5000 REINSURANCE POLICY

REVISION DATE: 11/8/2023
EFFECTIVE DATE: December 15, 2021
REFERENCES: Section F3, Contractor Chart of Deliverables; 42 U.S.C. § 1396b (i); 42 USC § 1396d(r)(5); 42 CFR § 441.35; 42 CFR § 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; DDD Health Plans Contract; ACOM 408; ACOM 414; AMPM 1620-I; AMPM 310-DD; AMPM 300-2A; DDD Medical Policy Manual, Policy 310-DD; AdSS Operations Manual, Policy 414; AdSS Medical Manual, Policy 1001

PURPOSE

The purpose of this policy is to outline the requirements the Administrative Services Subcontractors (AdSS) must meet to request Reinsurance reimbursement from the Division of Developmental Disabilities (Division).

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. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following: 1. Claims processing, including pharmacy claims, 2. Pharmacy Benefit Manager (PMB), 3. Dental Benefit Manager, 4. Credentialing, including those for only

primary source verification (i.e., Credential Verification Organization [CVO]), 5. Management Service Agreements, 6. Medicaid Accountable Care Organization (ACO), 7. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, and 8. CHP and DDD Subcontracted Health Plan.

3. "Administrative Services Subcontractor" or "AdSS" means a person, individual, or entity who holds an Administrative Services Subcontract.
4. "Adverse Benefit Determination" means the denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.
5. "AHCCCS State Plan" means the written agreement between the State of Arizona and Centers for Medicare and Medicaid Services (CMS), which describes how the Arizona Health Care Cost Containment System (AHCCCS) meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
6. "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.

7. "Biologic Drugs" means products produced by biotechnology. These drugs are referred to as biologicals, biological drugs, or biopharmaceuticals.
8. "Case" means a record for a Member that is composed of one or more Adjudicated Encounters.
9. "Case Type" means a description of the type of Reinsurance being paid to the AdSS 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.
10. "Catastrophic Reinsurance" means reimbursement, full or partial, depending on the Case Type, from the Division to the AdSS for the cost of care associated with certain medical conditions and specific drugs described in the Contract, AMPM, and DDD policy.
11. "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 being appealed or claims that are the subject of a grievance, under investigation for fraud or abuse, or claims under review for medical necessity.

12. "Coinsurance" means the percentage rate established each Contract Year by AHCCCS, at which the Division will reimburse the AdSS for covered services above the Deductible.
13. "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.
14. "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.
15. "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.

16. "Deductible" means the annual amount established each Contract Year by AHCCCS, of Reinsurance covered services that must be paid and encountered by the AdSS for each individual Member before the AdSS receives Reinsurance payments from the Division.
17. "DES Case Type" means certain covered inpatient facility services as described in the Contract, AMPM, and this policy that may qualify for Reinsurance reimbursement.
18. "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.

19. "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.
20. "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.
21. "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.
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23. "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.

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

25. "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 AdSS regarding the service authorization request and includes the information required by this Policy.

26. "Prepaid Medical Management Information System" or "PMMIS" means the AHCCCS mainframe pricing system of record that the Division uses for accessing the Reinsurance System.

27. "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.

28. "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.

29. "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.
30. "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.
31. "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.
32. "Reinsurance System" means the PMMIS application for accessing Reinsurance Case data.
33. "Second Level Review" means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member's condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member's medical record to ensure Division Members are receiving medically appropriate and high quality care.

34. "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.
35. "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."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 AdSS shall comply with the terms and conditions of the Administrative Services Subcontract with the Division.
2. The AdSS shall be responsible for the annual Deductible levels as determined by AHCCCS for covered medical services for each Member for the Contract Year.
3. The AdSS shall submit Reinsurance requests to the Division for Reinsurance covered services incurred beyond the annual

Deductible level for Members enrolled with the AdSS on a capitated basis.

4. The AdSS shall ensure Encounters 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. The AdSS shall not submit final Reinsurance claims which cross over Contract Years.
6. The AdSS 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.

7. The AdSS 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.

8. The AdSS 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.

9. 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 AdSS shall submit requests for Reinsurance reimbursement to the Division 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 AdSS shall comply with medical audits on Reinsurance Cases upon request from the Division.

B. REGULAR REINSURANCE (DES CASE TYPE) REQUIREMENTS

1. The AdSS shall submit reimbursement requests 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 AdSS shall not request Regular Reinsurance from the Division 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 AdSS may request Regular Reinsurance reimbursement for the Member’s Prospective Coverage and Prior Period Coverage (PPC) enrollment periods.
4. The AdSS shall not submit requests for Regular Reinsurance on the following types of claims:
    a. Final claims that cross over Contract Years; and
    b. Interim claims.
5. The AdSS shall request Regular Reinsurance consideration from the Division 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 AdSS shall request from the Division 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 AdSS shall not pay Deductibles for Catastrophic Reinsurance Cases.
3. The AdSS shall request a new Catastrophic Reinsurance Case by submitting the following documents to the Division for initial review and submittal to AHCCCS within 30 days of the identification of the Member's initial diagnosis or enrollment with the AdSS:
   a. The Request for Catastrophic Reinsurance form; and
   b. Supporting clinical documentation.

4. The AdSS shall ensure the Member's medical condition meets the criteria in Sections D, E, and F prior to submitting a new request for a new Catastrophic Reinsurance Case to the Division.
5. The AdSS shall submit the following documentation to the Division 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 AdSS shall provide the Division with supporting clinical documentation for previously approved Catastrophic Reinsurance Cases upon request.
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 AdSS 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.
11. The AdSS shall be responsible for prior authorization and care coordination for all components covered under the Contract for their Members.
12. The AdSS shall submit Reinsurance requests to the Division for catastrophic claims that contain any PPC and Prospective Coverage.

D. CATASTROPHIC REINSURANCE REQUIREMENTS FOR BLOOD DISORDERS

1. The AdSS shall request Catastrophic Reinsurance for adjudicated Encounters for services provided to Members diagnosed with Hemophilia.

2. The AdSS shall request Catastrophic Reinsurance for Members diagnosed with the following von Willebrand Disease types only:
    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 AdSS shall review clinical records to confirm the Member's type of von Willebrand's Disease and whether or not the Member has responded to a DDAVP medication prior to requesting Catastrophic Reinsurance.
4. The AdSS shall request Catastrophic Reinsurance for all Members diagnosed with Gaucher's Disease Type I.
5. The AdSS shall not request Catastrophic Reinsurance for Gaucher's Disease Type 2 and Type 3.

E. CATASTROPHIC REINSURANCE REQUIREMENTS FOR BIOLOGIC OR HIGH COST SPECIALTY DRUGS

1. The AdSS shall request Catastrophic Reinsurance to cover the cost of medically necessary Bologic and high cost specialty drugs for Members. .
2. The AdSS 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 AdSS shall be reimbursed the following by the Division when a biosimilar or generic equivalent of a Biologic Drug is available and AHCCCS has determined that the biosimilar 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 AdSS shall be reimbursed the Catastrophic Coinsurance rate the lesser of the following by the Division in the instances in which AHCCCS has specialty Contracts, or when legislation and policy limits the allowable reimbursement,:
   a. The AHCCCS contracted or mandated amount;or
   b. The AdSS's paid amount.
5. The AdSS may submit requests for new biological drugs or high-cost specialty drugs to the Division for consideration for Reinsurance purposes.
6. The AdSS shall encounter all Biologic or high-cost specialty drugs on a Form C pharmacy claim to be eligible for Reinsurance.

F. CATASTROPHIC REINSURANCE REQUIREMENTS FOR HIGH COST BEHAVIORAL HEALTH

1. The AdSS shall request Catastrophic Reinsurance reimbursement from the Division 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 AdSS shall submit the following to the Division 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 AdSS shall comply with the 10 business day timeframe and documentation requirements as required in item 2 of this section or the Division will deny additional Reinsurance reimbursement.
4. The AdSS shall ensure Encounters for covered services provided to enrolled BEH Members are adjudicated to be eligible for Reinsurance reimbursement.
5. The AdSS shall ensure medical documentation substantiating the Member's treatment is provided in the least restrictive treatment setting to be eligible for Reinsurance.

6. The AdSS may request Reinsurance reimbursement for ALTCS behavioral health Members for medically necessary covered services provided during the Contract Year.

G. HIGH DOLLAR CATASTROPHIC REINSURANCE REQUIREMENTS- $1,000,000+

1. The AdSS shall request Reinsurance reimbursement for all medically necessary Reinsurance covered expenses provided in a Contract Year, 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 AdSS shall notify the Division once a Reinsurance Case total value reaches $1 million.
3. The AdSS shall submit the following to the Division once a Reinsurance Case total value reaches $1 million:
   a. Request to create Case Types:
      i. Catastrophic Regular Acute (DDC);
      ii. Catastrophic Hemophilia (CHM);

iii. Catastrophic Biological or high-cost specialty drug (CRB); or

iv. Catastrophic ALTCS (CLT).

b. List of Encounters in numerical order that are to be transferred to the DDC, CHM, CRB, or CLT Case.

4. The Division shall disqualify the AdSS from receiving 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. TRANSPLANT REINSURANCE OVERVIEW

1. The AdSS shall request the AHCCCS contracted Coinsurance rate for transplant services from the Division 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 in 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 AdSS shall comply with the terms and conditions of the AHCCCS transplant specialty Contract.

3. The AdSS shall not pay Deductibles for Transplant Reinsurance Cases.

4. The AdSS shall request transplant Reinsurance at the current AHCCCS contracted rates located on the AHCCCS website 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).

5. The AdSS shall notify the Division and AHCCCS when a Member is referred to a transplant facility for evaluation for an AHCCCS-covered organ transplant.

6. The AdSS shall be responsible for the following when the AHCCCS transplant specialty is contract is used:

a. Prior authorization; and

b. Care coordination.

I. TRANSPLANT CASE CREATION REQUIREMENTS

1. The AdSS shall timely submit the following documentation to the Division within 30 days of the Member's first component of the transplant to request approval for Case activation and transplant Reinsurance from AHCCCS:

a. Request for Transplant Reinsurance form, located on the AHCCCS website;

b. Supporting clinical documentation; and

c. AdSS policy supporting the transplant.

2. The AdSS, prior to submitting the request for transplant Reinsurance to the Division, shall ensure the documentation listed in item 1 of this section confirms the transplant is:
    a. Medically necessary;
    b. Covered by AHCCCS;
    c. Considered the standard of care; and
    d. Not considered experimental.
3. The AdSS shall submit the Transplant Reinsurance Crossover List, located on the AHCCCS website, to the Division for AHCCCS approval of Members requiring continuation of previously approved transplant Reinsurance.
4. 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.

5. 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.
6. If the AdSS receives a request for transplant that is outside of the criteria required in AMPM 310-DD, the AdSS may consult an independent review organization to determine whether or not the requested transplant is considered the standard of care and is medically necessary.
7. If the AdSS determines the transplant request should be authorized as a result of the consultation with the independent organization, the AdSS shall:
    a. Inform the Division of the pending decision; and
    b. Submit a Request for Transplant Reinsurance form to the Division for review by AHCCCS within 30 days of the initiation of the first transplant component.
8. The AdSS shall submit a Second Level Review to the Division for any transplant services and transplant immunosuppressant related medications prior to denying services.

9. If the AdSS denies the transplant based on medical necessity or coverage criteria, the AdSS shall issue a Notice of Adverse Benefit Determination as outlined in the AdSS Operations Policy Manual, Chapter 400, Policy 414.

J. REQUIRED TRANSPLANT CASE COMMUNICATION

1. The AdSS shall communicate the AdSS's transplant activity by submitting the Quarterly Transplant Log to the Division no later than 10 days after the end of each quarter.
2. The AdSS shall not alter or password protect the format of the Quarterly Transplant Log prior to submission to the Division, or the log will be rejected and considered as a nonsubmission.
3. The AdSS shall complete the Quarterly Transplant Log as follows:
    a. Highlight in yellow the Member's name and the cell(s) that contain information that has been changed or updated since the previous submission.
    b. Note in the Comments Section general comments, which may include:
        i. New activity,
        ii. Transplants that have been denied,

iii. Transplant Cases that are closed and rationale,

iv. Availability of TPL or Medicare if the transplant is not covered or the Member has no benefit remaining.

4. The AdSS shall submit to the Division the Quarterly Transplant Log with all the transplant activity from the previous Contract Year on or before October 10th of each year.

5. The AdSS shall remove all non-active Members from the Quarterly Transplant Log that is submitted for the new Contract Year on or prior to January 10th, to include:

   a. Members who expired.

   b. Members removed from the transplant wait list.

   c. Members who received a transplant prior to September 30th.

   d. Members who terminated with the AdSS.

   e.

6. The AdSS shall only include on the Quarterly Transplant Log transplant components that are covered and reinsurable by AHCCCS.

K. TRANSPLANT CLAIM REINSURANCE REIMBURSEMENT

1. The AdSS shall not request Regular Reinsurance reimbursement for a transplant that is determined by AHCCCS to be ineligible for transplant Reinsurance coverage.
2. The AdSS shall pay claims for all transplant services approved by the AdSS regardless of a denial of Reinsurance reimbursement from AHCCCS.
3. The AdSS shall not request Reinsurance reimbursement for the following transplants that are not eligible for Reinsurance coverage:
    a. Bone graft transplants;
    b. Corneal transplants; and
    c. Kidney transplants.
4. The AdSS may submit to the Division a request for Regular Reinsurance for transplants that do not qualify for transplant Reinsurance for consideration by AHCCCS.
5. The AdSS shall not request transplant Reinsurance reimbursement for Members who have TPL including:
    a. Medicare Part A; or

b. Medicare Parts A and B.

6. The AdSS may request transplant Reinsurance reimbursement, 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.

7. The AdSS shall request 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.
8. The AdSS shall not request quick pay discounts or interest to transplant Reinsurance reimbursements.
9. 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.
10. The AdSS shall submit clean Reinsurance claims to the Division no later than 15 months from the end date of service for each transplant component in order to receive transplant Reinsurance reimbursement.
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 AdSS shall file transplant Encounters with a CN1 code of 09 to ensure the Encounter associates to a Case.
13. The AdSS shall 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 AdSS shall
    a. Submit a request to the Division 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 AdSS shall request transplant reimbursement for adjudicated Encounters that are associated with the transplant Case.

16. The AdSS shall ensure billed amounts and AdSS paid amounts for adjudicated Encounters agree with the transplant facility's related claims and invoices to receive Reinsurance payment for transplant stages.
17. The AdSS shall request prorated calculations from the Division only when:
    a. Tandem transplants occur; or
    b. A member changes Health Plans, in the middle of a transplant stage.
18. To file a claim for Reinsurance reimbursement, the AdSS shall submit the following documentation to the Division:
    a. The Transplant Stage Invoice Cover Sheet, available on the AHCCCS website; and
    b. All required documents listed on the transplant checklist from the AHCCCS Reinsurance Processing Manual.
19. The AdSS shall recognize that timeliness for each stage payment is based on the latest adjudication date for the complete set of Encounters related to the stage.

L. REQUIREMENTS FOR TRANSPLANTS THAT SPAN CONTRACT YEARS

1. The AdSS shall recognize that the transplant stage Reimbursement rate is based on the end date of the stage.
2. The AdSS shall split a transplant stage spanning two Contract Years based on the actual dates within the two Contract Years.
3. The AdSS shall not split transplant Encounters spanning two Contract Years unless a transplant component exceeding 60 days exists.
4. The AdSS shall submit to the Division a Reinsurance Action Request Form to request the transfer of Encounter(s) spanning Contract Years to the Case based on the end date of the stage.

M. OUTLIER THRESHOLD COVERAGE FOR TRANSPLANTS

1. The AdSS may qualify for transplant outlier coverage when a specified contractual outlier threshold listed on the transplant rate sheets is met or exceeded.
2. The AdSS shall submit the following documentation to the Division to request consideration for transplant outlier coverage from AHCCCS:

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.

N. CLAIM ENCOUNTER DOCUMENTATION AND TIMEFRAMES FOR TRANSPLANT CONTRACTS

1. The AdSS shall submit Clean Claims for each stage of the solid organ transplantation or hematopoietic cellular therapy to the Division no later than 15 months from the end date of service for each particular transplant stage.
2. The AdSS shall submit outlier claim components to the Division no later than fifteen 15 months from the end date of the last completed stage.
3. The AdSS shall submit the transplant Encounter file to the Division at least 45 days prior to the 15-month deadline to ensure that the adjudication meets the 15-month timeframe.
4. The Division shall deny the claim for transplant Reinsurance reimbursement if the AdSS submits the Encounter file less than

45 days before the 15-month timeframe and the adjudication has not been completed by the 15-month deadline.

5. The AdSS shall base the timeliness of the claim submission for each stage of the transplant based on the submission date for the complete set of Encounters related to the stage.
6. The AdSS shall base timeliness for each stage payment on the latest adjudication date for the complete set of Encounters related to the stage.

O. POST TRANSPLANT INPATIENT STAYS EXCEEDING 11 OR 61+DAYS

1. The AdSS 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 and from day 61+ for all other Case Types:
    a. The AdSS shall request reimbursement at 75% of the transplant per diem rate less the Deductible for claims or Encounters for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other Case Types for all Members.

b. The AdSS shall request 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 AdSS shall submit all day 11+ and day 61+ Encounters representative of the continuous inpatient stay to the Division prior to adjudication.

d. The AdSS shall split Encounters submitted for a day 11+ or day 61+ stage that spans Contract Years.

2. The AdSS shall submit the Day 11+ or 61+ Outlier Worksheet and Instructions form, located on the AHCCCS website, to the Division to request 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.

P. TRANSPLANT TRANSPORTATION AND LODGING REINSURANCE REIMBURSEMENT REQUIREMENTS

1. The AdSS shall request Reinsurance reimbursement for transportation, room, and board at the AHCCCS allowable rates

for the transplant candidate or recipient, potential donor or donor and, if needed, one adult caregiver.

2. The AdSS shall submit a request to AHCCCS Reinsurance Finance using the Transplant Transportation Lodging form found on the AHCCCS website.

Q. MULTI-ORGAN TRANSPLANTS THAT ARE NOT COVERED IN THE AHCCCS SPECIALTY CONTRACTS

1. The AdSS may submit a request to the Division for authorization from AHCCCS 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 AdSS 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 prorate 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 AdSS 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.

R. MULTI-SEQUENCE TRANSPLANTS

1. The AdSS may submit a request to the Division for authorization from AHCCCS 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 AdSS 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 AdSS shall follow all applicable notification and claims filing requirements when requesting Reinsurance reimbursement for multi-sequence transplants.

S. OUT OF STATE OR NON-CONTRACTED FACILITIES AND NON-CONTRACTED TRANSPLANTS

1. The AdSS, prior to the Member receiving out of state transplant services, shall 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 AdSS shall 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 AdSS shall request Reinsurance reimbursement for an approved transplant performed out of state at a non-contracted facility 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 AdSS shall obtain prior approval from the AHCCCS Medical Director to use a non-contracted transplant facility or out-of-state contracted facility for a contracted transplant type that is available in state.
6. Depending on the unique circumstances of each AHCCCS approved out-of-state transplant, the AdSS shall request for consideration Reinsurance coverage at 85% of the AdSS's paid amount for comparable Case or component rates.

T. ENCOUNTER SUBMISSION REQUIREMENTS

1. The AdSS shall submit Encounters that associate to a Reinsurance Case to qualify for reimbursement of Reinsurance claims.
2. The AdSS shall ensure all Reinsurance-associated Encounters except as provided below for claim disputes, 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, or the AdSS may be subject to administrative action by AHCCCS.

4. The AdSS shall void Encounters that are recouped in full.

U. 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 AdSS shall submit written requests for Reinsurance consideration for all other Reinsurance claims to the Division, except for Regular Reinsurance, using the forms and adhering to the claims submission time frames as required in this policy.

3. The AdSS shall submit Encounters that have attained clean status no later than 15 months from the end date of service.

4. The AdSS shall 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 AdSS shall ensure:
   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.

V. ADMINISTRATIVE DISPUTE REQUIREMENTS

The AdSS shall 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.

W. DIVISION OVERSIGHT OF THE ADSS

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:

a. Not submitted timely; and

b. Did not adjudicate; and

c. Did not reach approved status (CLM STAT 31) within the same Encounter Cycle; and

d. The original Encounter (Encounter identified on the 837 & NCPDP) Reinsurance paid amount is greater than $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 third party 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, Third Party 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.

Quick Reference

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	**DEFINITION**	**SUB CAP**	**DESCRIPTION**
Blank		00	• No sub-capitated payment arrangement • Services: fee-for-service basis. (FFS) • Subscriber Exception code is 25 (PMMIS Screen Ri320), • Sub-Cap code is 05.
01	DRG	00	• Full sub-capitation arrangement • Services: Fully sub-capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
02	Per Diem	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
03	Variable PerDiem	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
04	Flat	00	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.

05	Capitated	01	• Full Sub-Capitation arrangement • Services: Fully Sub-Capitated contractual arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
06	Percent	00	• Partial Sub-Capitation arrangement • Services: Sub-Capitated provider that's excluded from the Sub-Capitated payment arrangement. • Subscriber exception code is 25 (PMMIS Screen Ri320) • Sub-Cap code is 05.
09	Other	08	• Negotiated settlement • Services: Negotiated settlement, for example grievance settlement • Subscriber exception code is not 25 (PMMIS Screen Ri320)
09	Other	04	• Contracted Transplant Service • Services paid via catastrophic reinsurance • Subscriber exception code is 25 (PMMIS Screen Ri320)
	Identified by Filename	06	• Denied claim used to report valid Division services that are denied. For example, if a claim was denied for untimely submission.

Summary of Reinsurance Coverage

Case Type	***Deductible***	***Co-Ins***
RAC-Acute Contractors	$75,000	75%
RAC-DCS/CHPContractor	$75,000	75%
Catastrophic–Biologics/ High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High$	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	$10,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	$20,000	75%
AC-ALTCS – EPD No PT.A 0-1,999	$20,000	75%
RAC-ALTCS – EPD No PT.A 2,000+	$30,000	75%

Reinsurance Contract Year	Contract Year Ending
YR 38	10/1/194 – 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

Reinsurance Reports

The following reports (available in comma delimited or text format) are available via the Division FTP Server for AdSS' use and reference:

RI91L205 - Reinsurance Pend Report

This report is a summary of Case information for all active Cases that have pending Reinsurance Encounters during that reporting period. It lists the edit codes, edit descriptions, and edit counts.

RI81L310 - Reinsurance Remittance Advice Report

This report is generated after the monthly Reinsurance payment cycle and is a summary of all financial activity applied to only those Cases that were included in the payment cycle. Financial activity and Reinsurance Encounters

detailed on the Reinsurance Remittance Advice includes payments, replacements, voids, recoupments and denials.

RI91L105 - Reinsurance Case Summary Report

This report is a summary of Case information for all active cases during the monthly Reinsurance cycle and lists the status of all Reinsurance Encounters associated to each Reinsurance case. Also included are the Case level totals for the allowed amount, liability, Deductible, premium tax paid and total paid.

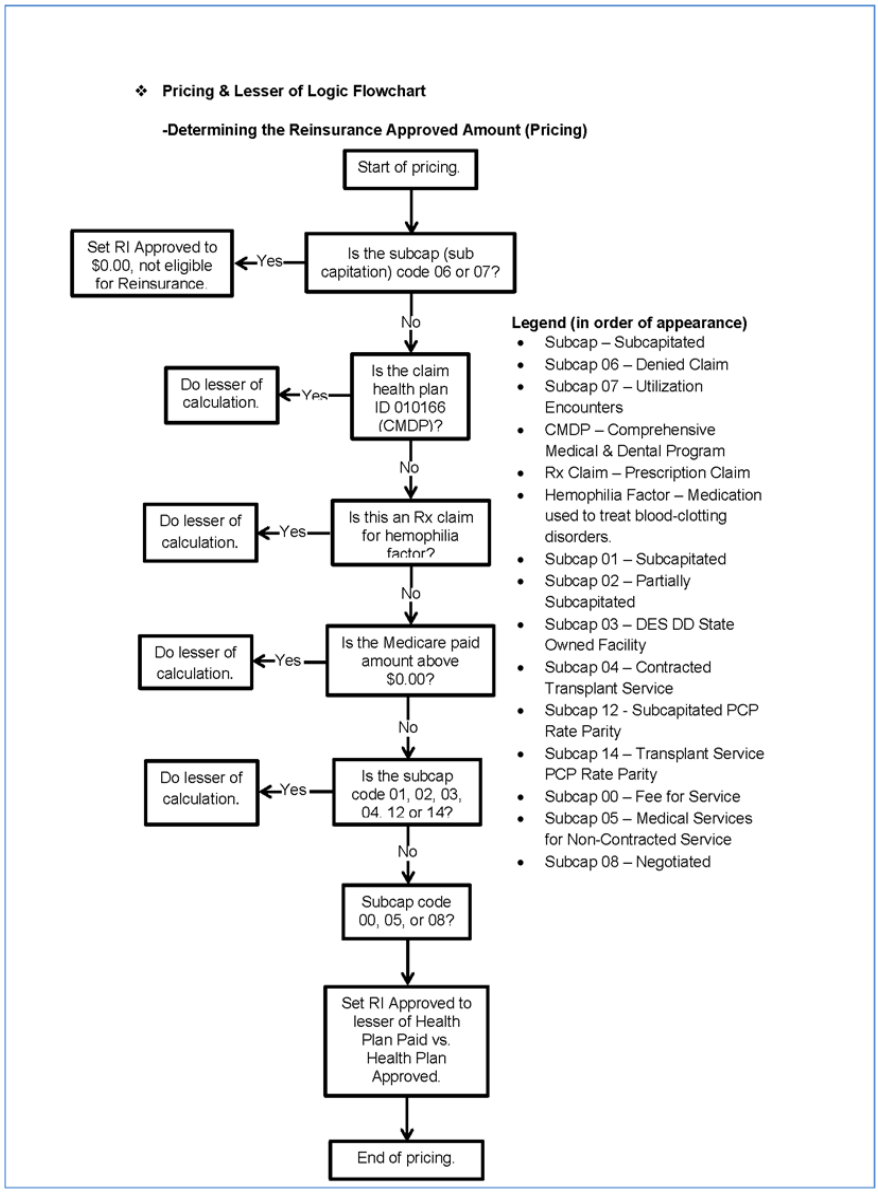
RI91L100 - Reinsurance Case Initiation Report

This report is a summary of Case information created during the previous month’s Reinsurance Case creation cycle including Encounter information for those Encounters associated to the Cases created in the reporting period.

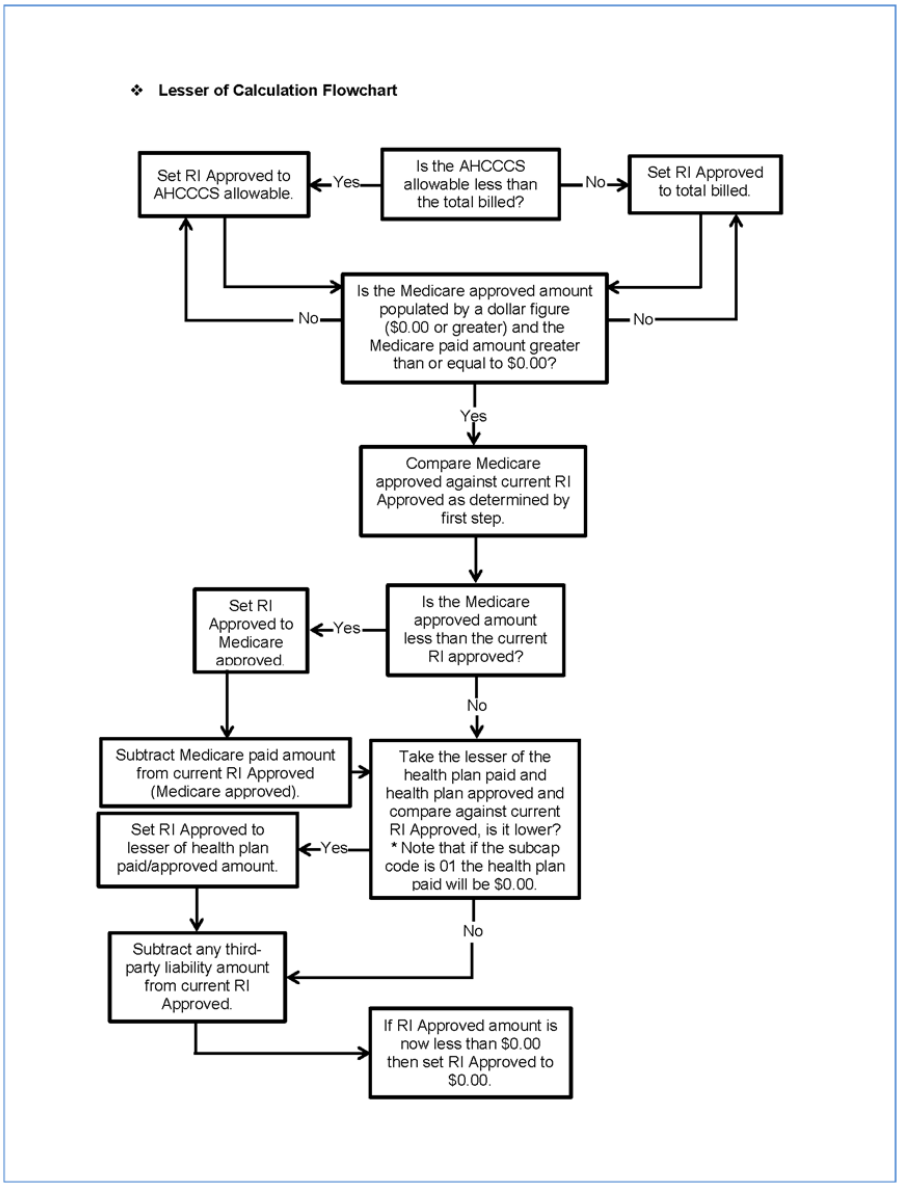
RI91L315 - Reinsurance Case Reconciliation Report

This report is a summary of Case information with a detailed listing of Encounters that potentially apply to an active Reinsurance Case but have not been associated to the Case due to pend errors. Also included are those Encounters in the edit/audit process to enable reconciliation of the Encounter records with the Reinsurance records.

PRICING & LESSER OF LOGIC FLOWCHART



LESSER OF CALCULATION FLOWCHART



DISCOUNT DETERMINATION FLOWCHART