lost, injured or otherwise physically or

mentally impaired and needs assistance.

4. Protected health information which may be disclosed by staff includes address and applicable individual, parent or guardian contact information, and any health care information relating to the Member that staff determines is needed by the caller in order to provide appropriate medical treatment to the Member or to provide for the Member's safety and welfare until the Member's parent, guardian, or responsible party is able to resume custody of the Member.

5. Staff will not disclose protected health information to a caller who is not law enforcement or emergency medical providers, and contacts the Member's parent, guardian, or responsible party, and arrange for them to resume custody of the Member as soon as possible.

Signature of Chief Medical Officer: Anthony Dekker (Jul 31, 2023 15:16 PDT)
Anthony Dekker, D.O.

6002-F INVESTIGATIVE PROCESS

REVISION DATE: 11/8/23, 6/29/22, 12/18/19, 10/01/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: Division Medical Policy 960 and 961

PURPOSE

To set forth the requirements for investigative activities performed by the Division of Developmental Disabilities' (Division) Quality Management Unit (QMU) to gather and review information and documentation related to reported incidents involving Members served by the Division.

DEFINITIONS

1. "Investigative Process" means a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident.

2. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

3. "Quality of Care Concern" means an allegation that any aspect of care or treatment, utilization of behavioral health services or utilization of physical health care services, that caused or could have caused an acute medical condition or acute psychiatric condition, or an exacerbation of a chronic medical condition or chronic psychiatric

condition, and may ultimately cause the risk of harm to a Member.

4. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability, or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed as defined in A.R.S. §36-551.

5. "Trauma-Informed Care" means an approach to care that acknowledges the need to understand an individual's life experiences in order to deliver effective care and has the potential to improve engagement, treatment adherence, health outcomes, and provider and staff wellness.

6. "Sentinel Event" means an unexpected event that results in death, serious physical injury, or severe psychological harm.

POLICY

A. INVESTIGATIVE PROCESS AND TRAINING

1. The Division's QMU shall provide investigative training for QMU staff.

2. The QMU nursing leadership shall ensure that clinical staff

complete all required investigative training and achievement of competencies before conducting investigations independently.

3. The Division shall incorporate the principles of Trauma-Informed Care in the training content and requirements for investigations involving individuals with intellectual and developmental disabilities.

4. The Division shall maintain records of attendance and dates for all required investigative training.

B. INVESTIGATIVE PROCESS REQUIREMENTS AND TIMEFRAMES

1. The Division's QMU shall initiate the Investigative Process for all reportable incidents requiring further investigation and adhere to the following investigative requirements and timeframes:
   a. Upon notification of an incident determined to be a Quality of Care (QOC) Concern, initiate the Investigative Process within one business day.
   b. Assign a QMU investigative team to conduct the QOC Concern investigation.
   c. Ensure protective measures are in place to protect the health and safety of the Member or Members.

d. Ensure measures are in place to prevent any direct contact between the Member and any individual alleged to have endangered the health or safety of the Member until the completion of the investigation and any subsequent remediation.

e. Complete information requests for Sentinel Events within one business day.

f. Complete information requests for non-Sentinel Events within seven business days.

g. Information gathering may be completed for incidents determined not to be a QOC Concern as necessary and appropriate.

C. COORDINATION WITH OTHER AGENCIES

1. The QMU may delay its Investigative Process if an external investigation is initiated by a protective services agency, law enforcement agency, other state agencies or regulatory boards, until the external investigation has been completed in order to avoid potential conflicts.

2. If another state agency is involved, the QMU may coordinate

investigative activities with that agency when applicable and appropriate.

D. INVESTIGATIVE ACTIVITIES

1. The QMU shall include the following investigative activities in accordance with the principles of Trauma-Informed Care and the special needs of Members with intellectual and developmental disabilities:

    a. Collection and review of documentation, reports, and information relevant to the incident.

    b. Interview individuals involved in the incident and any witnesses, family members, qualified vendors, Division staff, first responders, or any other individual who may have relevant information.

    c. Allow the Responsible Person to decline an interview at any time during an investigation.

2. The QMU shall enter documentation of investigative activities in the AHCCCS Quality Management Portal.

3. The QMU shall store the compilation of collected information on a QMU shared drive and readily available to QMU staff on a

need-to-know basis containing:

a. The original incident report;

b. Completed District Assignment form; and

c. Information and documents gathered during the Investigative Process.

4. The QMU shall consider all information and documentation obtained during the Investigative Process as confidential and privileged for use in conducting quality assurance activities and use by Division review committees, as well as the information obtained through the Division's Investigative Process, inclusive of the determination and any remediation, is protected from release or discovery under the following Arizona Revised Statutes §§ 36-441, 36-445, 36-445.01, 36-2401 through 36-2404, 36-2917, 36-2932(O) and 41-1959(C)(5).

Signature of Chief Medical Officer: Anthony Dekker (Nov 2, 2023 08:14 PDT)
Anthony Dekker, D.O.

6002-G REPORTING MEMBER ABUSE, NEGLECT, AND EXPLOITATION

REVISION DATE: 6/14/23, 3/16/22, 9/4/19, 11/29/17, 10/1/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: Title 13, Chapter 14, A.R.S. §§ 13-3620, 13-3401, 14-1501, 46-451(A), 46-454, 36-569, 8-201(2), Division Medical Policies 960, 961, 1620-O

PURPOSE

This policy applies to all Division of Developmental Disabilities (Division) staff and sets forth the responsibilities for reporting suspected Abuse, Neglect, and Exploitation of Members served by the Division to the Department of Child Safety (DCS) and Adult Protective Services (APS), and Tribal Social Services, when applicable, for Members enrolled in the Tribal Health Program.

DEFINITIONS

1. "Abuse" means the infliction of or allowing another individual to inflict or cause physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a

Member receiving behavioral health services or community services. Abuse also includes sexual misconduct, assault, molestation, incest, or prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

a. "Abuse of a Child" means, as specified in A.R.S. §8-201(2):

i. The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage, as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts of omissions of an individual who has the care, custody, and control of a child. Abuse includes:

ii. Inflicting or allowing sexual abuse, sexual conduct with a minor, sexual assault, molestation of a Child, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, or child sex trafficking as those acts are described in the Arizona Revised Statute Title 13, Chapter 14.

iii. Physical Injury that results from permitting a Child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in A.R.S. § 13-3401.

iv. Unreasonable confinement of a Child.

b. "Abuse of a Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(1):

i. Intentional infliction of physical harm,

ii. Injury caused by negligent acts or omissions,

iii. Unreasonable confinement,

iv. Sexual abuse or sexual assault.

2. "Adult" means a member 18 years of age or older.

3. "Child" means a Member under the age of 18 years.

4. "Exploitation of a Vulnerable Adult" means, as specified in A.R.S. § 46-451(A)(5), the illegal or improper use of a Vulnerable Adult or the Vulnerable Adult's resources for another's profit or advantage.

5. "Incapacity" means an impairment by reason of mental illness, mental

deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning their person.

6. "Member" means an individual enrolled with the Division of Developmental Disabilities.
7. "Neglect" means, as specified inA.R.S. § 36-569:
    a. Intentional lack of attention to physical needs of Members such as toileting, bathing, meals, and safety.
    b. Intentional failure to report health problems or changes in health condition to an immediate supervisor or nurse.
    c. Sleeping on duty or abandoning workstation.
    d. Intentional failure to carry out a prescribed treatment plan for a Member.
8. "Neglect of a Child" means, as specified in A.R.S. § 8-201:
    a. The inability or unwillingness of a parent, guardian, or custodian of a Child to provide that Child with supervision, food, clothing, shelter, or medical care if that inability or unwillingness causes substantial risk or harm to the Child's health or welfare, except if the inability of a parent, guardian, or custodian to provide

services to meet the needs of a Child with a disability or chronic illness is solely the result of unavailability of reasonable services.

b. Allowing a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person with the intent and for the purpose of manufacturing a dangerous drug as defined in section 13-3401.

9. "Neglect of a Vulnerable Adult" means, as specified in A.R.S. § 46-451(A)(7), the deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating, or other services necessary to maintain a vulnerable adult's minimum physical or mental health.

10. "Physical Injury" means the impairment of physical condition, including skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

11. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, including assessment or treatment in an emergency room, treatment center, physician's office, urgent care, or admission to a hospital.

12. "Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(10), a Member who is 18 years of age or older who is unable to protect themselves from Abuse, Neglect, or Exploitation by others because of a mental or physical impairment. Vulnerable Adult includes an incapacitated person as defined in A.R.S. §14-1501.

POLICY

A. REPORTS TO DEPARTMENT OF CHILD SAFETY

1. Division staff who suspect Abuse of a Child or Neglect of a Child shall immediately report to the Department of Child Safety (DCS) in accordance with A.R.S. §13-3620.

    a. Reports must be made to DCS within 24 hours per instructions provided on the DCS website at https://dcs.az.gov/, including notification by phone: 1-888-SOS-CHILD (1- 888-767-2445), and documenting the Member's progress notes in Focus.

2. Division staff shall provide all pertinent information regarding the alleged Abuse or Neglect to the DCS worker, including:

    a. The names and addresses of the minor and their parents or person(s) having custody of such minor.

b. The minor's age and the nature and extent of their Abuse,Neglect, or Exploitation including any evidence of previous Abuse, Neglect, or Exploitation.

c. Any other information that might be helpful in establishing the cause of the Abuse, Neglect, or Exploitation.

3. Division staff shall cooperate with the DCS investigator during the DCS investigations.

4. Division staff shall submit a completed Incident Call Report (DDD-1746A-FORFF) to the appropriate District Incident Report mailbox when a report is made to DCS.

5. The Quality Management Unit shall triage all reported incidents to determine if the incident requires a quality of care investigation in accordance with Division Medical Policies 960 and 961.

B. REPORTS TO ADULT PROTECTIVE SERVICES

1. Division staff who suspect Abuse, Neglect, or Exploitation of an Adult shall immediately report to Adult Protective Services (APS).

2. Division staff shall report all pertinent information to APS, including:

a. The names and addresses of the Adult and any persons

having responsibility for or custody of the Adult, if known.

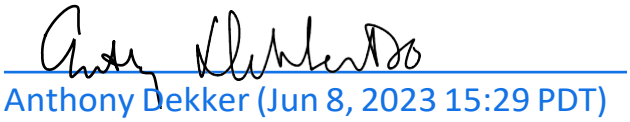
b. The Adult's age and the nature and extent of their incapacity or vulnerability.

c. The nature and extent of the Adult's Abuse, Neglect, or Exploitation.

d. Any other information that might be helpful in establishing the cause of Abuse, Neglect, or Exploitation.

3. Division staff shall submit a completed Incident Call Report to the appropriate District Incident Report mailbox when a report is made to APS.

4. The Division Quality Management Unit shall triage all reported incidents to determine if the incident requires a quality of care investigation in accordance with Division Medical Policies 960 and 961.

Signature of Chief Medical Officer: 
Anthony Dekker (Jun 8, 2023 15:29 PDT)
Anthony Dekker, D.O.

6002-I INCIDENT AND QUALITY OF CARE CONCERN CORRECTIVE ACTIONS AND CLOSURE

REVISION DATE: 8/2/23, 1/26/22, 11/29/17, 3/2/15

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §36-551; AMPM 960

PURPOSE

To establish the requirements for assigning Corrective Action Plans related to Incidents and Quality of Care Concerns, and closing cases.

DEFINITIONS

1. "Corrective Action Plan" means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish Corrective Action Plan (CAP) goals and objectives, and staff responsible to conduct the CAP within established timelines.

2. "Incident" means an occurrence which has or could potentially affect the health and well-being of a Member enrolled with the Division of Developmental Disabilities or poses a risk to the community.

3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

4. "Member-Specific Corrective Action" means a corrective action that requires the Member's Planning Team to reconvene to discuss the Incident and review the need for any changes in the Planning Document or Risk Assessment to ensure the health and safety of the Member.

5. "Quality of Care Concern" means an allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services, which caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition, and may ultimately cause the risk of harm to a Member.

6. "Systemic Corrective Action" means a corrective action that requires the vendor to revise or clarify their own policy, procedure, implement specialized training of staff, or take other quality improvement actions to increase the ability of the vendor to improve the health and well-being of Members served.

7. "Systemic Concern" means a concern derived from tracking and trending that indicates an issue inherent in the overall system.

POLICY

A. CORRECTIVE ACTION PLANS

1. The Division's Quality Management Unit shall determine if an Incident is deemed a Quality of Care (QOC) Concern. A QOC may require corrective action(s) which could be Member-Specific or Systemic.

2. If a QOC investigation results in substantiated allegations, the Division's Quality Management Unit (QMU) Investigative Nurse shall:

   a. Request the service provider to submit a corrective action for each substantiated allegation;

   b. Track the requests for corrective action;

   c. Send follow-up requests to the service provider if the previous requests remain unmet; and

   d. Elevate the matter to QMU Leadership if the service provider is unresponsive to the requests for corrective action.

3. The Quality Management (QM) Nursing Supervisors shall make referrals to the Contract Action Unit and notify the Chief Quality Officer, QM Medical Director and Chief Medical Officer of the service

provider's non-compliance and involvement of the Contract Action Unit.

4. The Division shall conduct monitoring through Incident track and trend data or an onsite visit to validate sustainment of the vendor's submitted Corrective Action Plan (CAP).

5. The QM Nursing Supervisors shall elevate non-compliance with CAP remediation to the Chief Quality Officer, QM Medical Director and Chief Medical Officer, which may involve the Contract Action Unit.

B. INCIDENT CLOSURE

1. The QMU shall send an Incident that is not deemed a QOC Concern to the corresponding District personnel. The Division shall consider it complete when District personnel makes a notation in Focus and closes the file, which is to be kept on record for tracking and trending.

2. The Division shall consider an Incident that is deemed a QOC Concern by the Division's QMU complete when all the following are completed:

   a. The fact-finding and investigation are completed;

b. Recommendations for corrective action(s) are identified and communicated to the qualified vendor or provider of service;

c. QMU monitors the receipt of CAPs;

d. QMU approves the CAPs;

e. QMU monitors the implementation of CAPs and recommends closure when the remediation is complete;

f. Designated District personnel receive either a No Action Required letter or a Remediation CAP letter indicating that the investigation is complete, then verifies the information entered in Focus and closes the case; and

g. QMU Investigator submits the QOC to AHCCCS via AHCCCS QM Portal.

Signature of Chief Medical Officer: Anthony Dekker (Jul 31, 2023 16:49 PDT)
Anthony Dekker, D.O.

6002-L MORTALITY REVIEW AUDITS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations, and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, i.e., entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance, or management information system change.

6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 6/14/23, 11/10/21, 11/29/17, 3/02/15
EFFECTIVE DATE: July 31, 1993

PURPOSE

To set forth the mortality review process and requirements used by the Division of Developmental Disabilities (Division) upon notification of deaths of Members served by the Division. The mortality review process is designed to identify issues and concerns that may have compromised the medical, behavioral, or overall care provided to a Member and trigger corrective action and strategies to mitigate future risk.

DEFINITIONS

1. "Fatal Five" means a group of preventable conditions that are often fatal for people with intellectual and developmental disabilities. They include aspiration, bowel obstruction, dehydration, gastroesophageal reflux, seizures.
2. "Member" means, for purposes of this policy, an individual enrolled with the Division of Developmental Disabilities at the time of death.
3. "Quality of Care Concern" means, for purposes of this policy, an allegation that any aspect of care or treatment, utilization of behavioral health services or utilization of physical health care

services, which caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition, and ultimately caused or contributed to the death of a Member.

4. "Support Coordinator" means an individual assigned as responsible for locating, accessing, and monitoring the provision of services to individuals in conjunction with a clinical team.

POLICY

A. NOTIFICATION

1. The Division may receive notification of a Member's death from various sources including:

    a. Vendors,
    b. Family members,
    c. Support coordinators,
    d. Health Care Services,
    e. Subcontracted health plans, and
    f. Claims data or eligibility files.

2. Upon notification of the death of a Member Division staff shall ensure that an incident report is completed and entered in the

Incident Management System.

3. A triage nurse shall send the incident reports involving a death of a Member to the Chief Medical Officer (CMO) or designee for review.

4. The CMO or designee shall notify the Quality Management Unit (QMU) for investigation if the CMO or designee determine a death should be reviewed as a Quality of Care (QOC) Concern.

5. A QMU investigative nurse shall prepare a monthly mortality tracker spreadsheet that contains information from all deaths in the Incident Management System database since the last reporting period, and includes information collected from other sources relevant to the death such as:

    a. The deceased Member's service plan,
    b. Information about the qualifying diagnosis(es) of the deceased Member,
    c. Identity of the provider of services at the time of death,
    d. Location of death,
    e. Any other recent incident reports involving the deceased Member, and

f. Support Coordinator progress notes.

B. MORTALITY REVIEW COMMITTEE

1. The Division's Mortality Review Committee shall meet monthly to review and discuss deaths of Members served by the Division, and includes:

   a. Reviewing the monthly mortality tracker spreadsheet;
   b. Determining unanimously that a death is explained, involved no QOC Concerns, and needs no further investigation;
   c. Referring cases to the QMU for further investigation if at least one committee member believes it should be a QOC Concern;
   d. Identifying process or systemic issues surrounding a death;
   e. Identifying and maintaining aggregate data on cases involving deaths from one of the Fatal Five and deaths related to Covid-19; and
   f. Making recommendations to develop or revise policies, procedures, and standard work.

2. The MRC shall not review any cases with an incomplete QOC investigation.

3. The QM Nurse Administrator shall forward the MRC meeting minutes to the Quality Management Subcommittee and the Quality Management/Performance Improvement Committee for reporting to Division Executive Leadership, including aggregate data on deaths from one of the Fatal Five and deaths related to COVID-19.

4. The Mortality Review Committee may directly refer cases to the Division's Peer Review Committee, if appropriate.

5. The QM Medical Director shall forward cases identified as peer review to the Nursing Program Administrator for tracking and presentation at the Peer Review Committee.

Signature of Chief Medical Officer: Anthony Dekker (Jun 8, 2023 15:16 PDT)
Anthony Dekker, D.O.

6002-N FRAUD AND FALSE CLAIMS

REVISION DATE: 07/28/2021, 10/1/2019, 11/29/2017, 6/10/2016, 3/2/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. § 13-1802, 13-2002, 13-2310, 13-2311, 36-2918; A.A.C. R6-6-801 et seq., R6-6-1001 et seq., R6-6-1101 et seq., R6-6-1501 et seq.; 42 CFR 455.2; Public Law No: 109-171 (Deficit Reduction Act of 2005); 31 U.S.C. § 3729-3733 (False Claims Act)

PURPOSE

This policy provides an overview of key provisions of the False Claims Act (FCA) and related legal requirements as required by the Deficit Reduction Act of 2005 (DRA) for the Division of Developmental Disabilities (Division). This policy defines fraud and describes the procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

POLICY OBJECTIVES

The objectives of this policy are to:

A. Prevent or detect fraud and abuse

B. Delineate reporting requirements

C. Define procedures

D. Explain Corporate Compliance

E. Describe training requirements

F. Specify policy requirements for providers

DEFINITIONS

Abuse - Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program as specified in 42 CFR 455.2.

Code of Federal Regulations (CFR) - is the codification of the general and permanent rules and regulations published in the Federal Register by the departments and agencies of the Federal Government.

Claim – Under the False Claims Act , the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

Deficit Reduction Act (DRA) –The Deficit Reduction Act of 2005, is a United States Act of Congress concerning the budget (Public Law No: 109-171 (02/08/2006)). It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

False Claims Act (FCA) - The FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs (31 U.S.C. § 3729-3733). It is the federal Government's primary litigation tool in combating fraud against the Government. The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

Fraud - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law, as specified in 42 CFR 455.2. 42 CFR 455.2

An act of fraud has been committed when a member or provider:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government

Potential - Based on one's professional judgment, the appearance that an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practice, it may conduct a preliminary fact-finding to determine whether there is a sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

Prevention - Keeping something from happening.

Primary Contact - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS as specified in this policy.

Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

Remittance Advice - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

Waste - As defined by AHCCCS, the overutilization of services or other practices that result in unnecessary costs to the Medicaid program.

POLICY

PREVENTION AND DETECTION

The Division is committed to fostering a culture of compliance and an environment conducive to preventing and detecting fraud, waste, and abuse. The Division provides training to its employees about their role in reporting concerns and problems in relation to compliance and ethics. All Division employees are required to report any concerns relating to potential fraud, waste, and abuse, including false claims. This responsibility is intended to allow the Division to monitor and do improvement planning pertaining to false claims processing or other aspect of organizational compliance. Any employee who fails to report properly either through internal lines of communication or to AHCCCS Office of Inspector General (AHCCCS OIG), when that person knows of conduct constituting a violation of the FCA or any other related legal provision in the Division's Corporate Compliance Program, will be subject to discipline, up to and including termination.

As part of the Division's Compliance Program objectives, all employees, contractors, agents, subcontractors, in particular those involved in the provision or arrangement of provision of services, under government programs including members and providers, must report potential violations of this policy. Reports may be made anonymously; the person doing the reporting may request confidentiality and will be protected from any retaliatory action. The Division establishes internal controls on the member payment system including claim edits and prior authorization requirements. The Claims System is used to prevent and/or detect payments to providers when services were not performed, not authorized, or otherwise inappropriate. The original claims process is tested for the validity of its ability to detect fraud and misuse by reporting high utilization by members, underutilization by members, inappropriate service costs, and analyzing units by service title, month by month over the fiscal year. referral to AHCCCS OIG for suspicion of fraud, waste, or abuse. The Business Operations Unit conducts a post-payment review process, as outlined below:

A. Claims Edits

Claims are edited through a computerized system. During the initial processing of a claim, the claim is reviewed for items such as member eligibility, covered services, excessive or unusual services, duplication of services, prior authorization, invalid rate codes, and duplicate claims. Claims are reviewed if the provider has exhausted all authorized units.

The Division segregates the functions of service authorization and claims processing.

B. Post Processing Review of Claims

Once claims are paid, the Division conducts a retrospective review of a sample of claims to ensure that the processing of the claim was specific to the processing instructions for the specific review. The Division conducts audits of claims payments to attain reasonable assurance that payments are being prepared correctly for the claims submitted by authorized providers for eligible AHCCCS members. The Division reviews detailed remittance advice. The Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

C. Prior Authorization

All services must receive prior authorization. Prior authorization criteria are determined using the guidelines set forth in DDD Provider Policy Manual and the AHCCCS Medical Policy Manual (AMPM).

D. Utilization/Quality Management

The Division complies with the requirements set forth in the AMPM.

E. Contract Provisions

All providers must comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement."

F. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff.

Report suspected fraud, waste, or abuse via one of the following:

1. Call the toll-free DES/DDD Hotline at 877-822-5799.

2. Report the incident by completing the online referral form:

   https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

3. Mail to:

   DES/DDD
   Attention: Corporate Compliance Unit
   1789 W. Jefferson Street
   Phoenix, AZ 85007

4. Email: DDDFWA@azdes.gov

5. Contact AHCCCS through their website:

   https:/www.azahcccs.gov/Fraud/AboutOIG/

FALSE CLAIMS ACT

The False Claims Act (FCA) covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $11,665 to $23,331 (adjusted time to time for inflation) for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistleblower" is protected under the FCA. The FCA and related law commits that no person will be subject to retaliatory action for reporting credible misconduct. Pursuant to the Division's commitment to compliance with the FCA and other applicable laws, no employee will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the Division solely because of actions taken to report potential fraud, waste and abuse, or other lawful acts by the employee in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

CORPORATE COMPLIANCE

The Corporate Compliance Officer implements, oversees, and administers the Division's compliance program including fraud and abuse control. The Corporate Compliance Officer is an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the Corporate Compliance Committee meeting held at least quarterly. The committee is a body comprised of the Chief Compliance Officer and Executive Leadership. Executive Leadership is limited to the following positions/designees:

- Assistant Director/Chief Executive Officer
- Office of Person-Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Chief Medical Officer

- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The Corporate Compliance Committee meeting includes information that has been forwarded for review through more frequent standing committees. Information that may be included at a Corporate Compliance Committee meeting includes but is not limited to:

- Incident Management System data (including suspected fraud)
- Resolution System data
- Program Monitoring reviews, claim disputes, appeals and state fair hearings
- Monthly meetings between the Attorney General's Office, Office of Administrative Review, Assistant Director and Executive Leadership to review any pending litigation
- Compliance Risk Management data analysis and remediation
- Development of strategies to promote compliance and detect any potential violations
- Development, implementation and monitoring of Corrective Action Plan (CAP)
- Training and Education
- Review of Compliance policies and procedures
- Approval of Standards of Conduct
- Identification of staffing needs and resources of the Compliance Unit
- Communications to all colleagues regarding compliance issues (e.g., HIPAA, Code of Conduct violations, Whistleblower Protections, False Claims)

The committee makes recommendations for improvement of the compliance program as identified through the analysis and review of reports. This committee is authorized to implement or require implementation of all necessary actions to ensure that the Division achieves the goals of an effective compliance program.

TRAINING

The Division provides training through the continuous core curriculum and computer-based training regarding fraud, waste, and abuse. The Corporate Compliance Unit provides additional in-service training to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.

6003-C APPEAL PROCESS FOR MEMBERS WHO RECEIVE STATE FUNDED SERVICES

REVISION DATE: 8/28/2019, 2/26/2016, 1/15/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the Department of Economic Security (DES) Office of Appeals. The appeal request must be made in writing and received by Office of Administrative Review (OAR) no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3 3rd Floor, Suite 301p 2HE5
Phoenix, Arizona 85012

Once the hearing request is made, OAR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OAR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and the record supplied by OAR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified by the Hearing Officer of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than 15 calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The Board will issue a final written decision on the matter within a reasonable time period.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-D NOTICE OF INTENDED ACTION (STATE ONLY)

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1802

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

A. Service denial, change, reduction, termination; or,

B. Eligibility is denied or terminated.

The notice must be issued on the Division form, *Notice of Intended Action* or *Service System Discharge*, and include the following information:

A. The name and address of the responsible person;

B. The date that the notice is mailed;

C. The name of the member affected by this action;

D. The action that is being taken;

E. The effective date of the action;

F. The reason for the action;

G. What the member/responsible person can do if he/she does not agree with the action being taken; and,

H. The signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with interpretation.

6003-E ADMINISTRATIVE REVIEW PROCESS (STATE ONLY)

REVISION DATE: /2 /201 , 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1803

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Administrative Review (OAR). Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.

B. Responsible person's name, relationship, and telephone number.

C. Support Coordinator's name and telephone number.

D. Physician's name, if applicable.

E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3 3rd Floor, Suite 301p 2HE5
P hoenix, Arizona 85012

OAR will complete a review and investigation of the stated issues. OAR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OAR within 5 calendar days. OAR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.

There will be no change in the member's status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if necessitated by a change in health status).

6003-F FAIR HEARINGS AND APPEALS

REVISION DATE: 02/22/2023, 03/02/2015

EFFECTIVE DATE: July 31,1993

REFERENCES: A.A.C R6-6-2201; A.A.C. R6-6-2202

PURPOSE

The purpose of this policy is to outline the process of appealing the outcome of an Administrative Review.

DEFINITIONS

1. "Administrative Decision" means the Division's written decision resulting from an Administrative Review.
2. "Appeal" means a request for a hearing pursuant to Article 22 under this Chapter to adjudicate the Division's Administrative Decision or proceeding pursuant to R6-6- 1808(B)(1).

POLICY

A. APPEALING AN ADMINISTRATIVE REVIEW DECISION

The Division shall accept a request for a hearing with the AHCCCS Administration to appeal the Administrative Decision when a member disagrees with a decision the Division rendered in an administrative review when:

1. The request is in writing, and
2. Filed no later than 15 calendar days of the personal delivery or postmark date of the Administrative Review decision.

B. FILING AN APPEAL

1. The Division shall consider appeals received when the document is received:
   a. Transmitted via the United States Postal Service, on the date it is mailed. The mailing date shall be:
      i. As shown by the postmark; or
      ii. As shown by the postage meter mark of the envelope in which it is received if there is no postmark; or
      iii. The date entered on the document as the date of its completion, if there is no postmark, or no postage meter mark, or if the mark is illegible.
   b. On the date it is received by the Department, if transmitted by any means other than the United States Postal Service.

c. The submission of any document not within the specified statutory or regulatory period shall be considered timely if it is established to the satisfaction of the Department that the delay in submission was due to Department error or misinformation, or to delay caused by the United States Postal Service.

2. The Division shall forward the request directly to the AHCCCS Grievance and Appeals Division.
3. Any document mailed by the Division shall be considered as having been served on the addressee on the date it is mailed to the addressee's last known address. The date mailed shall be presumed to be the date of the document, unless otherwise indicated.
4. The Division shall advise the requestor of the right to counsel and, if requested, provide additional information on how to complete the hearing request.

6003-G MEMBER INQUIRY AND GRIEVANCE RESOLUTION

REVISION DATE: 1/10/2024, 4/29/2020, 8/14/2019, 4/10/2019, 6/10/2016, 3/2/2015

REVIEW DATE: 6/3/2023

EFFECTIVE DATE: July 31, 1993

REFERENCES: 45 CFR Part 164, 42 CFR Part 438, Subpart F, 42 CFR §§ 438.408(a) and (b), A.A.C. Chapter 34: R9-34-202, R9-34-209, R9-34-210 and R9-34-212, AHCCCS Contract, Section D, Program Requirements, 20 Grievance and Appeal System, AHCCCS Contract, Section F, Attachment F1.

PURPOSE

This policy outlines the Division's responsibilities when an Inquiry is received or a Grievance is filed with the Division's Customer Service Center (CSC).

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. § 1-301.
2. "Complainant" means the person(s) expressing the dissatisfaction or requesting to file a grievance.
3. "Functional Area" means a business unit or department within the Division.

4. "Grievance" means a verbal or written expression of dissatisfaction with any matter, other than an adverse benefit determination.

5. "Grievance Manager" means the individual who is assigned to work with the complainant through resolution.

6. "Inquiry" means a question received by the Customer Service Center.

7. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

8. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

9. "Quality of Care Concern" or "QOC Concern" means an

allegation that any aspect of care or treatment, utilization of behavioral health services, or utilization of physical health care services that:

a. Caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition; and

b. May ultimately cause the risk of harm to a member.

10. "Resolution System" means the application within Focus used to document Member and Provider Grievances.

11. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

12. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. INTAKE TRIAGE

1. The Division's Customer Service Center (CSC) shall receive Inquiries and Grievances by:

   a. Phone - 1-844-770-9500 option 1, or

   b. Email - DDDCustomerServiceCenter@azdes.gov, or

   c. Mail - DES/DDD Customer Service Center

      1789 W. Jefferson St.

      Mail Drop 2HB3

      Phoenix, AZ 85007

   d. Referral from Division staff

2. The CSC shall evaluate each phone call, email, or letter received to determine if the correspondence is a Quality of Care Concern (QOC), an Inquiry, or a Grievance.

3. The CSC, when a QOC has been identified, shall:

   a. Notify the appropriate Functional Area immediately,

but no later than the close of the next business day, when an imminent health, safety, or clinically urgent risk exists.

b. Inform the individual who contacted the CSC that the concern will be elevated as a QOC and that the QOC triage process will be followed per Division Medical Policy 960.

4. The CSC shall respond to the Inquiry or inform the individual who contacted the CSC that they will be contacted within five Business Days when the Inquiry or Complaint is related to the Division, its contracted entities, or authorized services.

5. The CSC shall not disclose any confidential information in accordance with 45 CFR Part 164 Health Insurance Portability and Accountability Act (HIPAA) and in accordance with A.R.S. § 36-2917.

6. The CSC shall provide the individual who contacted the CSC with the contact information for the appropriate organization(s) when the Inquiry or Complaint is not

related to the Division, its contracted entities, or authorized services.

7. The CSC, when a Grievance is filed, shall provide the individual who contacted the CSC with their Grievance number and inform them they will be assigned a Grievance Manager who will work with them through resolution.

B. INQUIRY RESOLUTION

1. The CSC shall monitor Inquiries to ensure the individual who contacted the CSC is assisted timely.

2. The CSC shall maintain tracking logs that record the receipt, relevant information, and resolution of Inquiries.

3. The CSC shall request technical assistance when an Inquiry cannot be resolved timely.

4. The CSC shall resolve the Inquiry and provide the individual who contacted the CSC with a response.

C. GRIEVANCE RESOLUTION

1. The CSC shall provide the Complainant with a verbal

receipt of the Grievance at the time the Grievance is made and when requested by the Complainant, provide a written receipt of the Grievance.

2. The CSC shall document the receipt of the Grievance and the substance of the Grievance in the Division's Resolution System.

3. The CSC shall provide updates to the complainant on the progress of the Grievance.

4. The CSC shall ensure the person completing the Grievance investigation has no involvement in any previous level of review or decision-making regarding the Grievance.

5. The CSC shall ensure healthcare professionals have the appropriate clinical expertise to complete an investigation and make the decision when:

    a. A Grievance regarding a denial of an expedited resolution of appeal is received, or

    b. A Grievance involves clinical issues.

6. The CSC shall ensure all applicable documentation, including all aspects of care, is reviewed prior to making a decision.

7. The CSC shall engage additional Functional Areas when necessary to resolve the Grievance.

8. The CSC shall resolve the Grievance within 10 Business Days, but not to exceed 90 days, after the CSC receives the Grievance.

9. The CSC shall contact the Complainant to inform them of the resolution.

10. The CSC shall mail the Grievance disposition closure letter to the Complainant within 10 Business Days of resolution.

11. The CSC shall provide a Grievance disposition closure letter that includes a summary of the Grievance submitted and the resolution.

12. The CSC shall not provide the resolution in the Grievance disposition closure letter when the Grievance is closed due

to a QOC escalation.

13. The CSC shall ensure documentation of the Grievance, investigation steps, and actions taken for resolution are documented in the Division's Resolution System.

E. SUPPLEMENTAL INFORMATION

1. Refer to Division Operations Policy 446 for Grievances and Investigations concerning persons designated with a Serious Mental Illness.
2. For Provider Inquiries and Grievances, refer to Division Operations Policy 6003-H.

6003-H PROVIDER INQUIRY AND GRIEVANCE RESOLUTION

EFFECTIVE DATE: January 10, 2024
REFERENCES: Division Operations Policy 6003-G

PURPOSE

This policy outlines the Division's responsibilities when an Inquiry is received, or a Grievance is filed with the Division's Customer Service Center (CSC) by a Qualified Vendor or provider.

DEFINITIONS

1. "Business Days" means 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding holidays listed in A.R.S. § 1-301.
2. "Complainant" means the person(s) expressing the dissatisfaction or requesting to file a grievance.
3. "Functional Area" means a business unit or department within the Division.
4. "Grievance" means a verbal or written expression of dissatisfaction with any matter, other than an Adverse Benefit Determination or provider Inquiries that are older than 30 days.
5. "Inquiry" means a question received by the Customer Service

Center.

6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

POLICY

A. INTAKE TRIAGE

1. The Customer Service Center (CSC) shall receive Inquiries and Grievances by:
   a. Phone - 1-844-770-9500 option 1, or
   b. Email - DDDcustomerservice-providers@azdes.gov, or
   c. Mail - DES/DDD Customer Service Center
      1789 W. Jefferson St.
      Mail Drop 2HB3
      Phoenix, AZ 85007
   d. Referral from Division staff
2. The CSC shall evaluate each phone call, email, or letter received to determine if the correspondence is a Quality of Care Concern (QOC), an Inquiry, or a Grievance.
3. The CSC, when a QOC is identified, shall:
   a. Notify the appropriate Functional Area immediately, but no

later than the close of the next Business Day, when an imminent health, safety, or clinically urgent risk exists.

b. Inform the individual who contacted the CSC that the concern will be elevated as a QOC and that the QOC triage process will be followed as outlined in Division Medical Policy 960.

4. The CSC shall not disclose any confidential information in accordance with 45 CFR Part 164 Health Insurance Portability and Accountability Act (HIPAA) and in accordance with A.R.S. § 36-2917.

B. INQUIRY RESOLUTION

1. The CSC shall log and assign an Inquiry number when the Inquiry requires additional follow-up.

2. The CSC shall respond to the Inquiry or inform the individual who contacted the CSC that they will be contacted within three Business Days when the Inquiry is related to the Division, its contracted entities, or authorized services.

3. The CSC shall maintain a tracking log to record the receipt, relevant information, and resolution of Inquiries.

4. The CSC shall resolve the Inquiry and provide the individual who contacted the CSC with a response.

5. The CSC shall elevate any Inquiry not resolved within 30 days to a Grievance and document it in the Division's Resolution System.

C. GRIEVANCE RESOLUTION

1. The CSC shall provide the Complainant with a verbal or written receipt of the Grievance at the time the Grievance is made.
2. The CSC shall document the receipt of the Grievance and the substance of the Grievance in the Division's Resolution System.
3. The CSC shall provide updates to the Complainant on the progress of the Grievance.
4. The CSC shall engage additional Functional Areas when necessary to resolve the Grievance.
5. The CSC shall contact the Complainant to inform them of the resolution.
6. The CSC shall resolve a Provider Grievance within 30 days.
7. The CSC shall mail the Grievance disposition closure letter to the

Complainant within 10 Business Days of resolution.

8. The CSC shall provide a Grievance disposition closure letter that includes a summary of the Grievance submitted and the resolution.
9. The CSC shall not provide the resolution in the Grievance disposition closure letter when the Grievance is closed due to a QOC escalation.
10. The CSC shall ensure documentation of the Grievance, investigation steps, and actions taken for resolution are documented in the Division's Resolution System.

D. SYSTEMIC ACTION

The CSC, when Inquiry and Grievance trends are identified, shall take systemic action by elevating the trends to the CSC Managers and the Division's Leadership Team.

E. SUPPLEMENTAL INFORMATION

1. For Member Inquiries and Grievances, refer to Division Operations Policy 6003-G.
2. For Claim Disputes and Appeals, refer to Provider Chapter 11.

6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

REVISION DATE: 10/01/2021, 5/27/2020, 10/01/2019, 5/29/2019, 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R9-34-209, R9-34-216

Definitions

AHCCCS means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901.

Appeal means a request for review of an adverse benefit determination.

Administrative Services Subcontractors (AdSS) means an organization or entity that has a capitated contract with the Division to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, state statutes and rules, and Federal law and regulations.

Adverse Benefit Determination means any of the following:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

B. The reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a service;

D. The failure to provide services in a timely manner, as defined by the State;

E. The failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

F. For a resident of a rural area with only one Managed Care Organization (MCO), the denial of a member's request to exercise the right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

G. The denial of a member's request to dispute a financial liability, including cost sharing, co- payments, premiums, deductibles, coinsurance, and other member financial liabilities.

Arizona Revised Statutes (A.R.S.) means the statutory laws in the state of Arizona.

Arizona Administrative Code (A.A.C.) means the official publication of Arizona's codified rules.

Department means the Arizona Department of Economic Security.

Division means the Division of Developmental Disabilities within the Department.

Day means calendar day unless otherwise specified.

Enrollee means a person eligible for AHCCCS under A.R.S. Title 36, Chapter 29 and who is enrolled with an AHCCCS AdSS.

Filed means the date the AdSS or the Division, whichever is applicable, receives the request

as established by a date stamp on the request or other record of receipt.

Limited Authorization means a service authorization that falls short of the original request with respect to the duration, frequency, or type of service requested.

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

A. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489; or

B. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

1. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

2. Meets the solvency standards of 42 CFR 438.116.

Member means an individual enrolled with the Division.

Notice of Appeal Resolution means a written notice that includes the results of the resolution process per A.A.C. R9-34-216.

Notice of Adverse Benefit Determination means a notice that, per A.A.C. R9-34-205, explains:

A. The benefit determination the Division or AdSS has taken or intends to take;

B. The reasons for the benefit determination;

C. The enrollee's right to file an appeal with the Division or the AdSS;

D. The procedures for exercising the rights specified in Article 2 of A.A.C., Title 9, Chapter 34;

E. The circumstances under which an expedited resolution is available and how to request it; and

F. The circumstances under which an enrollee has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the enrollee is liable for the costs of services.

OAR means the Office of Administrative Review, which is the business unit within the Division of Developmental Disabilities responsible for processing member's appeals.

Prior authorization means a process used to determine in advance of provision whether a prescribed procedure, service, or medication will be covered.

Qualified Clinician means a behavioral health professional who is licensed or certified under A.R.S. Title 32 or a behavioral health technician who is supervised by a licensed or certified professional.

Recovering Costs means when the state fair hearing decision upholds the decision of the Division or the AdSS, the entities may initiate cost recovery for the service or services provided pending the outcome of the hearing decision. 42 CFR 431.230(b).

Representative means an individual authorized in writing by the responsible person to represent the member during the appeal process.

Responsible Person means the same as in A.R.S. § 36-551.

Rural means the same as in A.R.S. § 36-2171.

Seriously Mentally Ill (SMI) means persons who, as a result of a mental disorder as defined in section 36-501, exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, the mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation as in A.R.S. § 36-550.

Suspension of Service means a decision to temporarily stop providing a service that was previously authorized or approved.

Termination of Service means a decision to stop providing a covered service that was previously authorized or approved.

Working day means Monday, Tuesday, Wednesday, Thursday, or Friday from the hours of 8:00 a.m. to 5:00 p.m., unless:

A. A legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or

B. A legal holiday falls on Saturday or Sunday and the Division or AdSS is closed for business the prior Friday or following Monday.

Applicability

This policy applies to a decision made by the Division or its Administrative Services Subcontractors (AdSS) regarding:

A. Timely provision, approval, or authorization of a requested service or continuation of a covered service, benefit, or associated copayments including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

B. For members with SMI only, this also includes:

1. SMI Eligibility determination decisions

2. A PASRR determination related to a preadmission screening or an annual resident review which adversely affects member

3. Clinical Team findings regarding member's competency, capacity to make decisions, need for guardianship/other protective services or need for special assistance Planning Document or Inpatient Treatment and Discharge Plan (ITDP) service goals, objectives, or timelines and long-term views

4. Recommended services identified in assessment reports, Planning Documents, or ITDPs

5. Application of procedures and timeframes for developing a Planning Document or

ITDP

6. Sufficiency or Appropriateness of an Assessment

7. Access to or prompt provision of services identified in the Planning Documents or ITDPs

8. Denial of request to review outcome of, modification to, or failure to modify or termination of a Planning Document, ITDP or portion thereof

9. Decision to provide service planning including provision of an assessment or case management to a person who is refusing such services or a decision not to provide such services to the member

10. Decision regarding a person's fee assessment or the denial of a request to waive fees

11. Denial of payment of claims

12. Failure of the Division, AdSS, or AHCCCS to act within established Appeal timeframes

Non-Applicability

For members with SMI this procedure does not apply to:

A. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services

B. Title XIX Appeals of an adverse determination affecting services that are subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services, (See RHBA Contract Exhibit-14)

C. Adverse Determinations that are a result of changes in state or federal law requiring an automatic change or in order to avoid exceeding the legislatively appropriated state funding for program services and benefits

D. Allegations of rights violations made by members with SMI (See ACOM Policy 446)

E. Decisions involving a request for a service that requires a physician's order and the physician's refusal to order the service

Reasonable Entity for Appeals Process

The Division has delegated appeals to the AdSS for the following services:

A. Physical Health Care (i.e., prescription medications, DME, dental services, etc.)Behavioral Health Services

B. Seriously Mentally Ill (SMI) Services

C. Nursing Facility (NF) Services

D. Habilitative Physical Therapy for Members 21 Years of Age or Older

E. Emergency Alert System (EAS)

Filing an Appeal (Non-SMI)

When a Notice of Adverse Benefit Determination is given by the Division or the Administrative Services Subcontractors (AdSS) with whom the member/responsible person/representative does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person/representative.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Neither the Division nor AdSS allows punitive action against a provider for requesting expedited review of a member's appeal.

Filing an Appeal (SMI)

A member with SMI or the member's authorized representative may also appeal in writing or orally without prior receipt of a Notice of Adverse Benefit Determination when he/she is appealing any denial, decision, finding or recommendations outlined in the **Applicability** section of this policy pertaining to members with SMI only.

An authorized representative includes a legal guardian, guardian ad litem, designated representative or attorney, parent with legal custody, a court-appointed guardian ad litem or attorney of a member under 18 years, or a state or government agency that has executed an Intergovernmental/Interagency Service Agreement (IGA/ISA) with the Division for the provision of behavioral health services but which does not have legal custody or control of the member.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

Appeal Filing Timeframes

Any member/responsible person/representative must file an appeal within **60 calendar days** after the date of the Notice of Adverse Benefit Determination either orally or in writing.

For members with SMI, an appeal may also be filed at any time even when there is no Notice of Adverse Benefit Determination when a member contests/disagrees with any denial, decision, finding or recommendation outlined in the **Applicability** section of this policy as referenced above.

For appeals from DDD Tribal Health Program members or appeals related to Long Term Services and Supports (LTSS) delivered by the Division to its members the appeal must be filed with the Division's Office of Administrative Review (OAR) at:

DDD Office of Administrative Review

4000 North Central Avenue
3rd Floor, Suite 301, Drop 2HE5
Phoenix, Arizona 85012
602-771-8163 or 1-844-770-9500

For appeals from members who are enrolled with an AdSS, member appeals must be filed to the

AdSS address specified in each Notice of Adverse Benefit Administration delivered to the member by the AdSS when it made its decision to deny, reduce, suspend or terminate a service. For appeals from **members with SMI who are enrolled with an AdSS**, appeal must be filed to the AdSS address or phone number listed in the Member's Handbook or communicated through the Health Plan Customer Services who will transmit this appeal request to the appropriate Appeals unit of the respective AdSS.

Each appeal receipt will be acknowledged in writing within **five calendar days**. At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal.

Late appeals will be accepted from an SMI member or his/her authorized representative only upon showing of good cause. If the Division or AdSS refuses to accept a late appeal or determines that a service may not be appealed, the Division or AdSS will inform the member/authorized representative, in writing that he/she may request an Administrative Review of the decision with AHCCCS within 10 business days. AHCCCS will issue a final decision on a timely request for Administrative Review within 15 calendar days of the request.

If the final day of any timeframe falls on a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a holiday.

The Division will assist the member/responsible person/representative with the completion of forms and other procedural steps, upon request. The member/responsible person/representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person/representative may review the member's records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/representative is included as a party to the appeal process.

Appeal Notifications and Documents (SMI)

Notices and written documents will be available in each prevalent non-English language spoken within geographic service area. These will be made available in alternative formats such as Braille, large font, enhanced audio and other special communication devices and methods necessary to understand information. When needed, Oral interpretation services will be made available to members to explain written content contained in notices and written documents.

Member/authorized representative will not be made financially liable for all types of communication assistance provided.

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work or as specified in member/authorized representative's oral or written appeal.

Copies of notices will be maintained in the Division's official files using a unique docket number for each appeal filed. which will be referenced in all appeal correspondence generated. All records will be maintained in a secure and locked place in compliance with HIPAAA standards and requirements. The member/authorized representative will have the right to examine those documents and records maintained in member's docket file that will be used in informal conferences or Administrative Hearings upon request. The Division or AHCCCS may DENY access to Appeal case docket records when permitted by State and Federal law.

Continuation of SMI Services

If an appeal relates to the modification or termination of a behavioral health service, the service under Appeal will continue pending the resolution of the appeal through the Division's decision unless:

A. A Qualified Clinician (see definition) determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual or

B. The member or guardian, if applicable, agrees in writing to the modification or termination.

Appeal Resolution Process for Members with SMI

When the appealing member with SMI is enrolled with THP, the appeals process will be followed by the Division's OAR Appeals Unit. When the appealing member with SMI is enrolled with an AdSS, the Appeals Unit within each respective AdSS will follow the same appeal resolution process outlined below.

A. Division Informal Conference

1. Within seven days of receipt of an oral or written appeal, the Division or AdSS will hold an informal conference with the member/authorized representative. If member has been identified as needing special assistance and does not have an assigned Advocate, the Division or AdSS will contact AHCCCS Office of Human Rights to request for an advocate to be present during the informal conference or any part of the appeal process.

2. The Division or AdSS will schedule the informal conference at a convenient time and place and notify all participants in writing, at least two days prior to the scheduled conference listing date, time, location, and the option to participate by telephone or teleconference when preferred and the member's right to be represented by a designated representative of his/her choice.

3. The Informal Conference will be chaired by the designated representative of the Division or AdSS with authority to resolve the issues under appeal and who will seek to mediate and resolve the issues in dispute. The Division may designate a staff from its Behavioral Health Unit, Quality Management Unit, or Support Coordination to represent OAR during an informal conference.

4. During the informal conference the Division's designated representative will record a statement of the nature of the appeal, the issue presented, any resolution(s) agreed upon and the date(s) of implementation. Any unresolved issues will be identified for further appeal.

5. Upon a satisfactory resolution of member's appeal, the Division or AdSS will issue a dated written notice to all parties that contains the statement of the nature of the appeal, the issue addressed, the resolution(s) achieved, and the resolution implementation dates agreed upon.

6. If member's appeal is not resolved to member's satisfaction and the appeal issue does NOT relate to the member's eligibility for behavioral health services/SMI services, the member and other representative present during the Informal conference (member's designated representative/authorized representative, Advocate) will be informed that the appeal will be forwarded to AHCCCS for a

second informal conference. The procedure for requesting a waiver of the AHCCCS informal conference will be communicated to member/designated representative at this time.

7. If member's appeal is not resolved to member's satisfaction and the appeal issue relates to the member's eligibility for behavioral health services/SMI services, or the member has requested a waiver from the AHCCCS informal conference in writing, the Division or AdSS will:

   a. Provide a written notice to the member/authorized representative of the process to request an Administrative Hearing.

   b. Determine during the informal conference if the member/authorized representative or Advocate is requesting an Administrative Hearing. If so, the Division will file a request with AHCCCs within three business days of the informal conference.

   c. Send a copy of the Appeal, informal conference results, and written notice of the process to request an administrative hearing and notice of an Administrative hearing to the AHCCCS Office of Human rights for members in need of Special Assistance whether the member has an assigned Advocate who attended the informal conference or not.

8. For all appeals that are unresolved after an informal conference, the Division will forward the Appeal case record to AHCCCS within three days from the conclusion of the informal conference.

9. If the member fails to attend the scheduled informal conference and fails to notify the Division or AdSS, another informal conference will be rescheduled following written notification requirements followed previously.

10. If the member fails to attend the rescheduled informal conference and fails to notify the Division or AdSS prior to conference, the Division or AdSS will close the Appeal docket and send written notice of the closure to the member/authorized representative.

11. If the member requests the appeal to be re-opened due to failure to receive the informal conference notification and/or due to other good cause, the Division or AdSS may re-open the appeal and proceed with another informal conference.

B. Expedited Appeals Requests (SMI)

1. At the time an Appeal is initiated, the member may request an expedited Appeal in writing. The Division or AdSS will accept requests to expedite an Appeal for good cause, and for the following:

   a. A Denial of admission to or the termination of a continuation of inpatient services, or

   b. A Denial or termination of crisis or emergency services.

2. Within one day of receipt of a request for an expedited Appeal, the Division or AdSS will:

a. Inform the member in writing that the Appeal has been received and of the time, date, and location of the expedited informal conference; or

b. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal; and

c. Inform the member that he/she may, within three days of the Division or AdSS's decision, request an Administrative Review of the Division or AdSS's decision from AHCCCS.

3. Within two days of receipt of a written request for an expedited Appeal, the Division or AdSS will hold an informal conference to mediate and resolve the issues in dispute.

4. If the member requests an Administrative Review on a timely basis, AHCCCS will complete the review and issue a written decision within one day from the date of receipt. The decision of AHCCCS will be final.

C. AHCCCS Informal Conference

1. AHCCCS will hold another informal conference within 15 days of the notification from the Division that the Appeal was unresolved unless the member/authorized representative waives an informal conference with AHCCCS, or the appeal relates to eligibility for SMI services.

2. At least five days prior to the date of the AHCCCS-scheduled informal conference, AHCCCS will notify the participants in writing of the date, time, and location of the conference.

3. The informal conference will be chaired by a representative of AHCCCS who will seek to mediate and resolve the issues in dispute.The AHCCCS representative will record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further Appeal.

4. If the issues in dispute are resolved to the satisfaction of the member, AHCCCS will issue a dated written notice to all parties, which will include a statement of the nature of the Appeal, the issues involved, the resolution achieved, and the date by which the resolution will be implemented.

5. For a person in need of Special Assistance, AHCCCS will send a copy of the informal conference report to AHCCCS Office of Human Rights.

6. If the issues in dispute are not resolved to the satisfaction of the member, AHCCCS will:

a. Provide written notice to the member of the process to request an administrative hearing;

b. Determine at the informal conference whether the member is requesting AHCCCS to request an administrative hearing on behalf of the member and, if so, file the request within three days of the informal conference;

c. For a person in need of Special Assistance, send a copy of the notice to AHCCCS Office of Human Rights.

7. If the member requests an **expedited** AHCCCS Informal Conference, AHCCCS will hold an informal conference to mediate and resolve the issue in dispute, within two days of notification from the Division or AdSS, unless the member/authorized representative waives the informal conference, in which case the Appeal will be forwarded within one day to AHCCCS to schedule an administrative hearing.

8. If the AHCCCS informal conference is not waived, and AHCCCS fails to resolve the Appeal, the Appeal will be forwarded to AHCCCS to schedule an administrative hearing within one day of the informal conference.

9. If the member/authorized representative fails to attend the AHCCCS informal conference and fails to notify AHCCCS of this, AHCCCS may issue a written notice, within three working days of the scheduled conference, which contains a description of the decision on the issue under appeal and advises the member/authorized representative of his/her right to request an Administrative hearing.

10. In the event the member requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, AHCCCS may re-open the Appeal and proceed with the informal AHCCCS conference.

D. Requests for Administrative Hearing

1. In the event a request for administrative hearing is filed with the Division or AdSS, the Division or AdSS will ensure that the written request for hearing, Appeal case record, and all supporting documentation is received by AHCCCS within three days from such date. A written request for hearing filed by the Division or AdSS with AHCCCS will contain the following information:

   a. Name of the member and person receiving services (if different),

   b. Member's case docket number,

   c. The decision being Appealed,

   d. The date of the decision being Appealed, and

   e. The reason for the Appeal.

2. Administrative Hearings will be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

Standard Appeal Resolution Timeframe

The Division will respond to the standard appeal filed as a result of receipt of a Notice of Adverse Benefit Determination and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 30 calendar days after the date the Division receives the appeal. The Division will extend the 30-day timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division may request a 14-calendar day extension of the 30-day time frame if additional information is needed and the extension is in the best interest of the member. The OAR will provide the member/responsible person/representative written notice of the reason for the decision to extend the 30-day timeframe.

Appeal Notice Requirements

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work. In the event that it may be unsafe to contact the member/authorized representative at his/her home address, or the person indicated that he/she does not want to receive mail at home, the alternate communication methods specified by the member/authorized representative will be used.

Notices and written documents generated through the Appeals process will be available in alternative format such as Braille, large font, or enhanced audio and take into consideration the special communication needs of members.

Expedited Appeal

The member/responsible person/representative may request an expedited resolution of the appeal when the appeal is filed as a result of a Notice of Adverse Benefit Determination. The Division or AdSS will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person/representative, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the denial. It will send a written notice of the denial no later than two calendar days to the member/responsible person/representative. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, the Division's OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 72 hours from the day the Division or AdSS receives the request for an expedited appeal. The Division or AdSS will extend the 72-hour timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division or AdSS may request a 14-calendar day extension of the 72-hour timeframe if additional information is needed and the extension is in the best interest of the member. The Division or AdSS will provide the member/responsible person/representative written notice of the reason for the decision to extend the 72-hour timeframe.

Appeal Decisions and Timeframes

For standard and expedited appeals filed as a result of a Notice of Adverse Benefit Determination, the Division will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 72 hours for an expedited appeal, the member may consider the appeal denied. The

Notice of Appeal Resolution is issued to the member/responsible person/representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD or Division) decision.

If the Notice of Appeal Resolution is reversed, the Division or AdSS will notify Support Coordination and the other entity (Division or AdSS), as appropriate. Upon notification, services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division may recover the cost of services from the member.

The Division or AdSS will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The AdSS will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division or AdSS will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or within 72 hours for an expedited appeal, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/representative and the Division through the Office of Administrative Review. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the AdSS decision.

If the Notice of Appeal Resolution is reversed, the AdSS or the Division of Developmental Disabilities, Office of Administrative Review by the other. Upon notification services will be provided expeditiously as the member's health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division or AdSS may recover the cost of services from the member.

6003-J ARIZONA LONG TERM CARE SERVICES STATE FAIR HEARING PROCESS

REVISION DATE: /2 /201 , 04/24/2019, 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 41-1092.07

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings. The fair hearing request must be filed in writing and received by Office of Administrative Review (OAR) no later than 120 calendar days from the date of the Notice of Appeal Resolution. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301
Mail Drop 2HE5
Phoenix, Arizona 85012

Once the hearing request is filed, OAR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OAR staff will submit the file to AHCCCS within five (5) business days. This file will include the completed AHCCCS Submission of Request for Hearing form, a cover letter, copy of the entire file, copies of the Notice of Adverse Benefit Determination, request for fair hearing, investigative materials, and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is informal, and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence, and the record supplied by OAR and the appellant, the ALJ will prepare written findings of fact and conclusions of law and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OAR will arrange with the appropriate Division staff and/or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

he rehearin will be decided b the AHCCCS Director or desi nee and a final written decision of the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

6003-K CLAIM DISPUTES

REVISION DATES: 5/24/2021, 5/27/2020, 10/1/2019, 8/28/2019, 5/29/2019, 6/10/16, 1/15/2016,
3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-2903.01(B)(4) and 41-1092.01; A.A.C. R9-34-402 and R9-34- 405

Definitions

A. Administrative Services Subcontractors (AdSS) - means an organization or entity that has a capitated contract with the Division of Developmental Disabilities (Division) to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, Arizona statutes, Arizona rules, federal law, and federal regulations.

B. AHCCCS Administration - means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901(1).

C. Clean Claim - means the same as in A.R.S. § 20-3101(2).

D. Claim Dispute - A dispute, filed by a provider or DDD Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

E. Contractor - means the following:

1. A contractor or program contractor as defined in A.R.S. § 36- 2901(1);

2. The Comprehensive Health Plan (CHP) in the Department of Economic Security; and

3. The Children's Rehabilitation Services and Behavioral Health Services in the Arizona Department of Health Services.

F. Day - means calendar day unless otherwise specified.

G. Director - means the Director of the AHCCCS Administration or the AHCCCS Administration designee.

H. Director's Decision - means the final administrative decision under A.R.S. § 41-1092(5).

I. FFS Member - means a Fee For Service Member eligible for AHCCCS coverage under Arizona Revised Statutes Title 36, Chapter 29, who is enrolled with AHCCCS on an FFS basis, and who is not enrolled with an AHCCCS contractor.

J. Filed - means the date AHCCCS receives a request established by a date stamp on the request or other record of receipt.

K. State Fair Hearing - means an administrative hearing under Arizona Revised Statutes, Title 41, Chapter 6, Article 10.

Applicability

This policy is applicable to:

A Fee for Service Providers who are filing claims and claim disputes to the Division for services rendered to the Division's THP members.

B Providers who are affiliated with an AdSS which processes claims and claim disputes from its providers for services rendered to its enrolled members.

Claim Dispute Process

A Division representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division.

If the Division gives the service provider a notice that the service provider disagrees with, the service provider may file a claim dispute. The Division will accept a claim dispute only when the dispute involves a payment of a claim, a denial of a claim, an imposition of a sanction, or reinsurance.

The service provider must adhere to both of the following requirements when filing a claim dispute:

A. Submit the claim dispute to the Division in writing; and

B. Submit the claim dispute within the time period that will occur last out of the following, in accordance with A.R.S. § 36-2903.01(B)(4):

1. Within the 12 consecutive months immediately following the date(s) of service;

2. Within the 12 consecutive months immediately following the date that the member's eligibility is posted; or

3. Within the 60 calendar days immediately following the date of denial for a timely claim submission.

The Division will date all claim disputes upon the Division's receipt. The Division will send the service provider a written notice acknowledging receipt of the claim dispute within the five business days immediately following the Division's date of receipt. If the service provider wishes to submit any additional information to the Division for consideration, the service provider must submit the additional information within the 10 calendar days immediately following the Division's date of receipt. The Division will advise the service provider about the 10-day deadline for the service provider to submit any additional information.

Division Business Operation staff may contact the service provider to obtain additional information. The Division will consider and review, relevant Arizona Revised Statutes, Arizona Administrative Code, AHCCCS policies, and Division policies. The Division staff will be consulted, as necessary.

The Division will investigate every claim dispute using applicable authorities and facts obtained from all parties. Both the Division and the service provider must mutually agree to any deadline

extension(s). If both parties mutually agree to extend the decision deadline either to allow additional time for the Division to make a decision or the service provider to submit supporting documentation, the Division will issue a letter to the service provider.

When the Division completes the fact-finding, the Division will render a written Notice of Decision to the service provider. The Division will send the Notice of Decision within the 30 calendar days immediately following the Division's date of receipt unless the parties mutually agree to a deadline extension.

The Notice of Decision must both comply with relevant regulatory and contractual requirements, as well as include all of the following:

A. The date of the decision,

B. The factual and legal basis for the decision,

C. The service provider's right to request a fair hearing, and

D. The instructions for requesting a fair hearing.

State Fair Hearings for Claim Disputes

If a service provider disagrees with the Division's Notice of Decision on the service provider's claim dispute, then the service provider may file a request for a fair hearing with the Department of Economic Security (DES) Appellate Services Administration/Arizona Long Term Care System (ALTCS). The service provider must make the fair hearing request in writing to the Office of Administrative Review (OAR) within the 30 calendar days immediately following the Division's dated receipt of the Notice of Decision.

The service provider must send the fair hearing request to:

DES/DDD Office of Administrative Review (OAR)
4000 N. Central Ave, 3rd Floor Suite 301
Phoenix, Arizona 85012

Once the fair hearing request is made, OAR staff will prepare a duplicate file and submit the duplicate file with the hearing request to both the DES Appellate Services Administration/ALTCS and the Attorney General's Office. The OAR staff will prepare the duplicate file to include all of the following:

A. Copies of the claim dispute,

B. Investigative materials, and

C. The Notice of Decision.

OAR staff will submit the documents to the DES Appellate Services Administration/ALTCS within the five business days immediately following the Division's dated receipt of the request for hearing.

A DES Appellate Services Administration/ALTCS representative will schedule the fair hearing. The service provider will receive written notification of the fair hearing's scheduled date and time. The DES Appellate Services Administration/ALTCS representative will notify both the

Attorney General's Office and the OAR about the scheduled hearing.

At the fair hearing, the service provider, a DES/Division of Developmental Disabilities (DDD) representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/ALTCS Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, written conclusions of law, and render a decision. The Hearing Officer will render the decision based on the following:

A. Information the Hearing Officer gathers through testimony,

B. Any presentation of evidence, and

C. Any other records supplied by OAR.

A DES Appellate Services Administration/ALTCS representative will forward a copy of the decision to all of the following:

A. The AHCCCS Office of Administrative Legal Services,

B. The service provider,

C. DES/DDD, and

D. The Attorney General's Office.

If the service provider wants to petition for rehearing or review, then the service provider must submit the request to the AHCCCS Office of Administrative Legal Services within the 30 calendar days immediately following the date of the DES Appellate Services Administration/ALTCS Administrative Law Judge’s decision. The petition must completely explain the grounds for a rehearing or review.

Petitions for rehearing or review must be sent to:

AHCCCS Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division’s decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If the Division and the Attorney General's Office decide a review will not be petitioned, the OAR will arrange with the appropriate Division staff to both authorize payment and pay for the services as reasonably expeditious as possible.

If the Division or the service provider is still dissatisfied with the AHCCCS decision, the Division or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reversed Claim Disputes

The Division shall reprocess and pay both overturned and reversed claim disputes within the 15 business days immediately following the date of the decision. The Division will make payments

in a manner consistent with the decision.

IMPORTANT TO NOTE: The Division will adhere to the same claim dispute process described herein for FFS claims on behalf of THP members.

THE DIVISION HAS DELEGATED ACUTE CARE CLAIM DISPUTES TO THE ADSS FOR ADJUDICATION FOR ALL THE FOLLOWING SERVICES:

- Physical Health Care (i.e., hospitalizations, prescription medications, DME, dental services, etc.)
- Behavioral Health Services
- Seriously Mentally Ill (SMI) Services
- Nursing Facility (NF) Services
- Habilitative Physical Therapy for Members 21 Years of Age or Older
- Emergency Alert System (EAS)

Claim Dispute Process

The AdSS representative will provide written notice advising the service provider of both a denial of claim payment and the reason for denial. The AdSS representative may include the notice either in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the AdSS.

If the service provider disagrees with a notice given by the AdSS, the service provider may file a claim dispute. The AdSS will accept a claim dispute only if the dispute involves one of the following:

A. A payment of a claim,

B. A denial of a claim,

C. An imposition of a sanction, or

D. Reinsurance.

The service provider must file the claim dispute in writing with the AdSS. In accordance with

A.R.S. § 36-2903.01(B)(4), the service provider must submit the claim dispute within the time period that will occur last out of the following:

A. Within the 12 consecutive months immediately following the date(s) of service,

B. Within the 12 consecutive months immediately following the date that the member's eligibility is posted, or

C. Within the 60 calendar days immediately following the denial date of a timely claim submission.

The AdSS will date all claim disputes upon AdSS’s receipt. The AdSS will send the service

provider a written notice acknowledging receipt of the claim dispute within the five business days following the date the claim dispute is received. The AdSS will advise the service provider that any additional information the service provider wishes to submit to the AdSS for consideration must be done so in 10 calendar days.

The AdSS staff may contact the service provider to obtain additional information. Relevant Arizona Revised Statutes, Arizona Administrative Codes, and AHCCCS and Division policies will be reviewed, and the AdSS staff will be consulted as necessary.

AdSS will investigate all claim disputes using applicable authorities and facts obtained from all parties. Both parties must mutually agree on any deadline extensions. If there is a mutual agreement to extend the decision due date either to allow the AdSS to make a decision or allow the service provider additional time to submit supporting documentation, the AdSS will issue a letter to the service provider. Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within 30 calendar days of receipt of the services provider's claim dispute unless the provider and the AdSS agree to a longer period.

The Notice of Decision must comply with regulatory and contractual requirements. The Notice of Decision must include all of the following:

A. The date of the decision,

B. The factual basis for the decision,

C. The legal basis for the decision,

D. The service provider's right to request a fair hearing, and

E. The instructions for requesting a fair hearing.

State Fair Hearings for Claim Disputes

If a service provider disagrees with the AdSS's Notice of Decision on a claim dispute, the service provider may file a request for a fair hearing with the Office of Administrative Hearings (OAH). The service provider must make the request for fair hearing in writing to the AdSS within the 30 calendar days immediately following AdSS's receipt of the Notice of Decision.

In accordance with DDD Operations Manual Policy 445, the AdSS will forward the service provider's fair hearing request file to the Division's Office of Administrative Review (OAR) to be submitted to the AHCCCS Office of Administrative Legal Services (OALS). The AdSS staff will prepare a duplicate file along with the hearing request, copies of the claim dispute, investigative materials, and the Notice of Decision for submission to the DDD Office of Administrative Review (OAR). The AdSS will submit the duplicate file to the DDD Office of Administrative Review (OAR) within the three business days immediately following AdSS's receipt of the request for fair hearing. OAR staff will submit the documents to the AHCCCS Office of Administrative Legal Services (OALS) within the two business days immediately following OAR's receipt of the file from the AdSS.

The fair hearing will be scheduled by the AHCCCS Office of Administrative Legal Services (OALS). The service provider will receive written notification of the date and time. The AHCCCS Office of Administrative Legal Services (OALS) will notify both the AdSS and the Division of the scheduled hearing.

At the hearing, the service provider, an AdSS representative, and the AdSS General Counsel, if appropriate, will meet with an Office of Administrative Hearings (OAH) Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, conclusions of law, and render a decision. The Hearing Officer will render a decision based on the following:

A. Information gathered through testimony,

B. Any presentations of evidence, and

C. Any other records from the AdSS or service provider.

An Office of Administrative Hearings (OAH) representative will forward a copy of the decision to the Arizona Health Care Cost Containment Service (AHCCCS) Director.

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the AdSS decision, the AdSS will determine if a request for review will be petitioned to the AHCCCS Director. If the AdSS decides that a review will not be petitioned, the AdSS will arrange with the appropriate AdSS staff to both authorize and pay for the services as expeditiously as reasonably possible.

Parties may file a petition for rehearing or review with the AHCCCS Office of Administrative Legal Services (OALS) by the AdSS or service provider. The petition must be submitted within the 30 calendar days immediately following the date of the AHCCCS Director's decision. The petition must completely explain the grounds for rehearing or review.

Petitions for rehearing or review must be sent to:

AHCCCS Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

If the AdSS or the service provider is still dissatisfied with the decision, the AdSS or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

Overturned or Reverse Claim Disputes

The AdSS must reprocess and pay overturned or reversed claim disputes within the 15 business days immediately following the date of the decision. The AdSS will make payments in a manner consistent with the decision.

6003-L ATTORNEYS AT PLANNING MEETINGS

REVISION DATE: 5/20/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The member/responsible person may invite anyone to participate at planning meetings, including his/her attorney. It is recommended that the member/responsible person notify the Support Coordinator, at least two business days before the meeting is scheduled to occur, that legal counsel will participate with the responsible person at the planning meeting.

If prior notice is not given, the planning meeting may be postponed. If the Division's legal counsel is not present at the meeting and Division staff determines that legal counsel is needed, Division staff may temporarily stop the meeting in an effort to obtain legal counsel. In addition to Division staff, the Division may have an Assistant Attorney General at a meeting. Any meeting may be audio recorded.

6003-N ORAL AND WRITTEN REGULATORY INQUIRIES

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 U S Code 1396u–6, 42 U S C 1396w–2, 42 U S C 1396w–5

PURPOSE

To comply with applicable statutes, regulations, contractual program requirements and maintain the integrity of the Compliance Program, the Division shall document and track oral and written inquiries and responses

DEFINITIONS

Member Information Materials – Any materials given to DDD membership. This includes, but is not limited to member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications, and website content It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone

Vital Materials – Written materials that are critical to obtaining services which include, at a minimum, the following

1. Member Handbooks
2. Provider Directories
3. Consent Forms
4. Appeal and Grievance Notices
5. Denial and Termination Notices Policy A. Member Information Materials

POLICY

The Corporate Compliance Officer or designee shall ensure the log for regulatory inquiries is completed daily. The log shall be available for review during any internal and external audits. Any requests for information, guidance, and advice from any government agency, fiscal intermediaries, subcontractors, vendors, providers, agents, and members shall be documented on the log.

The logging of oral inquiries is extremely important if Division relies on the response as guidance in future decisions, actions, or claim reimbursement requests or appeals. The Corporate Compliance Team process regulatory inquiries as follows

1. DDD Long Term Care Services – Contract Compliance Unit
2. Acute Services Health Plans – Health Plan Compliance Unit

In addition, the log shall be relevant in a subsequent investigation to the issue of whether Division s reliance was reasonable and whether it exercised due diligence in developing procedures and practices to implement the advice.

This policy pertains to oral and written communication disseminated to the Division s enrolled members and to the content of the Division s website

A. The Division must comply with the requirements in this Policy for all member information materials as outlined in the Division's Operations Manual and AHCCCS Contractor Operations Manual (ACOM):

1. Chapter 400 Operations

2. Chapter 404 Contractor Website and Member Information

3. ACOM Policy 405 for requirements regarding Cultural Competency, Language Access Plan and Family/Patient Centered Care

4. ACOM Policy 406 for requirements regarding the Member Handbook and Provider Directory

5. ACOM Policy 425 for requirements regarding Social Networking activities

6. ACOM Policy 433 for requirements regarding Member ID Cards

7. ACOM Policy 414 for sample Notice of Adverse Benefit Determination and Notice of Extension

8. The Division Contract, Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters.

9 The Division must attest it is in compliance with member information requirements by signing and submitting ACOM 404, Attachment C, as specified in the Contract.

B. The Division must provide all member information materials to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.

C. The Division must inform members that member information is available in paper form, without charge and upon request, and must provide it upon request within five business days.

D. The Division must use State developed member notices as indicated in Contract and Policy [42 CFR 438.10(c)(4)(ii)].

6003-O RESPONDING TO GOVERNMENT AUDITS

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 455, Subpart A, A.R.S. §§36-2918 and 2957

PURPOSE

To establish a procedure for responding to government audits, interviews, and investigations beyond routine claims reviews.

DEFINITIONS

Federal Bureau of Investigation (FBI) – The investigative arm of the federal government

Centers for Medicare and Medicaid Services (CMS) – The federal agency overseeing the administration of the Medicare and Medicaid programs.

Medicaid Fraud Control Unit (MFCU) - The investigative arm of the state Medicaid agency.

Office of Inspector General (OIG) - The legal investigative arm of federal government programs.

State Attorney General's Office (AGO) - The legal prosecutorial arm of State government.

State Government Agency/AHCCCS - Any state agency responsible for clinical licensure or oversight of healthcare providers.

POLICY

The AHCCCS Office of Inspector General (AHCCCS-OIG) has the authority to conduct preliminary and full investigations relating to fraud, waste, and abuse involving the programs it administers. Pursuant to 42 CFR 455, Subpart A, an Intergovernmental Agreement with the Arizona Attorney General's Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG has the authority to make independent referrals to other law enforcement entities.

Pursuant to A.R.S. §36-2918, AHCCCS-OIG has the authority to issue subpoenas and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the Office.

Pursuant to A.R.S. §§36-2918 and 2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National

Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, AHCCCS-OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

RESPONSIBILITIES

The Corporate Compliance Officer or designee is responsible for leading the response to as well as coordinating and tracking all details of government audits, interviews, and investigations.

GUIDELINES

Federal and state governments have made the investigation and prosecution of healthcare fraud one of their highest priorities. They have also proposed many new initiatives for identifying fraudulent and abusive practices. A number of these initiatives include conducting audits of vendors. The Division's policy requires the implementation of internal controls to provide reasonable cooperation with these government authorities while at the same time protecting the rights of the Division and its employees.

A. Non-Routine Communication from Government Representatives

1. To fully understand a request from a government representative and provide a complete and accurate response to non-routine requests from a government representative, all such communications must be forwarded to the Corporate Compliance Officer.

2. Any employee receiving a nonroutine request or communication from a government representative should obtain the following information for the Corporate Compliance Officer or designee:

    a. The person's name, title, and department (if possible, obtain a business card), badge or identification number; for telephone requests, the office telephone number of the government representative; and

    b. As many details as possible about the information or documents being requested.

    c. If a list of requested items/documents is provided, prepare a copy of each document.

3. Inquiries into the location of files must be answered truthfully. All requests from a government representative to obtain any documents from the Division must be immediately forwarded to the Office of Administrative Review.

4. If an employee is contacted by an organization that is not on the list of agencies in the Definitions and Acronyms section of this policy and is unsure whether the organization is a federal or state government agency, they should contact their direct supervisor/manager, the Corporate Compliance Officer or designee directly.

5. If a request for documents or a subpoena is received from a government representative, it should be immediately forwarded to a supervisor/manager. The supervisor/manager should immediately send a copy to the Corporate Compliance Officer.

    a. Employees should not respond directly to the request until receiving direction from their supervisor/manager.

B. Interviews with Government Representatives

1. It is appropriate to respond to unannounced visits from a government representative with a reasonable request to schedule an appointment to speak with the representative at a later date. Any employee receiving an unannounced visit from a government representative should immediately contact their supervisor/manager and/or the Corporate Compliance Officer or designee, or AD for direction.

2. Division employees must contact their supervisor/manager and/or the Compliance Officer or designee as soon as possible after the contact by the government representative.

3. Employees are encouraged to take notes during any encounters with government representatives.

4. Division employees may have someone present during any interview with a government representative. The Division may arrange to have an appropriate individual (possibly an attorney) present at no cost to the employee or employees may consult with an attorney of their own choosing at their expense.

5. When a Division employee speaks with a government representative, they should answer the questions completely, accurately, and concisely to prevent any misunderstanding of the facts.

C. Searches by Government Representatives

1. Division employees should be courteous and helpful to government representatives but should not grant access for a search without guidance from a supervisor/manager, the Corporate Compliance Officer or designee, or AD.

2. A government search may not be conducted without a legally valid search warrant. Division employees should request time to contact the Corporate Compliance Officer and legal counsel to determine the validity of a search warrant.

3. Division employees must not:

    a. Alter or destroy documents sought in an investigation

    b. Falsely deny knowledge of information

c. Seek to influence another person to exercise the privilege against self-incrimination

d. Intimidate a witness with the intent of influencing testimony; or

e. Retaliate against a witness for testifying in an official proceeding.

4. Any Division employee that observes this prohibited behavior should immediately report this to the Corporate Compliance Officer.

5. Division employees should, when possible, make copies of all documents requested by a government representative. A government representative should not remove documents from the Division's premises without the Division first maintaining a copy of the documents. The Office of Administrative Review will provide instructions on the maintenance of these documents.

6. If a Division employee cannot make copies of all requested documents, they should request and obtain from the government representative a detailed log of all documents or items copied or removed.

7. Division employees are not authorized to sign, on behalf of the Division, any document that a government representative requests be signed. If a government representative requests that a Division employee sign an affidavit, that employee may request to have legal counsel review it before signing it.

D. Communications Regarding an Investigation

1. Inquiries for information from the media should be referred to the Department of Economic Security Public Information Officer (DES-PIO) at PIO@azdes.gov. Whenever possible, the employee should obtain the identity and telephone number of the inquiring party and provide that information to the Public Information Officer.

E. Administrative Issues

1. The Corporate Compliance Officer or designee will follow the Compliance Program policy and procedure for creation, maintenance, and retention of the documents related to a government audit, interview, or search under the guidance of legal counsel.

6003-R COMPLIANCE CONCERNS AND REPORTING REQUIREMENTS

RE ISION DATE 9/15/2021
EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 455.17, CMS FWA Reporting, MIP Manual, AAC R6-6-1517

PURPOSE

To ensure Division employees understand it is everyone's responsibility to assist in preventing, identifying, and reporting any suspicion of fraud, waste, and abuse of the Division's programs.

POLICY

To encourage and establish communications for Division employees that shall remain "confidential and non-retaliatory" regarding reporting misconduct. Reporting of fraud, waste, and abuse shall be completed without retribution and retaliation of the individual reporting or filing a complaint. Employees shall report suspicion about legal and/or ethical violations.

A. Opening lines of communication between the Corporate Compliance Officer/Compliance Unit and Division employees is critical to the successful implementation of a Compliance Program and the reduction of potential Fraud, Waste, Abuse, and misconduct.

B. In addition to serving as a contact point for reporting non-compliance, the Corporate Compliance Officer/Compliance Unit shall be a resource to whom staff can receive clarification regarding policies related to corporate compliance.

C. Questions and responses shall be documented and dated and, if appropriate, addressed with the Corporate Compliance Committee so that standards and policies can be improved to reflect any necessary changes or clarification of existing Policies and Procedures.

D. Division employees shall report legitimate concerns about legal, ethical, or quality of care issues. Any activity that may compromise a member's health, safety, or welfare and/or the Division's reputation related to ethical health care and business practices shall be reported to the Corporate Compliance Officer/Compliance Unit immediately.

E. The Corporate Compliance Committee members or the established Corporate Compliance Program Integrity hotline is another means by which reporting may occur.

F. Each employee shall be encouraged, but not required, to follow the chain of command when reporting any allegation(s) involving suspected fraud, waste, or abuse in Medicare and Medicaid programs:

G. The Division's Corporate Compliance Officer (Compliance Officer) and Corporate Compliance Unit shall be the first point of contact for employees to report any allegations of fraud, abuse, or waste.

H. Suspected fraud, waste and abuse may be reported via one of the following mechanisms:

Fraud Contact Information

DDD Corporate Compliance Unit

Phone: 1-877-822-5799

Online: https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

Email: dddfwa@azdes.gov

Or Write to:
DES/DDD
Attn: Corporate Compliance Unit
1789 W Jefferson St.
Mail Drop 2HA1
Phoenix, AZ 85007

AHCCCS OIG Fraud Prevention Unit

Phone: (602) 417-4193

Online: https://azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

Provider Fraud:

Maricopa County: (602) 417-4045
Outside Maricopa County: (888) 487-6686

Member Fraud:

Maricopa County: (602) 417-4193
Outside Maricopa County (888) 487-6686
General Questions:
Email: AHCCCSFraud@azahcccs.gov

I. Each employee has the right to remain anonymous when reporting any suspected allegations of fraud, waste, or abuse to Medicare, Medicaid, or other programs. The reporting process may be written or verbal.

J. The Compliance Officer or designee that receives reports of fraud, abuse, or waste may retain the confidentiality of staff member(s) who report information as deemed appropriate.

K. When reporting a compliance concern other than suspected fraud, waste and abuse, staff shall include information the Compliance Officer or designee will need to follow up. This includes but is not limited to:

1. The location where the concern occurred or is occurring
2. The date or dates of any incident
3. The names and job roles of individuals involved in the concern
4. A description of the concern
5. The name of the staff submitting the report
    a. If the person is comfortable letting the Compliance Officer/Office know.
    b. If the staff member is not comfortable leaving their name, staff may make an anonymous report by calling the FWA & Misconduct hotline or reporting directly to AHCCCS.

L. Anyone making such a report is assured that it will be treated as confidential and will be shared with others only on a need-to-know basis.

M. To protect those involved in a compliance investigation, the findings of the compliance investigation remain confidential. Therefore, details of the investigation shall be shared only on a need-to-know basis.

N. The Compliance Officer or designee ensures that all reports will be thoroughly and fairly investigated.

O. No adverse actions will be taken against someone for making a report in good faith or for cooperating with a compliance investigation in good faith.

6003-S COMPLIANCE PROGRAM TRAINING AND EDUCATION

EFFECTIVE DATE: September 8, 2021
REFERENCES: Division Operations Manual Chapter 6000 C. 1. A. v., 6000 C. 2, 6004-F, Compliance Program Components A, ACOM Chapter 100 Part B. 9, 10XXXXX

PURPOSE

To establish procedures for the mandatory compliance training and routine dissemination of information related to compliance activities.

POLICY

The Division will provide education and training related to compliance requirements and standards, to offer guidance, promote an organizational culture of ethics and compliance, and provide an environment in which stakeholders can act in good faith without fear of retaliation.

RESPONSIBILITIES

The Corporate Compliance Officer will ensure Division procedures for providing education and training are followed. In their absence, the Assistant Director will appoint an appropriate staff member.

GUIDELINES

Education and training are key factors in ensuring the effectiveness of the Division's Compliance Program. The Division must educate its employees on applicable federal, state, local, contractual, and organizational regulations by which the Division is governed. This includes the organization's policies the Division is committed to uphold. It is vital that all employees are informed of their individual responsibility to understand and comply with these regulations and policies. As a result, the Division's Compliance Program has established the following education and training policy.

A. Compliance Program Training Materials

1. The Corporate Compliance Officer or designee will create or oversee the creation of all training presentations and materials related to the Compliance Program, including the date on which the document was created and updated, if applicable.

2. The Corporate Compliance Officer or designee will review all Compliance Program training presentations and materials on an annual basis for content, and update as necessary to comply with, and include any regulatory changes.

3. The Compliance Officer or designee in coordination with the Office of Professional Development (OPD) will maintain a record of all compliance training programs, including training presentations, attendance records, and other related materials such as handouts and test results.

B. Compliance Program Orientation Training

1. The Corporate Compliance Officer or designee is responsible for ensuring that all new Division employees and associates receive the most current version of Compliance Program Orientation Training within 90 days of hire.

2. The Corporate Compliance Officer or designee will create and maintain records of training materials and attendance reports in the Corporate Compliance Unit permanent files.

C. Compliance Program Annual Refresher Training

1. The Corporate Compliance Officer or designee in coordination with OPD, is responsible for ensuring that all Division employees receive the most current version of Compliance Program Refresher Training every calendar year.

2. The Corporate Compliance Officer or designee will receive Refresher Training materials and attendance reports from OPD and monitor compliance.

3. The Corporate Compliance Officer or designee will work with OPD to coordinate Refresher Training.

D. Dissemination of Compliance Program Information

1. The Corporate Compliance Officer or designee in coordination with the Communications and Customer Care Units, is responsible for ensuring that Division employees are informed of compliance regulatory changes, events, and news, as it relates to Division services.

2. The Corporate Compliance Officer or designee may use a variety of tools or formats for these updates/newsletters, including, but not limited to e-mail bulletins, conference calls, and notices posted in employee break areas.

6003-U CORPORATE COMPLIANCE PROGRAM DOCUMENTATION

EFFECTIVE DATE: September 8, 2021
REFERENCES: 42 CFR 438.608, ACOM Policy 103, AHCCCS contract with DDD Section D paragraph 65 and 66

POLICY

To outline the process for establishing documentation creation, maintenance, and retention procedures for compliance activities such as:

A. Development and implementation of written policies and procedures

B. Reporting to the Compliance Committee

C. Training and Education

D. Developing effective lines of communication

E. Conducting internal and external monitoring and auditing

F. Enforcing standards through well publicized disciplinary guidelines

G. Responding promptly to detected noncompliance and undertaking corrective action

DOCUMENTATION

The Division's Corporate Compliance staff shall take steps to document its compliance processes. The Corporate Compliance Officer (Compliance Officer) will ensure procedures for document control are followed. In their absence, the Assistant Director (AD) or Corporate Compliance Committee will appoint an appropriate staff member.

Documentation is a key factor in the determination of a Compliance Program's effectiveness. An organization must be able to demonstrate the actions that have been taken throughout the development and implementation process to evaluate the reasonableness of decisions made in establishing and maintaining the program. Therefore, the Division's Compliance Program has established the following documentation guidelines to assist in creating an electronic record of the Division's compliance activities.

A. Maintenance of Compliance Program Documents

1. The Compliance Officer or designee will create and maintain and oversee the maintenance of all documentation of the Compliance Program, including the date on which the document was created and updated, if applicable.

2. The Compliance Officer or designee will maintain a log of all compliance-related documents of which he/she is aware or that are in his or her possession.

3. The Compliance Officer or designee may generate or receive documents that are of a confidential nature. These may include business documents, investigation materials, or member records that must be protected from

general disclosure or distribution. The Compliance Officer, in consultation with legal counsel when appropriate, will determine which documents should be maintained as "CONFIDENTIAL" documents. Each page of these documents will be labeled "CONFIDENTIAL/DO NOT DUPLICATE."

4. Records generated or obtained by the Compliance Officer or designee in the course of business may be of a confidential nature as a result of a communication with legal counsel. Those documents will be marked on each page: "CONFIDENTIAL ATTORNEY/CLIENT PRIVILEGED COMMUNICATION—NOT FOR REDISCLOSURE." The legend will be placed away from margins where it could be lost in the duplication process. All efforts will be made to refrain from duplicating documents that are "Confidential" or "Attorney/Client Privileged."

5. All documents that are "Confidential" or "Attorney/Client Privileged" will be maintained separately in secured electronic files. The Compliance Officer or designee will maintain records of who may access the "Confidential" and "Attorney/Client Privileged" documents.

B. Miscellaneous Documents (maintained in the Corporate Compliance Department Google drive)

1. Names, titles, and background for the Compliance Officer and any compliance staff.

2. Names, titles, and backgrounds for any high-level individuals responsible for compliance functions.

3. Job descriptions for the Compliance Officer and any compliance staff.

4. Information regarding the reporting structure to the Corporate Compliance Committee and the AD.

5. Copies of reports made to the Corporate Compliance Committee and the AD.

C. Human Resource Documents (maintained in Human Resource Department files)

1. Human Resource and Compliance Policies and Procedures regarding the hiring of new personnel.

2. Documentation evidencing background checks performed on new hires.

3. Documentation reflecting individuals refused employment based upon background check findings.

4. Information collected during exit interviews regarding compliance issues.

D. Compliance Training Documents (maintained in the Corporate Compliance Department Google drive)

1. Information regarding the development and roll-out of the compliance training program.

2. Information regarding the development and implementation of specialized training for certain groups of personnel.

3. Attendance sheets from all training sessions performed.

4. Agendas and contents of training, including length of session and instructor.

5. Copies of all training handout materials.

6. Copies of all tests given.

7. Copies of all employee-signed acknowledgement documents relating to the Compliance Program.

E. Disseminated Compliance-Related Materials (maintained in the Corporate Compliance Google drive and the Communications Team files)

1. Copies of all notices sent to employees, subcontractors, and vendors regarding the Compliance Program, the Compliance hotline, and other compliance-related topics.

2. Copies of all newsletters and other Division publications that address the Compliance Program.

F. Monitoring and Auditing Materials (maintained in the Corporate Compliance Department Google drive)

1. Information regarding the number and frequency of all audits and documentation requirements.

2. Information regarding benchmarks and progress made.

3. Information regarding individuals responsible for conducting audits, if outsourced.

4. Information regarding the individuals that make up the audit team if audits are conducted internally.

5. Information describing the scope, type, and frequency of audits performed.

G. Documentation Related to the Program Integrity (PIU) hotline (maintained in the Corporate Compliance Department Google drive)

1. Promotional materials on the PIU hotline.

2. Logbook of reports of potential non-compliant behavior received via the PIU hotline and through other means of communication made to the Compliance Officer.

3. Documentation regarding fraud, waste, and abuse (FWA) and misconduct referrals, if necessary, on each report received.

4. Documentation of corrective action measures and imposed corrective action plans (CAP).

H. Misconduct Investigation Records (maintained in the Corporate Compliance Department Google drive)

1. Referral information stored in PIU database.

2. Copies of all Standards of Conduct and Misconduct Investigations reports.

I. Documentation Related to the Response to, and Prevention of, Detected Offenses

1. Reports on the investigations conducted into areas of potential noncompliance.

2. Reports on monitoring and oversight of CAPs.

3. Information regarding voluntary self-disclosures on noncompliance.

J. Government Contacts (maintained in the Corporate Compliance Department Google drive)

1. Log of all contacts made between the Division and any government authority including, but not limited to, AHCCCS, a fiscal intermediary or carrier, CMS, HHS, and the Officer of Inspector General. The log will include the name, title, and agency of the person spoken to, the date and time of the call, the matter referenced, and the response received from the individual along with information regarding the source of the response.

2. All correspondence to/from a government authority.

3. Documentation of any response to a request from a government authority for documents, including a summary of any investigation conducted by Corporate Compliance Team prior to responding.

6004-A QUALITY MANAGEMENT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-550, 36-595 et seq.; A.A.C. R6-6, R9-28, R9-33, R6-18; 42 CFR 438.66

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.

B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.

C. Oversight for determining quality, efficiency, and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division's contracted Health Plans; and oversight of a variety of services; and settings such as:

A. Assisted living facilities;

B. Individual's home (not contracted with the Division);

C. Day programs (Day Treatment and Training (child and adult));

D. Employment programs;

E. Nursing facilities;

F. Provider's home; or,

G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes).

6004-E OPERATIONAL REVIEWS

EFFECTIVE DATE: May 20, 2016
REFERENCES: 42 CFR Part 438, AHCCCS 1115 Waiver

Purpose of Operational Reviews

The purpose of the Division performing an Operational Review (OR) is to:

A. Know the Contractor's system and operation.

B. Support Contractor compliance with Division requirements.

C. Improve Contractor's compliance with Division requirements.

D. Recognize Contractor accomplishments.

E. Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with the Arizona Health Care Cost Control System (AHCCCS) 1115 Waiver.

F. Determine whether the Contractor satisfactorily meets:

1. Division contract requirements
2. Division policies
3. Arizona Revised Statute
4. Arizona Administrative Code
5. 42 CFR Part 438, Managed Care.

G. Determine progress made in implementing recommendations made during prior reviews.

H. Determine Contractor compliance with its own policies and procedures.

I. Evaluate the effectiveness of Contractor policies and procedures.

Types of Operational Reviews

The following are types of Operational Reviews:

A. Full Review, which includes a review of all standards

B. Focused Review, which includes review of specific:

1. Areas across all Contractors, e.g., implementation of value based purchasing
2. Standards related to individual Contractor performance.

Prior to Onsite Review Timeline

The timeline for performing Operational Reviews is as follows:

A. Three (3) weeks before onsite review, the Division provides formal notification of the onsite review to the Contractor.

B. Two (2) weeks before onsite review, the Contractor submits the first documents, which include Populations for Samples, e.g., Prior Approval (PA) Logs.

C. Within three (3) days of receipt of above documents, the Division notifies Contractor of which samples will be reviewed.

D. One (1) week before onsite review, the Contractor uploads all documents to the Division's File Transfer Protocol (FTP) site.

After Onsite Review Timeline

After the onsite review occurs, the following occur:

A. Six (6) weeks after the onsite review, the Division forwards a draft of its findings to the Contractor.

B. Within one week after above action, the Contractor may challenge The Division's finding by submitting a Challenge Letter to the Division.

C. Nine (9) weeks after the onsite review, the Division issues its Final Report.

D. Eleven (11) weeks after the onsite review, the Contractor Corrective Action Plan(s) (CAP) is due to the Division.

E. Six (6) months after the Division approves the CAP approval – CAPs must be completed and closed.

The Process – Document Review

The Division reviews documents at the Contractor's place of business (on-site), off-site, or a combination of both.

When the Division requests additional documents:

1. Before noon, the Contractor supplies the documents by close of business on the same day.

2. After noon, the Contractor supplies the documents by 9:00 a.m. on the following day.

OR Categories

OR Categories are:

A. Case Management (CM)

B. Claims and Information Systems (CIS)

C. Delivery Systems (DS)

D. General Administration (GA)

E. Grievance System (GS)

F. Maternal/Child Health and EPSDT (MCH)

G. Medical Management (MM)

H. Member Information (MI)

I. Quality Management (QM)

J. Reinsurance (RI)

K. Third Party Liability (TPL)

L. Corporate Compliance (CC).

6004-F COMPLIANCE PROGRAM

REVISION: 10/1/2019
EFFECTIVE DATE: June 10, 2016
REFERENCES: 42 CFR 438.230(b), 42 CFR 438.608, ACOM Policy 103

Compliance Program Overview

The Corporate Compliance Program consists of the development, maintenance, and implementation of compliance policies and procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Administrative Services Subcontractors, providers and agents) meet all legal and regulatory requirements in the performance of their duties.

The Program provides measures to prevent, detect and correct issues of non-compliance with applicable policies, federal and state regulations, and AHCCCS' contractual requirement to guard against fraud, waste and abuse (FWA).

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

A. 42 Code of Federal Regulation (CFR)

B. Health Insurance Portability and Accountability Act (HIPAA)

C. Arizona Revised Statutes (ARS)

D. Arizona Administrative Code (AAC)

E. The Division's Contract with the Arizona Health Care Cost Containment System (AHCCCS).

F. Centers for Medicare and Medicaid Services (CMS)

Definitions

A. Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary, or which fail to meet professionally recognized standards for health care.

B. Claim – Under the FCA, the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

C. Corporate Compliance Program – a formal program specifying an organization's policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations. It is designed, structured and implemented to correct identified compliance issues and assist the Division, providers, agents, and subcontractors in meeting legal, regulatory, and contractual obligations pertaining the services provided on behalf of the Division.

D. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

E. Deficit Reduction Act (DRA) –The DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the federal government.

G. Governing Body – The Division as body of persons or officers who establishes the rules and policies, having the authority to exercise governance over its providers, agents and subcontractors.

H. Member – The eligible person enrolled to receive services with the Division.

I. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

J. Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

K. Prevention - Keep something from happening.

L. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.

M. Waste - As defined by the Arizona Health Care Cost Containment System (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

Corporate Compliance Structure

The Corporate Compliance Program is designed to fulfill the Division's commitment to foster a culture of compliance and an environment conducive to preventing, detecting and correcting non-compliance issues with all applicable policies, federal and state laws and regulations, and AHCCCS contractual requirements. In addition, the Corporate Compliance Program provides guidance to Division staff, providers, agents and subcontractors in guarding against fraud, waste and abuse all levels of the organization.

The Corporate Compliance Committee monitors, reviews, and assesses the effectiveness of the Corporate Compliance program and the timeliness of reporting to ensure that the Corporate Compliance Program structure facilitates compliance with all legal and governmental requirements.

Corporate Compliance Committee members include:

- Assistant Director/Chief Executive Officer
- Corporate Compliance Office/Deputy Assistant Director
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General's Office/DES Legal Representation

The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

- The Chief Compliance Officer, Corporate Compliance Committee, and all other Division Management
- Human Resources Department
- All other Division employees.

Corporate Compliance Program Components

The Corporate Compliance Program is based on the seven key elements of Compliance that facilitate prevention, detection and remediation of non-compliance with federal and state laws and regulations, AHCCCS contractual requirements and DES-DDD internal policies and procedures. The seven key elements are:

1. Written Policies, Procedures and Standards of Conduct
2. Corporate Compliance Program Oversight
3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards
6. Monitoring and Auditing
7. Correcting Areas of Non-Compliance

The Corporate Compliance Program is centered on the Corporate Compliance Plan, compliance policies and procedures, oversight of compliance to law, and contractual obligations, education, monitoring, and enforcement. The Plan:

- Details the process and steps taken to prevent, detect, and remediate instances of non-compliance,
- Adheres to the Division's contract with AHCCCS,
- Is submitted annually to the AHCCCS Office of Inspector General (OIG).

A. Written Policies, Procedures and Standards of Conduct

The Corporate Compliance Program is based on written Policies, Procedures, and Standards of Conduct that facilitate compliance with federal and state laws, regulations, and AHCCCS contractual requirements.

Pursuant to the Deficit Reduction Act of 2005, written Policies address the Federal False Claims Act, administrative remedies for false claims/statements, civil and criminal penalties for false claims/statements, and whistleblower protections under law. See Operations Manual Policy 6002-N Fraud and False Claims, Provider Manual Chapter 20 Fraud, Waste and Abuse, and Provider Manual Chapter 21 False Claims Act.

B. Corporate Compliance Program Oversight

The Divisions Chief Compliance Officer and Corporate Compliance Committee provides Division-wide oversight to ensure compliance with Program and Fiscal Integrity. The Chief Compliance Officer is responsible for the strategy, implementation and oversight of the Division's Compliance Program.

The Corporate Compliance Program is structured to include Division staff responsible for the oversight of compliance related activities to include but not limited to:

1. Risk assessment and management of internal and external compliance
2. Development, implementation and/or monitoring of training and educational events for all Division staff, subcontractors, providers, and agents pertaining Corporate Compliance.
3. Provide technical assistance to all Division staff, subcontractors, providers and agents regarding compliance
4. Documentation of all referrals suspecting potential FWA or other issues of non-compliance
5. Development and monitoring of corrective action plans
6. Timely processing of referrals deemed credible of FWA and submission to AHCCCS OIG
7. Reporting to, and providing reports to, the Corporate Compliance Committee

C. Training and Education

1. Mandatory Training
    a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:
        i. Compliance
        ii. Article 9
        iii. HIPAA (annually)
        iv. Standards of Conduct for State Employees
        v. Fraud Awareness (annually)
        vi. Business Continuity
        vii. Diversity
        viii. AHCCCS Overview
    b. The Division trains employees as appropriate to their job functions, including but not limited to:

i. Support Coordination/Member Services

ii. Network/Provider Relations

iii. Medical Management

iv. Quality Management

v. Claims/Business Operations

c. The Division provides refresher training to all employees as appropriate to their job functions, and as needed

2. Training Materials

The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by the Corporate Compliance Unit.

3. Effective Lines of Communication

a. The Division provides updates to their personnel via the following formats:

i. Unit meetings/AMS

ii. Statewide meetings

iii. E-mails

iv. Echo Employee Newsletter

v. Policies and Procedures

b. The Division may provide updates to contracted providers in the following formats:

i. Provider/Coordination meetings

ii. Vendor Blasts/e-mails

iii. Policies and Procedure Manuals

iv. Contract monitoring units.

D. Enforcement of Standards

1. Evaluate the ability of prospective providers to perform the activities to be delegated, and using accepted risk assessment criteria, as needed.

2. Establish a written agreement (as defined by the Division's contract with AHCCCS) that:

a. Specifies activities and reporting responsibilities delegated to the contractor

b. Provides for revocation of such delegation, and application of sanctions

c. Includes other specific requirements, as stated in the Division's contract with AHCCCS.

3. Retain authority to direct delegated contract requirements

4. Communicate deficiencies to the provider so the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Monitoring/Auditing and Enforcement

1. The Division monitors compliance via:

a. Compliance-related reports based on Division and Provider/AdSS data,

b. Investigations of allegations of non-compliance,

c. Review of functional areas and related systems,

d. Assessment of mechanisms to facilitate prevention, detection and remediation of non-compliance,

e. Internal and external audits.

2. Reporting of Non-Compliance to the Division

The Division maintains open lines of communication to support Division personnel, subcontractors, providers, agents, members, and all other individuals in reporting non-compliance. Toll-free hotlines and dedicated email addresses are identified in Division publications and available on the Division website for this purpose.

3. Correcting Areas of Non-Compliance

Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:

a. May conduct a preliminary fact-finding to determine the nature of the incident,

b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases),

c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.

d. Responds to compliance issues to the extent required by law and within the mandated timeframes.

e. Enforces compliance and takes corrective actions as appropriate.

The Division generates regular compliance-related reports that include, but are not limited to:

a. Grievance System Report

b. Resolution System Report

c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims

d. Claims Dashboard

e. Encounters Report

f. Support Coordination Reports.

g. HIPAA violations report

6004-G Monitoring and Oversight

EFFECTIVE DATE: January 29, 2020

REFERENCES: 42 CFR 438.230(b); 42 CFR 438.608; ACOM 103; Operations Manual, Chapter 6000, Policy 6004.

This Policy stipulates requirements for the internal auditing, monitoring, and oversight of Long-Term Services and Supports (LTSS) provided by the Division, in accordance with the Division's Monitoring and Oversight Plan.

Definitions

A. Monitoring - The collection of data on a consistent basis as part of a plan to ensure contractual compliance and operational excellence.

B. Operational Area - Synonymous with business unit, functional area, or department within the Division.

C. Compliance Assurance Audit - A focused review of an operational area's compliance with contract requirements utilizing a standardized audit tool; the audit tool will include standards by which each business unit audited will be measured.

D. Key Performance Indicator (KPI) - A metric selected to provide quantifiable data in relation to the operational performance of a specific operational area or Business Unit

E. LTSS KPI Schedule of Annual Data Submissions - An overview of the KPI's collected from each operational area/Business Unit including the designated Subject Member Expert, frequency of data collection, and submission for each KPI required.

F. LTSS KPI Annual Data Submissions Template - The template provided by the Corporate Compliance Unit used by each operational area SME to collect and submit respective KPI's.

Monitoring and Oversight Plan Overview

The Monitoring and Oversight Plan has been developed as part of the Division's formal Corporate Compliance program. The plan implements a continuous, formal monitoring mechanism and compliance assurance auditing of various operational areas across the Division. The combined approach of monitoring and auditing aims to provide a preventive and corrective action approach that ensures compliance with AHCCCS contractual requirements and federal and state laws and regulations, while ensuring quality in operational and service delivery. Monitoring will be conducted across the Division's operational areas and will provide executive leadership an aggregated view of the organization's compliance health status.

A. Compliance Assurance Audits

A primary component of the Division's overall Monitoring and Oversight Plan is a system of compliance assurance auditing of each major LTSS operational area. Compliance assurance auditing will be performed by an internal auditing/monitoring business unit within the Corporate Compliance department in accordance with a planned schedule of focused audits throughout the year. The type, number, frequency, and timing of compliance assurance audits will be determined by the Compliance department leadership and approved by the Corporate Compliance Committee. Additionally, special, comprehensive audits of programs and operational areas will be

selected and conducted throughout the year by the Corporate Compliance team. The audits will focus on detecting and correcting fraud, waste and abuse; Health Insurance Portability and Accountability Act (HIPAA) violations; and risks to fiscal integrity but may also be a source of discovery that would identify a need for further compliance audits of specific operational processes.

B. Key Performance Indicators

Another key component of the Monitoring and Oversight Plan is a system of ongoing collection, compilation, and dissemination of Key Performance Indicators (KPI) across the Division's operational areas on a regular basis. KPI's were selected based on current internal, self-audit data, and AHCCCS contractual requirements and deliverables. Each operational area subject matter expert (SME) will be responsible for collecting and submitting designated KPIs on a consistent basis in accordance with the annual data submission schedule via the template provided by the Corporate Compliance Unit.

6005 - A COMPLIANCE PROGRAM CHARTER

EFFECTIVE DATE: July 1, 2020
REFERENCES: United States Sentencing Commission; *Federal Sentencing Guidelines*, Chapter Eight Effective Compliance Program, United States Department of Health and Human Services, Office of Inspector General.

The purpose is to oversee the Division's implementation of the compliance program, policies and procedures designed to address any identified regulatory risks facing the Division, and assist with the oversight responsibility for the Division's contractual and regulatory compliance, and standards of conduct.

The oversight responsibility of the Committee shall not extend to planning or conducting audits, conducting investigations, or assuring compliance with relevant laws, the Division's Code of Conduct, or other relevant standards, including those imposed by any resolution agreements such as corrective action plans, notice to cure or monetary sanctions. These are the responsibilities of the Division's Executive Leadership.

Definitions

Compliance Program - A compliance program is a set of internal policies and procedures within the Division to comply with laws, rules, and regulations, or contractual obligations. A compliance team examines the rules set forth by government bodies, creates a compliance program, implements it throughout the Division, and enforces adherence to it.

Elements of a Compliance Program - According to the Department of Health and Human Services-Office of Inspector General, an effective compliance program can enhance the Division's operations, improve quality of care, and reduce overall costs. There are seven fundamental elements of an effective compliance program:

- Policies and Procedures
- Oversight
- Education and Training
- Monitoring and Auditing
- Reporting
- Enforcement and Discipline
- Response and Prevention

Policy

Health care operates in a heavily regulated environment with a variety of identifiable risk areas; an effective Compliance Program can help mitigate those risks. Therefore, in the fulfillment of the Division's oversight responsibilities, management will be charged with the responsible of establishing a Compliance Program to help ensure that appropriate information as to AHCCCS contractual obligations, and all applicable state and federal laws

and regulations, will come to the attention of the Compliance Committee and Executive Leadership will be notified in a timely manner as a matter of ordinary operation.

A. The Division will establish a Compliance Committee to develop and maintain an effective Compliance Program.

B. A Compliance Officer will be appointed with the delegated authority to manage the Compliance Program's day-to-day operation.

C. The Compliance Officer and designees will ensure that the Compliance Program includes the seven elements that make an effective compliance program.

D. An annual risk assessment will be completed for the Division. Identified potential risk areas will be evaluated periodically, and reported to the Assistant Director and the Compliance Committee.

E. A report of Compliance Program activities will be presented periodically to the Assistant Director and the Compliance Committee.

F. The Compliance Committee will conduct an annual self-assessment of the Compliance Committee's activities.

6005 B - COMPLIANCE INVESTIGATION

EFFECTIVE DATE: July 1, 2020

REFERENCES: Corporate Compliance: Guide to Conducting Workplace Investigation

The purpose of this policy is to ensure prompt and appropriate investigation of compliance concerns and allegations.

Definition

Internal Investigation – An investigation of any concerns or allegations within an organization. The concerns or allegations for the Compliance Officer or designee to investigate may include but are not limited to, any allegations or complaints regarding non-Medicaid related fraud, waste, and abuse of the program and misconduct.

Investigation Requirements

A. All investigations begin with a review of submitted concerns or allegations.

B. There should be a thorough review of any documentation and information that is involved in the investigation. It may include an audit of billing practices and corrective actions, if necessary. The Division should cease all of the contributing factors that may be the cause of the non-compliance, as appropriate.

C. Interviews with a participating individual(s) are as follows:

1. The interview includes the "Who, What, When, Where, and Why" of the circumstances.

2. All interview notes and document notes reviewed shall be kept as part of the investigation file.

D. The Division initiates Corporate Compliance in-services and training if necessary, to the appropriate departments or individuals involved.

E. The results of the investigation are the last components in the file. As a result of the investigation, the Compliance Officer or Designee may include a corrective measure with the referral to bring the issue into compliance. The referral is sent to the DDD Employee Relations and DES Internal Affairs. However, based on findings from the investigation, the Corporate Compliance Team may review the circumstances that formed the basis for the investigation to determine whether similar problems have been uncovered. When the investigation is completed, the results will be filed in its designated file.

1. The Compliance Officer or designee summarizes the investigation, corrective actions, if applicable, and procedures that are put in place to prevent the non-compliance circumstances from recurring.

2. If the Compliance Officer or designee investigates an alleged violation and believes the integrity of the investigation may be at stake because of the presence of employee(s) under investigation, Division shall remove the

individual(s) involved from current responsibilities until the investigation is completed.

6006 AHCCCS DELIVERABLE SUBMISSION REQUIREMENTS

EFFECTIVE DATE: June 28, 2023

PURPOSE

The purpose of this policy is to outline the requirements of the Division staff when reviewing and submitting deliverables to AHCCCS. This policy applies to any Division staff responsible for receiving deliverables from the subcontracted health plans or completing an AHCCCS contract or ad hoc requests deliverable.

POLICY

A. DELIVERABLES RECEIVED FROM THE DIVISION'S SUBCONTRACTED HEALTH PLANS

Responsible Assigned Division staff shall follow AHCCCS Deliverable Submission Requirements and Administrative Services Subcontractor Compliance Monitoring procedures when completing a deliverable submission or response to AHCCCS involving engagement with the subcontracted health plans.

B. AHCCCS DELIVERABLE SUBMISSION

1. The Division shall complete accurate and timely deliverable submissions to AHCCCS.

2. Assigned Division staff shall follow AHCCCS Deliverable Submission Requirements procedure and submit accurate and complete deliverables to AHCCCS in accordance with the established due date.
3. Division staff shall ensure a backup plan is in place for all contract deliverables by providing training to the identified accountable staff member.

C. The Division's Operational Compliance shall assign a corrective action plan to the functional area if any of the requirements in this policy are not met.

7001 PRIVACY INCIDENT AND BREACH NOTIFICATION

EFFECTIVE DATE: January 18, 2023
REFERENCES: 45 CFR § 164.402; 45 CFR § 164.404; 45 CFR § 164.410; 45 CFR § 164.408, 45 CFR § 164.412; 45 CFR § 164.502; 45 CFR § 164.530; A.R.S. § 12-2297

PURPOSE

This policy applies to all Division of Developmental Disabilities (Division) staff. It describes the process the Division follows when a privacy incident occurs.

DEFINITIONS

1. "Breach" means an impermissible use or disclosure of Protected Health Information (PHI) unless the Covered Entity or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Breach excludes:
    a. Any unintentional acquisition, access, or use of PHI by the Division's Workforce or a person acting under the authority of a Covered Entity or Business Associate if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further

use or disclosure in a manner not permitted under the Health Insurance Portability and Accountability Act (HIPAA).

b. Any inadvertent disclosure by a person who is authorized to access PHI at a Covered Entity or Business Associate to another person authorized to access PHI at the same Covered Entity or Business Associate, or organized health care arrangement in which the Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.

c. A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

2. "Business Associate" means a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a Covered Entity.

3. "Covered Entity" means health plans, health care clearinghouses, and health care providers who electronically transmit any health information in connection with transactions for which Health and Human Services (HHS) has adopted standards.
4. "Protected Health Information (PHI)" means individually identifiable health information about a member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.
    b. Relates to the:
        i. Past, present or future physical or mental health condition of a member;
        ii. Provision of health care to a member; or
        iii. Payment for the provision of health care to a member.

PHI excludes information in:

a. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
b. Records described at 20 USC 1232g(a)(4)(B)(IV);
c. Employment records held by a Covered Entity in its role as an employer; or
d. Regarding a person who has been deceased for more than 50 years.

5. "Workforce" means employees, volunteers, trainees, and other persons under the direct control of the Covered Entity, whether or not they are paid by the Covered Entity.

POLICY

A. DISCOVERY OF A BREACH

1. The Division shall treat a Breach as discovered as of the first day on which such Breach is known to the Division or, by exercising reasonable diligence, would have been known to the Division or any person, other than the person committing the Breach, who is part of the Division's Workforce or an agent of the Division.

2. Anyone in the Division's Workforce who believes that member information has been used or disclosed in any way that compromises the security or privacy of that information shall immediately notify the Division's Privacy Compliance Unit by completing the Division's online form.

3. Following the discovery of a potential Breach, the Division's Privacy Compliance Unit under the guidance of the Health Information Manager shall:

   a. Begin an investigation;

   b. Conduct a risk assessment; and

   c. Based on the results of the risk assessment, begin the process of notifying each member whose PHI has been, or is reasonably believed by the Division to have been, accessed, acquired, used, or disclosed as a result of the Breach.

B. BREACH INVESTIGATION

1. The Division's Privacy Compliance Unit shall be responsible for the:

a. Management of the Breach investigation,

b. Completion of the risk assessment,

c. Coordination with others in the Division as appropriate, and

d. Facilitation of all Breach notification processes.

2. Anyone in the Division's Workforce involved in the privacy incident shall assist the Division's Privacy Compliance Unit in the investigation and provide information as requested.

C. RISK ASSESSMENT

1. The Division shall presume an impermissible use or disclosure of PHI is a Breach unless the Division's Privacy Compliance Unit performs a risk assessment and the results demonstrate a low probability that the PHI has been compromised.
2. The Division's Privacy Compliance Unit shall complete a thorough risk assessment in good faith and the conclusions should be reasonable.
3. The Division shall include the following factors in a risk assessment:

a. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

b. The unauthorized person who used the PHI or to whom the disclosure was made;

c. Whether the PHI was acquired or viewed; and

d. The extent to which the risk to the PHI has been mitigated.

4. The Division's Privacy Compliance Unit shall consider the factors listed above in subsection C(3), or more, to determine the overall probability that PHI has been compromised.

5. Based on the outcome of the risk assessment, the Division's Privacy Compliance Unit shall determine the need to move forward with Breach notification.

6. The Division's Privacy Compliance Unit shall document the risk assessment and the outcome of the risk assessment process.

D. NOTIFICATION

1. Notice to member

a. If a Breach of PHI has occurred, the Division's Privacy Compliance Unit shall notify the affected member(s) without unreasonable delay and in no case later than 60

days after the Breach is discovered. "Unreasonable delay" means action based on a lack of good faith or justifiable reasons for the delay.

b. The Division shall ensure the notice is written in plain language and includes the following to the extent possible:

   i. A brief description of what happened,

   ii. A description of the types of information affected,

   iii. Steps that affected members should take to protect themselves from potential harm resulting from the Breach,

   iv. A brief description of what the Division is doing to investigate, mitigate, and protect against further harm or Breaches.

c. The Division's Privacy Compliance Unit shall notify the member as follows:

   i. Unless otherwise authorized by the member, by first class mail to the member's last known address.

   ii. If agreed to in writing by the member, by email.

iii. In the form of one or more mailing as information becomes available.

d. If the Division lacks sufficient contact information to provide direct written notice by mail to the member, the Division's Privacy Compliance Unit shall use a substitute form of notice reasonably calculated to reach the member.

i. If there is insufficient contact information for fewer than 10 affected members, the Division's Privacy Compliance Unit shall provide notice by telephone, email, or other means.

ii. The Division's Privacy Compliance Unit shall document if the Division lacks sufficient information to provide any such substitute notice.

iii. If there is insufficient contact information for 10 or more affected members, the Division's Privacy Compliance Unit shall do one of the following after consulting with the Department of Economic Security (DES) Chief Privacy Officer:

1) Post a conspicuous notice on the homepage of the Division's website for 90 days with a hyperlink to the additional information required to be given to members as provided above, or

2) Publish a conspicuous notice in major print or broadcast media in the area where affected members reside. The notice shall include a toll-free number that remains active for at least 90 days so members may call to learn whether their PHI was Breached.

e. The Division's Privacy Compliance Unit shall provide immediate notice to the member by telephone or other means if they believe that PHI is subject to imminent misuse. Such notice shall be in addition to the written notice described above.

2. Notice to next of kin for a deceased member

a. If the member is deceased and the Division knows the address for the member's next of kin or personal representative, the Division's Privacy Compliance Unit shall

mail the written notice described above to the next of kin or personal representative.

b. If the Division does not know the address of the next of kin or personal representative, the Division is not required to provide any notice to the next of kin or personal representative.

c. The Division's Privacy Compliance Unit shall document the lack of sufficient contact information.

3. Notice to Health and Human Services (HHS)

a. In the event a Breach of unsecured PHI affects 500 or more of the Division's members, the Division's Privacy Compliance Unit shall coordinate with the DES Chief Privacy Officer to ensure HHS will be notified.

b. If fewer than 500 of the Division's members are affected, the Division's Privacy Compliance Unit shall maintain a log of the Breaches to be submitted to the DES Chief Privacy Officer annually.

4. Delay of notification authorized for law enforcement purposes for notices made to members, the media, HHS, and by the Division's Business Associates

   a. If a law enforcement official states in writing that a notification, notice, or posting would impede a criminal investigation or cause damage to national security and specifies the time for which a delay is required, the Division's Privacy Compliance Unit shall delay for the time period specified by the official.

   b. If a law enforcement official states orally that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the Division's Privacy Compliance Unit shall:

      i. document the statement, including the identity of the official making the statement; and

      ii. delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

E. MAINTENANCE OF BREACH INFORMATION

1. The Division's Privacy Compliance Unit shall maintain a process to record or log all Breaches of unsecured PHI, regardless of the number of members affected.

F. WORKFORCE TRAINING

1. The Division shall ensure that everyone in the Workforce is trained on the Division's policies and procedures with respect to PHI as necessary and appropriate to carry out their job responsibilities.
2. The Division shall ensure that everyone in the Workforce is trained how to identify and report Breaches within the Division.

G. SANCTIONS

1. The Division shall refer anyone in the Workforce who fails to comply with this policy to the Program Integrity Unit and/or Human Resources for disciplinary action.

H. RETALIATION/WAIVER

1. The Division shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any member for exercising his or her privacy rights.

2. The Division shall not require members to waive their privacy rights as a condition of the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits.

7002 AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.502 and 45 C.F.R. § 164.508

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. It outlines the process for the authorization for use and disclosure of Protected Health Information (PHI) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that

conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives members rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Payment" means the same as in 45 CFR 164.501.
6. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

7. "Responsible Person" means the same as in A.R.S. § 36-551.

8. "Treatment" means the same as in 45 CFR 164.501.

9. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

10. "Psychotherapy Notes" are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the patient's medical record.

POLICY

A. AUTHORIZATIONS

1. Uses and disclosures for which authorization is required.
    a. The Division shall develop an authorization form in writing and in plain language.
    b. The Division shall not require the Member to use the Division's authorization form.
    c. The Division's Privacy Officer and Records Manager shall determine whether an authorization form that was not

developed by the Division contains all of the required elements, as stated per the HIPAA Privacy Rule.

d. If a determination could not be reached, the Division's Privacy Officer and Records Manager shall consult the Attorney General's Office for additional guidance before disclosing protected health information based on that authorization.

B. VALID AUTHORIZATION CORE COMPONENTS

1. The Division shall verify that an authorization form contains the following components:
   a. A description of the information to be used or disclosed;
   b. The name or other specific identification of the Member or class of persons authorized to make the requested use or disclosure;
   c. The name or other specific identification of the Member or class of persons to whom the Division shall make the requested use or disclosure;
   d. A description of each purpose of the requested use or disclosure;

e. The statement "at the request of the Member" is a sufficient description of the purpose when a Member initiates the authorization and does not, or elects not to, provide a statement of the purpose;

f. An expiration date or an expiration event that relates to the Member or the purpose of the use or disclosure;

g. The signature of the Member and date;

h. If the authorization is signed by a personal representative of the Member, a description of such representative's authority to act for the Member, including a copy of the legal court document, if any, appointing the personal representative.

C. REQUIRED ADDITIONAL AUTHORIZATION INFORMATION

1. The Division shall ensure that the authorization form contains a statement informing the Member of their right to revoke the authorization at any time and how the Member may revoke the authorization.

2. The Division shall:

a. Not require the Member to sign an authorization as a condition of eligibility for benefits, enrollment in a health plan or the provision of treatment or payment; and

b. Make a statement on the authorization form to that effect.

3. Notwithstanding the requirement in subsection (2) of this section:

a. The Division may condition services to a Member on a signed authorization for the use or disclosure of protected health information for research purposes prior to providing research-related treatment.

b. The Division shall require a Member to sign an authorization if the information needed will determine the Member's eligibility, and the authorization does not include the use or disclosure of psychotherapy notes.

c. The Division shall require a Member to sign an authorization form before providing health care services unless otherwise approved by the Division as creating an impediment to the health and well-being of the Member.

D. INVALID AUTHORIZATION

1. The Division shall consider an authorization invalid if:
    a. The expiration date has passed or the expiration event is known by the Division to have occurred;
    b. The authorization form has not been filled out completely as to the core elements outlined in this policy;
    c. The authorization has been revoked;
    d. An authorization that states eligibility for benefits, enrollment in a health plan or treatment or payment of an authorization is a required condition, except as outlined in this policy;
    e. The authorization is a compound authorization, requesting information from separate and distinct sources that require separate authorizations, such as psychotherapy notes along with other protected health information;
    f. The Member did not voluntarily sign the disclosure form or was coerced into signing the authorization form; or
    g. Any material information in the authorization is known to be false.

E. The Division shall give a copy of the authorization to the Member upon request and maintain a copy in the Member's case file.

7003 MINIMUM NECESSARY STANDARD FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

REVIEW DATE:

EFFECTIVE DATE: December 27, 2023

REFERENCES: 45 C.F.R. § 164.502; 45 C.F.R. § 164.512

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. The purpose of this policy is to outline the requirements for making reasonable efforts to limit the use and disclosure of protected health information (PHI) as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Business Associate" means the same as in 45 CFR § 160.103.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information and applies to health plans,

health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.

5 Minimum Necessary Standard" means the same as referenced in 45 CFR § 164.514(d)(2)(i)(A).

6. "Payment" means the same as in 45 CFR 164.501.

7. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:

   a. Created or received by a:

i. Health care provider,

ii. Health plan,

iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

8. "Treatment" means the same as in 45 CFR 164.501.

POLICY

A. The Division shall limit unnecessary or inappropriate access to PHI:

1. Through the provision of healthcare services and related healthcare operations;
2. When it is required by law to be disclosed for an audit, for health oversight and public health; and
3. For use in court or administrative law proceedings.

B. The Division shall ensure the following utilizing the Minimum Necessary Standard:

1. Uses or disclosures for treatment, payment, and health care operations (TPO);
2. Uses or disclosures requiring the member to have an opportunity to agree or object;
3. Uses or disclosures that are permitted without the Member's authorization; and

4. Uses or disclosures by Business Associates if they are not for the reasons outlined in section (D) of this policy.

C. The Division shall disclose only the PHI necessary to accomplish the intended purpose of the use, disclosure, or request by:

1. Identifying persons or classes of persons who need access to the PHI to accomplish their job responsibilities, and
2. Establishing protocols that reasonably limit access to PHI.

D. The Division shall not utilize the Minimum Necessary Standard for the following:

1. Disclosures or requests by a health care provider for treatment.
2. Disclosures to a Member who is the subject of the PHI.
3. Uses or disclosures made pursuant to a Member's authorization on a HIPAA-compliant form.
4. Uses or disclosures required for compliance with HIPAA standard transactions.
5. Uses or disclosures required by the U.S. Department of Health and Human Services (DHHS) except when the Division has been required to provide PHI to DHHS for enforcement purposes.

6. Uses or disclosures that are required by law.

7004 ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

REVIEW DATE:

EFFECTIVE DATE: December 13, 2023

REFERENCES: 45 C.F.R. § 164.528

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy establishes the Division's requirements for the accounting of Disclosures of Protected Health Information (PHI) required by the Health Information Portability and Accountability Act of 1996 (HIPAA) as outlined in 45 CFR 164.528.

DEFINITIONS

1. "Business Associate" means the same as in 45 CFR § 160.103.
2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
3. "Health care operations" means the same as in 45 CFR 164.501.
4. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes

national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,

ii. Health plan,

iii. Employer, or

iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

7. "Payment" means the same as in 45 CFR 164.501.

8. "Responsible Person" means the same as in A.R.S. § 36-551.
9. "Treatment" means the same as in 45 CFR 164.501.

POLICY

A. The Division shall provide the Member the right to receive an accounting of Disclosures of certain Protected Health Information (PHI).

B. The Division shall only accept an accounting of Disclosure when requested by the Responsible Person in writing.

C. The Division shall track the following types of PHI Disclosures:

1. Disclosures to a public health authority as permitted by law;
2. Disclosures to health oversight agencies as permitted by law, including government agencies that oversee the health care system, government benefits programs requiring health information, or other government regulatory programs;
3. Disclosures required by law, including court rules, administrative and court orders, statutes or agency rules, administrative and court subpoenas, or other lawful process;
4. Disclosures to Business Associates that are not exempt under section (D) of this policy;

5. Disclosures made in error or in violation of the law that are not exempt from accounting; and
6. Disclosures to law enforcement.

D. The Division shall not track the following PHI for accounting purposes:

1. Disclosures to carry out treatment, payment, and health care operations;
2. Disclosures to the Member who is the subject of the Protected Health Information;
3. Disclosures incidental to those permitted by the privacy rules;
4. Disclosures pursuant to a HIPAA-compliant authorization;
5. Disclosures to others involved in a Member's care or for disaster relief when the Member had an opportunity to agree or object;
6. Disclosures made for national security or intelligence purposes as provided in the regulations;
7. Disclosures to correctional institutions or law enforcement officials having custody of a Member if the Disclosure of the PHI is for treatment, the health and safety of other inmates, the health and safety of law enforcement staff, or the administration of the correctional institution; and

8. Disclosures when made as a limited data set.

E. The Division shall temporarily suspend a Member's right to an accounting of Disclosures of PHI to a health oversight agency or law enforcement agency under the following circumstances:

1. When the Division receives an oral request by the agency or entity for a suspension, the Division's Privacy Officer shall ensure it is documented:
   a. That an accounting to the Member would likely impede the Division's activities;
   b. The length of time of the suspension is not to exceed 30 days from the date of the oral statement, unless a written statement providing the time limit is submitted during the 30 days;
   c. The identity of the person in the agency or entity making the statement and the agency or entity represented; and
   d. That the right to an accounting is temporarily suspended.
2. When the Division receives a written, dated request for a suspension of an accounting, the Division's Privacy Officer shall ensure that the following is documented:

a. The name and identifying information of the Member who is the subject of the accounting;

b. A statement that such an accounting to the Member would be reasonably likely to impede the agency or entity activities;

c. The time for which such a suspension is required;

d. The official letterhead of the agency or entity requesting the suspension; and

e. The signature and title of the person representing the authorized agency that is requesting the suspension.

F. The Division shall account for Disclosures of PHI that occurred during the six years prior to the request for an accounting if the accounting is not past the retention period for documentation of the accounting for the Disclosure.

G. The Division's Privacy Officer shall provide a written response to a request for an accounting that contains:

a. Date of Disclosure of PHI;

b. Name of the entity or person who received the PHI;

c. Address of the entity or person, if known;

d. A brief description of the PHI disclosed; and

e. A brief statement of the purpose of the Disclosure that reasonably informs the Member of the basis for the Disclosure, or in lieu of such a statement, and a copy of the written request for Disclosure.

H. If, during the period covered by the accounting, the Division has made multiple Disclosures of PHI to the same person or entity for a single purpose, the Division shall ensure the accounting of Disclosure contains:

a. The information in section (G) of this policy;

b. The frequency, periodicity, or number of Disclosures made during the accounting period; and

c. The date of the last such disclosure during the accounting period.

I. After receipt of the written accounting request, the Division shall either:

1. Provide the accounting requested; or

2. If the Division cannot provide the accounting within the 30-day timeframe provide a one-time 30-day extension letter in writing that provides:
   i. An explanation of the delay, and
   ii. The date by which the accounting will be provided.

J. The Division shall maintain documentation of the Accounting for the Disclosure in the Member's case file and retain the documentation for six years from the date of the entry.

7005 RIGHT TO REQUEST RESTRICTION OF USES AND DISCLOSURES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.522

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the requirement when a Member requests a restriction of uses and disclosures, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Designated Record Set" means a group of records maintained by the provider that contains the following:
    a. Medical and billing records maintained by a provider,
    b. Case and medical management records, or
    c. Any other records used by the provider to make medical decisions about the Member.
2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.

3. "Health care operations" means the same as in 45 CFR 164.501.
4. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
5. "Member" means the same as "client" as defined in A.R.S. § 36-551.
6. "Payment" means the same as in 45 CFR 164.501.
7. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is

transmitted or maintained in any medium where the information is:

a. Created or received by a:
    i. Health care provider,
    ii. Health plan,
    iii. Employer, or
    iv. Health care clearinghouse.

b. Relates to the:
    i. Past, present, or future physical or mental health condition of a Member;
    ii. Provision of health care to a Member; or
    iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:
    i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
    ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a Member who has been deceased for more than 50 years.

8. "Responsible Person" means the same as in A.R.S. § 36-551.

9. "Treatment" means the same as in 45 CFR 164.501.

10. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. The Division shall give Members the right to request a restriction of the uses and disclosure of their Protected Health Information (PHI) under the following circumstances:

1. For treatment, payment, or health care operations; and
2. To family members, other relatives, or any other person identified by the Member who may be directly involved in the Member's care and for notification purposes.

B. The Division's Privacy Officer shall determine if the request will be accepted or denied based on the requirements of the Privacy Rule.

C. Notwithstanding the provision of section (A) of this policy, the Division shall not require the Division's Privacy Officer to agree to the restriction of the use and disclosure of PHI.

D. The Division shall advise the Responsible Person of the following:

1. If the Member is applying to another agency for benefits, restricting the disclosure of PHI may result in a delay or denial of benefits.
2. By restricting which providers can receive PHI may limit the services that can be provided by the Division.
3. If the restriction is agreed-upon, any use or disclosure by the Division contrary to the agreed restriction would be a violation of the Privacy Rule.

E. RESTRICTED RECORDS DISCLOSED FOR EMERGENCY TREATMENT

1. The Division shall request that the health care provider receiving the PHI shall not further use or disclose the information.
2. The Division shall document this request to the provider in the Member's designated record set.

F. The Division shall not restrict PHI when that information is:

1. Required for investigations by the Secretary of the Department of Health and Human Services (DHHS).
2. Required by law.
3. Required for emergency treatment, unless the Member has expressly advised that they do not want treatment.

G. TERMINATION OF RESTRICTION ON USE OR DISCLOSURE

1. The Division shall terminate or modify an agreement to a restriction if:
   a. The Responsible Person agrees to or requests termination or modification in writing;
   b. The Responsible Person orally agrees to the termination and the oral agreement is documented; or
   c. The Division informs the Member that it is terminating the agreement to a restriction with respect to the PHI created or received after the Division has informed the Member.

H. The Division's Privacy Officer shall provide a response to the request for restriction to the Member in writing within 30 days and maintain the response in the designated record set.

7007 RIGHT TO RECEIVE ALTERNATIVE MEANS OF COMMUNICATION FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 11/8/2023

REFERENCES: 45 C.F.R. § 164.522 and 45 C.F.R. § 164.502

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the Member's right to request privacy protection utilizing alternative means of communication.

DEFINITIONS

1. "Designated Record Set" means a group of records maintained by the provider that contains the following:
    a. Medical and billing records maintained by a provider,
    b. Case and medical management records, or
    c. Any other records used by the provider to make medical decisions about the Member.

2. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.

5. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:

   a. Created or received by a:

      i. Health care provider,

      ii. Health plan,

      iii. Employer, or

      iv. Health care clearinghouse.

   b. Relates to the:

      i. Past, present, or future physical or mental health condition of a Member;

      ii. Provision of health care to a Member; or

      iii. Payment for the provision of health care to a Member.

   c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

6. "Responsible Person" means the same as in A.R.S. § 36-551.

POLICY

A. The Division shall allow the Responsible Person the right to request an alternate means of communication and an alternative address to receive communication of Protected Health Information (PHI).

1. The Division shall condition on the provision of a reasonable accommodation on:

a. When appropriate, information as to how payment, if any, will be handled; and

b Specification of an alternative address or other method of contact.

2. If a Member clearly indicates in the request for an alternative means of communication that disclosure of the PHI would put them in danger, then the Division shall make the accommodation.

B. The Member shall make the request for, and describe, the alternative means of communication or alternative location in writing.

1. The Division's Privacy Officer shall grant or deny the request based on 45 C.F.R. § 164.522 and 45 C.F.R. § 164.502.

2 The Division's Privacy Officer shall maintain all documentation regarding the request and whether the request is granted or denied in the designated record set.

C. The Division shall allow the Responsible Person to request the Division to send electronic PHI (ePHI) in an unencrypted format.

D. If the Responsible Person requests to receive PHI in an unsecured email transmission, prior to using an unsecure email transmission to provide PHI, the Division shall:

1. Inform the Responsible Person of the risk of unsecured email transmissions, and
2. Require the Responsible Person to acknowledge in writing the risk of unsecured email transmissions when transmitting PHI.

E. The Division shall review requests for an unencrypted transmission on an annual basis and maintain all documentation identified, reviewed, or involved in the request, in the case records.

7008 NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: 3/13/2024

REFERENCES: 45 C.F.R. § 164.520

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the requirements for the Notice of Privacy Practices (the Notice) of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health care operations" means the same as in 45 CFR 164.501.
3. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that

conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.

b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

6. "Payment" means the same as in 45 CFR 164.501.

7. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental

disability who is a member or an applicant for whom no guardian has been appointed.

8. "Treatment" means the same as in 45 CFR 164.501.
9. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. The Division shall provide the Notice of Privacy Practices (the Notice) to Members receiving services from the Division annually and upon request.

B. The Division shall ensure the Notice:

1. Outlines the Uses and Disclosures of Protected Health Information (PHI),
2. Notifies the Member of their rights regarding PHI, and
3. Notifies the Member of the Division's legal duties with respect to PHI.

C. The Division shall Use or Disclose PHI in a manner consistent with the Notice.

D. The Division shall ensure the Notice is written in plain and simple language that Members, employees, or personal representatives can easily read and understand.

E. The Division shall promptly revise the Notice whenever there is a material change to:

1. The Uses or Disclosures,
2. The Member's rights,
3. The Division's legal duties, or
4. Other privacy practices stated in the Notice.

F. Except when required by law, the Division shall not implement a material change to any term of the Notice prior to the effective date of the material change.

G. The Division shall ensure the Notice of Privacy Practices contains:

1. The following statement as a header or otherwise prominently displayed:

   "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

2. A description of the types of Uses and Disclosures that the Division is permitted to make for treatment, payment, and health care operations and include at least one pertinent example.
3. A description of all other purposes for which the Division is permitted or required to Use or Disclose PHI without the Member's written authorization.
4. A statement that if a Use or Disclosure for any purpose is prohibited or significantly limited by another applicable law, the description of such Use or Disclosure shall reflect the more stringent law.
5. A statement that other Uses and Disclosures will be made only with the Member's written authorization and that the Member may revoke such an authorization at any time.
6. A statement of the Member's rights with respect to PHI and a brief description of how the Member may exercise these rights, as follows:

a. The right to request restrictions of certain Uses and Disclosures of PHI, including a statement that the Division is not required to agree to a requested restriction.

b. The right to receive communications of PHI confidentially.

c. The right to inspect and copy PHI.

d. The right to request an amendment to PHI.

e. The right to receive an accounting of applicable Disclosures of PHI; and

f. The right of a Member, including an individual who has agreed to receive the Notice electronically, to obtain a paper copy of the Notice from the Division upon request.

7. A statement that the Division is required by law to maintain the privacy of PHI.

8. A statement of the Division's legal duties and privacy practices with respect to PHI.

9. A statement that the Division shall abide by the terms of the Notice currently in effect.

10. A statement that the Division reserves the right to change the terms of the notice and how it will provide a revised notice, along with the date the Notice goes into effect.
11. A statement that the Member has a right to file a complaint with the Division Privacy Officer, including their name and telephone number, and with the Secretary of the Department of Health and Human Services if a Member believes their privacy rights have been violated.
12. A statement that the Member will not be retaliated against if they file a complaint.

H. The Division shall document compliance with the Notice requirements by retaining copies of the Notices issued by the Division and, if applicable, any written acknowledgments of receipt of the Notice or documentation.

7009 DE-IDENTIFICATION - PROTECTED HEALTH INFORMATION

EFFECTIVE DATE: February 28, 2024

REFERENCES: 45 C.F.R. § 164.502; 45 C.F.R. § 164.514

PURPOSE

This policy applies to all Division of Developmental Disabilities (the Division) staff. This policy outlines the de-identification of protected health information as required by the Health Insurance Portability and Accountability Act of 1996 "HIPAA".

DEFINITIONS

1. "Disclosure" means the release, transfer, or provision of access to or divulgence in any other manner of PHI to parties outside the entity holding the information.
2. "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule" means the Federal Regulation that establishes national standards to protect individuals' medical records and other individual health information that applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule

requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the Uses and Disclosures that may be made of such information without authorization from the Responsible Person. The Rule also gives Members rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

3. "Member" means the same as "client" as defined in A.R.S. § 36-551.
4. "Protected Health Information" or "PHI" means individually identifiable health information about a Member that is transmitted or maintained in any medium where the information is:
    a. Created or received by a:
        i. Health care provider,
        ii. Health plan,
        iii. Employer, or
        iv. Health care clearinghouse.
    b. Relates to the:

i. Past, present, or future physical or mental health condition of a Member;

ii. Provision of health care to a Member; or

iii. Payment for the provision of health care to a Member.

c. PHI excludes information in:

i. Education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;

ii. Records described at 20 USC 1232g(a)(4)(B)(IV);

iii. Employment records held by a Covered Entity in its role as an employer; or

iv. Regarding a person who has been deceased for more than 50 years.

5. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

6. "Use" means the sharing, employment, application, utilization, examination, or analysis of PHI within the entity that maintains such information.

POLICY

A. DE-IDENTIFIED PHI IS CREATED BY REMOVING IDENTIFIERS

1. The Division shall determine when Protected Health Information (PHI) is subject to de-identification by ensuring all of the identifiers defined as PHI are removed from the documents regarding the Member.
2. The Division shall ensure that the following identifiers of the Member, the Member's relatives, employers, or individuals living in the same household, are removed from the documents:
    a. Names
    b. All geographic subdivisions smaller than a State, including:
        i. Street address,
        ii. City,
        iii. County,
        iv. Precinct,
        v. Zip code, and

vi. Their equivalent geocodes.

c. All elements of dates, except year for dates directly related to an individual, including:

i. Birth date,

ii. Admission date,

iii. Discharge date,

iv. Date of death, and

v. All elements of dates that identify an individual to be age 90 or older are aggregated into a single category.

d. Telephone numbers.

e. Fax Numbers.

f. Electronic mail addresses.

g. Social Security Numbers.

h. Medical record numbers.

i. Health plan beneficiary numbers.

j. Account numbers.

k. Certificate/license numbers.

l. Vehicle identifiers and serial numbers, including license plate numbers.

m. Device identifiers and serial numbers.

n. Web Universal Resource Locators (URLs).

o. Internet Protocol (IP) address numbers.

p. Biometric identifiers, including finger and voice prints.

q. Full face photographic images and any comparable images.

r. Any other unique identifying number, characteristics, or code that can be re-identified.

B. ACTUAL KNOWLEDGE THAT INFORMATION CAN BE USED TO IDENTIFY AN INDIVIDUAL

1. If the Division has actual knowledge that any information remaining after de-identification could be used alone or in combination with other information to identify the Member, then the Division shall consider the information to be individually identifiable and not use or disclose without proper authorization.
2. If an employee of the Division has knowledge of any remaining identifiable information, the employee shall consult with the Division's Privacy Officer prior to releasing the information.

C. CODED DATA

1. The Division shall assign a code to health information or use some other similar means of identifying PHI to allow otherwise de-identified information to be re-identified provided that:
    a. The code or other means of identification do not come from or are related to the Member's identifying information.
    b. The code shall not be capable of being translated so as to identify the Member by an outside entity.
2. The Division shall document the codes in writing and record all analyses and information used to re-identify health information.
3. The Division shall not use or disclose the code or other means of record identification for any other purpose, and shall not disclose the mechanism for re-identification.