DDD SHOUT
VENDOR & PROVIDER NEWSLETTER
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AHCCCS Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) tracks and monitors timely service delivery and access to care for members. EVV applies to all providers of these services, including paid family direct care workers. EVV is a federal requirement and is a mandatory program. All individuals who receive services from AHCCCS must participate. The hard claims edit for Electronic Visit Verification went into effect on Sunday, January 1, 2023. This means that Qualified Vendors cannot be paid for claims for services with dates of service on or after January 1, 2023, if all EVV requirements are not met. At a minimum, the EVV system must electronically verify the:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

The DDD services impacted are:

- Attendant Care
- Homemaker/Housekeeping
- Habilitation Hourly
- Home Health (Nursing, Licensed Health Aid, Home Health Aid)
- Respite

Services including Speech Therapy, Occupational Therapy, and Physical Therapy provided by a Qualified Vendor that is enrolled as a “Provider Type 39-Habilitation Provider” or as a “Provider Type 01 Group Biller” are not required to use Electronic Visit Verification when providing services.

Additionally, EVV is only required for the following Place of Service (POS) codes:

- 12-Home
- 13-Assisted Living Facility
- 99-Other

Common Errors

Qualified Vendor Agencies are now submitting claims for services provided after the Electronic Visit Verification claims “hard edit” was implemented. The Division has identified four common errors. Please consider the following before submitting claims:

1. Timing of claims: Please upload your visit data in Sandata before submitting the claim to WellSky for that visit. Otherwise, WellSky will deny claims submitted before the verified EVV data has been uploaded. For example, if you submit a claim on Tuesday and verified visit data on Thursday, the claim will be denied.
2. Incorrect payor: Visit data in Sandata must have "AZDDD" as the payor so the WellSky claims system validation process can "see" the visit. If the payor is another managed care organization (MCO) or AHCCCS, DDD's claims system cannot see the visit data. This is due to Sandata's data compliance protection that ensures HIPAA compliance.
3. Visit data does not match the claim: The visit data has to match the claim (aggregating is allowable). The number of verified visits must equal the total on the claim, or match it exactly.
4. Time zone: Be aware of the time zone used by Alt EVV systems and use the proper coding when uploading to Sandata. Using incorrect time zones may prevent the system from validating claims. Please refer to the AHCCCS Alternate EVV Vendor Specification guidelines for more information.

If you're a Qualified Vendor who made one of these errors and received a claim denial due to EVV compliance, please resubmit your claim only after correcting the errors.

Available Resources

The Division has created a page on its website dedicated to Electronic Visit Verification. This page includes a link to the AHCCCS website, an FAQ with questions specific to DDD and EVV, and a Google Form that members, families, stakeholders, and providers can use to submit EVV questions to the Division. Additional information about EVV can be found in the Division's Provider Manual Chapter 62 Electronic Visit Verification.

As outlined in Provider Policy Manual Chapter 2 Provider Responsibilities and Expectations, direct support professionals, including family members being paid to provide care, are limited to working no more than 16 hours in a 24-hour period. Services that are assessed for more than 16 hours in a 24-hour period must be provided by another direct support professional. Qualified Vendor agencies should ensure all direct support professionals are not violating this requirement through their work with additional Qualified Vendor agencies.

Federal COVID-19 Public Health Emergency

On January 30, 2023 the federal government announced the federal COVID-19 public health emergency would end on May 11, 2023. This means the remaining COVID-19 public health emergency flexibilities not ending on April 1, 2023, will end on June 30, 2023. The Division has updated its Actions Related to COVID-19 web page, so it's easier to understand changes to COVID-19 flexibilities. All flexibilities have been combined into a single table that lists their effective dates and end dates. Additionally, the Division has archived the "DDD Qualified Vendor and Provider Frequently Asked Questions" document. These questions and answers have been moved to a Google Document that is available for viewing from the updated Service Delivery Changes section. Qualified Vendors and Providers should reference the updated table in the Service Delivery Changes section in regard to the end of any flexibilities granted throughout the PHE rather than the frequently asked questions document.

Parents as Paid Caregivers for Their Minor Children

Parents as paid caregivers for their minor children is a flexibility that was implemented at the start of the federal COVID-19 PHE. This reduced the number of people members had to be in contact with from outside their homes. This flexibility is set to expire at the end of the COVID-19 PHE. However, this flexibility was

included in the AHCCCS American Rescue Plan Act (ARPA) spending plan. This plan was approved by the Centers for Medicare and Medicaid Services (CMS). Under ARPA funding, this flexibility will be available through September 30, 2024. The ARPA plan will take effect when the federal COVID-19 PHE expires on June 30, 2023.

Parents will not be allowed to provide more than 40 hours of total paid care **per ALTCS member** in any given week after the federal COVID-19 PHE expires. This applies even if they are employed by multiple agencies. Each ALTCS member who is under the age of 18 can receive paid care from a parent for up to 40 hours a week. In cases where two parents are paid caregivers, they can provide up to 40 hours of combined services per week per ALTCS member. The member may be assessed for more than 40 hours based on their needs. **However, any hours greater than 40 must be provided by a non-parent direct support professional.**

Progress Reporting Requirement Reminder

As outlined in Provider Policy Manual Chapter 35, providers are required to submit member progress reports on a defined schedule. All progress reports must be submitted using the Division's secure FTP. Since the FTP site is secure, files uploaded should not be locked or require any passwords to open. The files are now uploaded directly to the member's files and if they are uploaded by the vendor with any type of security, the Support Coordinator is not able to access the report. The FTP can be accessed using Windows File Explorer or using the FileZilla FTP client. Qualified Vendors having trouble accessing the FTP should review the guide, Progress Report Upload Printable Directions with FTP Information, for assistance. Progress reports must not be submitted to the Division via email.

Statewide Day Treatment Summer (DTS) Qualified Vendor Enrollment Process for Summer 2023

On February 28, 2023, all DTS contracted providers will receive a survey via email from the Division's Network District Resources team that will enable the Division to develop its DTS provider list. This list will be shared with members/responsible persons over the next few months, as Support Coordinators begin assessing this service for members aged 3-18 years. The DTS 2023 Survey will be sent from NetworkDistrictResources@azdes.gov. Qualified Vendor agencies are encouraged to add that email address to their contacts and validate their contact information in Focus is up-to-date to ensure the survey is received. Qualified Vendors interested in providing DTS services should respond to ensure their DTS programs are included on the list.

RFQVA DDD-2024 Contract Implementation Qualified Vendor Required Tasks and Actions

The Request for Qualified Vendor Application (RFQVA) is the Division's contract for Home and Community-Based Services (HCBS). The Division intends to end the current Agreement, RFQVA DDD-710000, and implement the new Agreement, RFQVA DDD-2024, in March 2024. Qualified Vendors will need to take action to correct or complete information in CAS or their FOCUS account. Failure to maintain compliance and take action timely on required activities will create barriers to a successful application for RFQVA DDD-2024 and may result in the denial of a Qualified Vendor's new application.

Qualified Vendors will be required to comply with the requirements and take action as needed on tasks listed below:

1. Maintain insurance compliance prior to and throughout DDD-2024 contract application review.
2. Maintain agency/business HCBS certification as current and in good standing.

3. Ensure timely revalidation of AHCCCS IDs associated with the agency/business's Qualified Vendor Agreement and ensure that all AHCCCS IDs are active.
4. Have at least one signatory or owner with an exactly matching first name, last name, and email address in BOTH the Contract Administration System (CAS) and the vendor's FOCUS account.
    a. Each vendor must ensure that at least one signatory or owner has a FOCUS account. If at least one signatory or owner does not have a FOCUS account, they will need to set up a new account. Go to section 2 of the DDD QVA User Guide and Manual.
        i. It is recommended that the account use the first name, last name and email address of the owner or signatory already in use in CAS to avoid the submission of an amendment to the vendor's QVA which requires review and approval.
5. Vendors must ensure that each active service in CAS that requires an AHCCCS ID has one associated with that service.

The Division has created a webpage specific to this project that includes a PDF copy of the final RFQVA DDD-2024 document, the projected timeline to help Qualified Vendors and applicants plan for the implementation of RFQVA DDD-2024 and a summary of changes between the current and future RFQVA for Qualified Vendor reference.

The RFQVA DDD-2024 posted online is final. If the Division is required to make changes as a result of updated regulations or new state or federal requirements, the Division will provide notice to all applicants, and post notice of the changes on this page. Current Qualified Vendors that have submitted their DDD-2024 application prior to any changes being made will be asked to submit a new signature page and acknowledge receipt after they have reviewed and agreed to the updated terms and conditions.

Qualified Vendors with questions about the new RFQVA should submit them using this Google Form.

AHCCCS Revalidation

Providers must revalidate enrollment of their provider IDs with AHCCCS periodically to maintain Medicaid billing privileges. In general, providers are required to revalidate every four years. AHCCCS also reserves the right to request off-cycle revalidations. As part of the revalidation process, the provider is subject to the same screening and disclosures captured during the initial enrollment. Additionally, based on provider type, the process could include an enrollment fee, site visit, and a Fingerprint Clearance Card criminal background check via the screening requirements.

The provider types most often used by DDD Qualified vendors are due for revalidation no later than the following dates:

- February 1, 2023 - Group Billers (PT 01)
- May 1, 2023 - Habilitation Providers (PT39)
- August 1, 2023 - Home Health Agencies (PT 23 and 95)

Failure to revalidate will require DDD to stop paying claims and potentially terminate a Qualified Vendor agreement. Additional provider types and dates for revalidation can be identified on this Provider Revalidation Dates Spreadsheet.

What AHCCCS Providers Need to Know:

- Any provider who has not completed the revalidation process in the AHCCCS Provider Enrollment Portal (APEP) will be listed on the Provider Revalidation Spreadsheet, receive written notification, and have 90 days to apply.

- The notification will include a temporary 14-digit application ID number required to access the provider file for the first time.
- Providers who fail to respond to the request could experience delays such as loss of billing privileges and/or termination and access to the AHCCCS Online Portal.
- For providers with questions, those who are no longer participating as a Medicaid provider, and those no longer employed with an organization, please contact APEPTrainingQuestions@azahcccs.gov.

How Providers Can Complete the Revalidation Process

To begin your revalidation application today, login to your existing account via the AHCCCS Provider Enrollment Portal.

Providers can use these step-by-step instructions to complete a revalidation.

For additional questions on how to troubleshoot through APEP to complete the revalidation application, contact APEPTrainingQuestions@azahcccs.gov or Provider Assistance at (602) 417-7670, option 5. Please include the provider name, NPI, and a brief description of the issue.

Group Home Monitoring Pilot Program - House Bill 2865

As previously communicated in the January Shout Vendor and Provider newsletter, Arizona House Bill 2865 (HB 2865) was passed by the Arizona Legislature and signed into law in June 2022. The legislation requires the Division to contract with the Arizona Center for Disability Law (ACDL) to implement a 3-year pilot program, beginning January 1, 2023, which includes:

- ACDL monitoring group homes that serve members with complex behavioral needs, and
- ACDL conducting quality of care complaint investigations for group homes.

The Division will identify group homes that support members with complex behavioral needs and refer those homes to ACDL for monitoring. ACDL will monitor the following areas during the Group Home Monitoring Pilot Program:

- If the members received services identified in their person-centered service plans, including medication monitoring and habilitation treatment, as applicable.
- If the provision of services identified in the person-centered service plan has effectively addressed the member's complex needs.
- If the services have resulted in a reduction in behaviors that interfered with the ability of members to live safely in the community.
- If all physical interventions used by the group home staff complied with the member's Behavior Plan and applicable state laws.

ACDL is in the process of hiring staff to implement the pilot program and expects to begin the monitoring and investigations within the next couple of months.

The Division hosted a technical assistance session on January 27, 2023, for Group Homes vendors that covered:

- Details regarding House Bill 2865
- The role of ACDL and the Group Homes during Group Home Monitoring and Quality of Care investigations
- Refresher training regarding the Program Review Committee process
- Information about the Behavior Plan Writing Workshop training available to Qualified Vendors

A recording of the technical assistance session held on January 27, 2023, is available online that Group Home service providers can reference as needed. Questions about House Bill 2865 and this Pilot Program can be submitted via email to DDDQMProgramMonitoring@azdes.gov.

Program Review Committee Monthly Update

The Division has created a folder in Google Drive that includes helpful resources to support PRC member reviews. Resources include information/description of behavioral functions, alternative replacement behaviors, protocol on the use of protective devices, DDD required forms and more.

The PRC team especially would like to highlight the Behavior Plan template created by the Division. This resource will provide plan writers with a streamlined template for statewide consistency, which will better support plan writers when submitting BPs and preparing for annual PRC reviews. The PRC team strongly encourages plan writers to make the shift to using this template and encourages any Qualified Vendor or provider with questions or who needs technical assistance to contact their PRC District Chair.

Fraud, Waste and Abuse (FWA)

Fraud: 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. It includes any act that constitutes fraud under applicable State or Federal law [42 CFR 455.2].

Examples of Fraud:

- Billing for services that were never provided to members
- Billing for a service that has a higher reimbursement than the service produced
- Misrepresenting who provided the services, altering claim forms, electronic claim records or medical documentation

Waste: Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Examples of Waste:

- Providing services that are not medically necessary
  - Healthcare providers ordering excessive diagnostic tests
  - Excessive use or overuse of benefits by members

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. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program. 42 CFR 455.2.

Abuse is similar to fraud, except there is no requirement to prove or demonstrate the abusive acts were committed knowingly, willfully, and intentionally.

Examples of Abuse:

- Abuse includes, but is not limited to, a range of the following improper behaviors or billing practices:
  - Billing for non-covered services
  - Misusing codes on a claim (i.e. the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered)
  - Inappropriately allocating costs on a cost report

Town Hall Meetings

The Office of Individual and Family Affairs (OIFA) continues to host town hall meetings for members, families, and providers. The next town hall meeting will be held on Thursday, March 2, 2023, from 6:00 p.m. to 8:00 p.m. Please share this information with members and families and encourage them to participate at the next event. The town hall schedule and instructions to join via the Internet or phone can be found at bit.ly/dddtownhall.

Get Caught Up

Did you know the Division posts vendor announcements and editions of the Shout on the web? Get caught up and stay informed by visiting the Vendor Announcements page online.

Report Fraud, Waste, Abuse and Misconduct

Report to DDD

- Call DDD at 1-877-822-5799
- Send an email to dddfwa@azdes.gov
- Send a letter to DES/DDD
  Attn: Corporate Compliance Unit
  1789 W Jefferson St.
  Mail Drop 2HA1
  Phoenix, AZ 85007
- Complete this online form.

Report to AHCCCS

- Provider Fraud
  - In Arizona: 602-417-4045
  - Outside Arizona: 1-888-ITS-NOT-OK (1-888-487-6686)
- Report Member Fraud:
  - In Arizona: 602-417-4193
  - Outside Arizona: 1-888-ITS-NOT-OK (1-888-487-6686)
- If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, email the AHCCCS Office of Inspector General (OIG) at AHCCCSFraud@azahcccs.gov.