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101 MARKETING

REVISION DATE: 04/29/2020

EFFECTIVE DATE: October 1, 2019

REFERENCES: Section F3, Contractor Chart of Deliverables; ACOM Policy 101 Attachment A Marketing Attestation Statement; ACOM Policy101 Attachment B, Marketing Activities Report; A.A.C. R9-22-501 et seq, A.A.C. R9-28-501 et seq, A.A.C. R9-31-501 et seq, 9 A.A.C. 34; 42 CFR 438.10(a), 42 CFR 438.104, 45 CFR 155.20

DELIVERABLES: Marketing Activities Report; Marketing Attestation Statement; Marketing Materials

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines and restrictions for an AdSS regarding marketing activities related to AHCCCS and the Division.

Definitions

A. Administrative Services Subcontract/Subcontractor - An 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 for only primary source verification (i.e. Credential Verification Organization),
3. Management Service Agreements,
4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,
5. DDD Subcontracted Health Plan.

A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor.

B. Dual Eligible Member - For the purposes of this policy, a member who is eligible for both Medicare and Medicaid.

C. Dual Marketing - Marketing efforts specifically targeting an AdSS enrollee who is eligible for Medicare and Medicaid.

D. Financial Sponsor - 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.

E. Health Message - 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.

F. Health Related - 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 must have a Health Message or a health care purpose to be considered health related.

G. Marketing - Any communication from the AdSS to a member not enrolled with the AdSS that can reasonably be interpreted as intended to influence the member to enroll with the AdSS, or to not enroll or disenroll with another Contractor's Medicaid product in 42 CFR 438.104. Marketing does not include communication to any Medicaid member about a Qualified Health Plan, as defined in 45 CFR 155.20.

H. Marketing Materials - Materials produced in any medium, by or on behalf of the AdSS that can reasonably be interpreted as intended for marketing purposes. This includes general audience materials such as general circulation brochures, AdSS web site and other materials that are designed, intended, or used to increase AdSS membership or establishing a brand.

I. Member – An eligible individual who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981. Also referred to as Title XIX/XXI Member or Medicaid Member.

J. Potential Member - A Medicaid-eligible recipient who is not yet enrolled with an AdSS; or a member during Annual Enrollment Choice (AEC).

K. Promotion - Any activity in which marketing materials are given away or displayed where the intent is to increase the AdSS's membership.

L. Social Networking Applications - Web-based services (excluding the AdSS's State mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services.

M. Subcontractor -

1. A provider of health care who agrees to furnish covered services to members.

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

3. 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

As required by 42 CFR 438.104, marketing materials may only be used if they are approved by the Division and comport to this policy. In addition to approval of advertising copy, approval of the publication in which the ad will be placed is also required.

The AdSS is responsible for ensuring its subcontractors comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in penalties to the AdSS.

Marketing Materials, Giveaways, Events, Sponsorships, Press Releases and AdSS and Division Logo and Name Use

A. Materials and Giveaways

Member materials that have been previously approved as member information under AdSS Operations Policy Manual, Policy 404 may be used during marketing activities only if they comply with the requirements of this policy.

The AdSS must submit a description and image of marketing materials and marketing items (giveaways) for approval to the Division as required under this policy and as specified in Contract. If approved, the materials and giveaways may be distributed by the AdSS for a period of two years from the date of approval. Any changes or amendments to previously approved materials must also be submitted in advance to the Division for approval. In addition to marketing materials and giveaways, the AdSS must submit templates for flyers or posters that advertise regular meetings or events where only the dates and times of the events change. If approved, these templates may be distributed by the AdSS for a period of two years from the date of approval.

The AdSS may distribute health educational materials without prior Division approval. The materials must be health-related and developed based on information from a recognized organization. For a list of approved recognized organizations see ACOM Policy 404, Attachment A. If these materials include AdSS specific information related to the Division Integrated Contract (e.g. enrollment, network or information on services) the materials are considered marketing materials and must be submitted for approval.

The AdSS must ensure that:

1. The value of any marketing item (giveaway) to the general public by the AdSS must not exceed $15.00.

2. Giveaway items are health related (e.g. toothbrush, dental floss) or if non-health related (e.g. cups, key chains, buttons, t-shirts), include a health message on the item (e.g. Don't Smoke, Get Your Flu Shot).

3. All marketing materials identify the AdSS as a Division provider and are consistent with the requirements for information to members described in the contract and in Division policies.

4. All marketing materials that have been produced by the AdSS and refer to contract services must specify: "Contract services are funded in part under contract with the State of Arizona Department of Economic Security/Division of Developmental Disabilities".

5. Marketing materials that are distributed by the AdSS must be distributed statewide. Exclusion of any particular group or class of members would be considered to be a discriminatory marketing practice and subject to contract action.

6. The AdSS does not market directly to members eligible for the Division.

7. The AdSS does 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. This prohibition covers all situations, whether sponsored by the AdSS, their parent company, or any other entity.

B. Events

The AdSS may participate in health-related marketing events that are listed in Figure 1 in the "Pre-Approved" column. However, all events that are listed in this "Pre-Approved" column must either be health related or have a health education component (e.g., celebration events.). If the event is not listed as a "Pre-Approved" event, the AdSS must submit a request as specified in contract for prior approval. The submission must include the event name and date with the location and address. The AdSS's participation in events must be substantive; an unmanned booth with handouts is not acceptable. The AdSS is not required to obtain approval from the Division to attend pre-approved events listed in Figure 1 of this policy, with the following exceptions:

1. AdSS pays sponsorship fees,

2. AdSS donates benefits or items (e.g. raffle items, gift baskets, cash), and/or

3. AdSS distributes materials not previously approved by the Division within the last two years.

4. The AdSS may not attend events that are listed in the "Not-Approved" column in Figure 1 of this policy, or any event determined by the Division to not be in the best interest of the State of Arizona.

5. If the AdSS is not certain if an event would qualify as "Pre-Approved," the AdSS must submit a request for approval to the Division prior to the event. The request must include the Name and date of the Event, the location and the address.

***Example**:*

Roosevelt Shot Clinic (Name of Event)
Phoenix Ranch Market (Location) 1602 E
Roosevelt St (Address) Phoenix, AZ
85006

9AM-1PM (Start and End Time) Flu
Shots (Service)

We will distribute the following:
Toothbrush Approved 12/10/17

We will be handing out the toothbrush kits as the Roosevelt Clinic has been stressing dental hygiene this month. (Health related purpose)

Figure 1 – Pre-Approved and Not Approved Events

PRE-APPROVED HEALTH RELATED EVENTS	NOT-APPROVED
Back to School Events	Events that are not health related or do not have a health education component
College/University Events	
DES Health and/or Resource Events – if open to all AHCCCS plans	DES offices (except those listed on the approval list)
WIC Health and/or Resource Events – if open to all AHCCCS plans	WIC Offices (except those listed on the approval list)
Events where health education is a component (e.g. Celebration events – Angeles Del Barrio, etc.)	Job Fairs
Community Center/Recreational Events (e.g. Golden Gate, Boys and Girls Club, YMCA, parks and senior center)	County/State Fairs
Community/Family Resource Events (e.g. Food banks, food distribution locations, homeless and/or women's shelters)	Bi-national Health Events (e.g. Mexican consulate on their premises)
Provider Events (e.g. Doctors, hospitals, and/or specialist) that the AdSS is contracted	Political Events
Faith Based Events	Pharmacy Events not open to all Contractors
Farmers Market Events	
Health Educational Forum (community sponsored) (e.g. Nutritional, health benefits, and prevention topics)	Swap Meets
Safety Events (e.g. Sun safety, water safety, and fire safety)	AdSS Event that is created and sponsored by the AdSS or through its affiliates for Division's members not enrolled with the AdSS, or for the general public
Immunization Clinics	
Senior Events	
Shopping Mall Events	
AdSS Event that is created and sponsored by the AdSS for its own members only	

C. Sponsorships

The AdSS may participate as a financial sponsor of health-related marketing events that are listed in Figure 1 of this policy in the "Pre-Approved" column. In addition to the information required to be submitted for events, the request must include the dollar amount of the participation (the dollar amount should be broken down and listed individually by each line of business, as applicable), and either a copy or description of any materials (including websites) on which the AdSS's name or logo will appear prior to production.

D. Press Releases

The AdSS may issue press releases or announcements about program innovations and events that promote the goals of the Division. Press releases that do not include AdSS-specific information related to the Division Integrated Contract (e.g. benefits, how to enroll, provider network) do not require prior Division approval. All other press releases must be submitted to the Division for prior approval.

E. Contractor Logos and Name Inclusion

The AdSS is responsible for preventing misuse of their name and logo. Upon receiving Division approval for an event, the AdSS's logo can be included on event flyers or websites that are produced by hosting organizations without prior approval. The use of the AdSS's name or logo is prohibited for television advertising of the event. If the AdSS is a financial sponsor for the event, the event flyers or websites will require prior approval by the Division.

Restrictions

The following restrictions apply to all marketing activities (42 CFR 438.104).

A. The following must ***not*** be allowed:
   1. Solicitation of any individual, whether directly or indirectly, (e.g., face-to-face, door-to-door, over the telephone, via email or text, or other cold-call marketing activities),
   2. References to a competing AdSS,
   3. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance,
      a. For the purposes of this policy, Qualified Health Plans are not considered private insurance, and
      b. The AdSS may discuss its affiliated Qualified Health Plan in promotional materials; however, the AdSS is a separate legal entity from all other affiliated health plans and is therefore subject to restrictions on the use of Protected Health Information (PHI).
   4. Television advertising,
   5. Direct mail advertising,
   6. Social Networking Applications (see AdSS Policy Manual, Policy 425 for requirements regarding social networking),
   7. Marketing of non-mandated services,

8. Utilization of the word "free" in reference to covered services,
9. Listing of providers in marketing materials who do not have signed contracts with the AdSS,
10. Use of the Arizona Department of Economic Security, Division of Developmental Disabilities logo or AHCCCS logo,
11. Inaccurate, misleading, confusing or negative information about the Division or the AdSS; and any information that may defraud members or the public,
12. 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.
13. AdSSs providing services where its enrollment is capped to prohibit members from selecting the AdSS may not engage in marketing activities but may engage in outreach and retention activities with its current members.
14. Marketing materials cannot contain any assertion or statement (whether written or oral) that the member must enroll with the AdSS to obtain benefits or to not lose benefits, and,
15. Marketing materials cannot contain any assertion or statement (whether written or oral) that the AdSS is endorsed by CMS, the Federal or state government, or a similar entity.

B. Any activities, materials, or mediums in violation of this policy are subject to administrative actions, regardless of previous approval or terms of privately held contractual agreements.

C. The Division reserves the right to impose additional restrictions.

Dual Eligible Marketing

Dual Marketing focuses on enrollment in the AdSS's Medicare Dual Special Needs Plan (D-SNP). The state understands that the Medicare D-SNP is able to enroll any dual eligible member, but to increase alignment, encourages the AdSS to only market to individuals enrolled in its ALTCS plan. Marketing to dual eligible AdSS enrollees may include print advertisements, radio advertisements, billboards, bus advertising, and television.

A. In the case of marketing materials for dual eligible enrollees the process will be as follows:

The Division does not review for approval dual marketing materials that have been approved by CMS and/or that do not include reference to Division benefits and/or service information. However, all dual marketing materials that have not been approved by CMS and/or include reference to Division benefits and/or service information require submission to the Division as specified in Section F3, Contractor Chart of Deliverables. While the Division may accept CMS approval of dual marketing materials as sufficient for distribution of materials, the Division retains and reserves the right to review before or after the fact, materials that have received CMS approval.

B. The AdSS must adhere to the following regarding use of billboards that use the terms 'Medicaid' or 'AHCCCS':

1. Limited to two in each urban county (Maricopa and Pima), and

2. Limited to one in each rural county.

AdSS Responsibilities

A. The AdSS is required to 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.

B. The AdSS must review and revise all materials on a regular basis in order to reflect current practices. Any changes or amendments to previously approved materials (e.g., prior leaflet approved, but subsequently modified) must also be submitted in advance to the Division for approval as indicated above.

C. The AdSS CEO (or designee) must sign and submit to the Division, ACOM 101, Attachment A, Marketing Attestation Statement, as adopted by the Division and as specified in Section F3, Contractor Chart of Deliverables. The AdSS's Attestation Statement will address the compliance of its subcontracted health plans with the requirements of this policy.

D. The AdSS must submit a Marketing Activities Report of the previous month's marketing activities as specified in Section F3, Contractor Chart of Deliverables. This includes events in which the AdSS was a participant. Participation includes but is not limited to having a booth at the event, and/or having a presence at the event. The report must be submitted using the excel format in Attachment B, Marketing Activities Report of this policy. The DDD AdSS's Report will address marketing activities of its subcontracted health plans.

DDD Communications will review the AdSS's monthly submission to determine if the AdSS' participation in the events was in compliance with this policy. If the Division determines a violation has occurred, the AdSS may be subject to sanctions. Failure to disclose an event attended may also result in Administrative Action.

E. Submission Requirements

All marketing materials including, giveaways, event requests, sponsorships and press releases, and dual eligible marketing materials must be submitted as individual requests for approval at least 21 days prior to dissemination as specified in Contract. Section F3, Contractor Chart of Deliverables. Bulk submissions (i.e. submissions that include more than one event, sponsorship, press release etc.) are not permitted with the exception of giveaway items. Giveaway items shall be submitted for approval separately from any event or sponsorship submission and may consist of more than one giveaway. All submissions shall be complete and include all corresponding documents.

When a 21-day notice is not possible, the AdSS may request an expedited review. The AdSS must follow the submission requirements as noted above but also submit notification of the expedited request to the DDD Communications mailbox. The expedited notification must be clearly marked as expedited and also indicate the reason for the shortened timeframe.

Division approval will only apply to the form of communication or specific date described with the submission. Any substantial modifications of previously approved marketing materials must be resubmitted for approval.

Pursuant to 42 CFR 438.104, DDD Communications will consult with the Arizona State Medicaid Advisory Committee (SMAC) in reviewing submitted marketing materials.

The AdSS may request a reconsideration of any DDD Communications decision by submitting a written request for reconsideration to the DDD Communications Unit and following the submission requirements for marketing materials as specified in Contract. The AdSS may provide information in support of its request for reconsideration.

Administrative Action

Any violation of this policy may result in Administrative Action, including but not limited to, sanctions as specified in Division Operations Policy Manual, Policy 408.

103 FRAUD, WASTE AND ABUSE

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2903, 2918 and 2957; A.A.C. R9-22-702; 42 CFR 438.608, 42 CFR 455.2, 12-23, 100-106, and 436; State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act, Federal False Claims Act

DELIVERABLES: Attestation of Disclosure Information: Ownership and Control and Persons Convicted of a Crime; Change in Contractor Organizational Structure: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information; Corporate Compliance External Audit Plan; Corporate Compliance Plan; Corporate Compliance: Executive Audit Summary; Corporate Compliance: External Auditing Schedule; Corporate Compliance: External Auditing Schedule-Changes; Exclusions Identified Regarding Persons Convicted of a Crime; Recovered Overpayment; Report Alleged Fraud/Waste/Abuse of the AHCCCS Program

Purpose

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (The Division or DDD). The purpose of this policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste, and abuse, involving services funded by the Division. This policy also addresses additional responsibilities regarding compliance with broader program integrity, regulatory, and programmatic requirements.

Definitions

A. Abuse of the Program - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS 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 cost to the AHCCCS Program. 42 CFR 455.2.

B. Administrative Services Subcontract - An 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 for only primary source verification
3. Management Service Agreements
4. Service Level Agreements with any division or subsidiary of a corporate parent owner; providers are not AdSS.

C. Corporate Compliance Officer - The on-site management official designated by each AdSS to implement, oversee and administer the AdSS' compliance program. The Corporate Compliance Officer must be available to all of the AdSS's employees, and possess the authority to access and provide records, and make independent referrals to the AHCCCS Office of Inspector General (42 CFR 438.608).

D. Credible Allegation of Fraud - A credible allegation of fraud may be an allegation, which

has been verified by the State, from any source, including, but not limited to, the following:

1. Fraud hotline complaints

2. Claims data mining

3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis (42 CFR 455.2).

E. 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).

F. Managing Employee - 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 (42 CFR 455.101).

G. Provider - Any person or entity that furnishes Division-funded services.

H. Waste - Overutilization or inappropriate utilization of services. Misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Policy

A. 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 455.12-23 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.

1. 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.

2. 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.

3. 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, OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

4. If AHCCCS-OIG determines that a credible allegation of fraud exists, AHCCCS-OIG may suspend payments to providers pursuant to 42 CFR 455.23.

B. AdSS Responsibilities

The AdSS must:

1. Have in place internal controls, policies, and procedures, to prevent, detect, and report fraud, waste, and abuse activities to the Division.

2. Have a Corporate Compliance Program that complies with the AdSS's contract with the Division and with all state and federal laws. The program must be developed by a plan that includes:

   a. Program integrity goals and objectives

   b. Descriptions of internal and external controls employed by the AdSS

   c. The AdSS's corporate compliance activities

   d. The roles and responsibilities of the AdSS's staff, as they relate to the Corporate Compliance Program.

   The Division has adopted Attachment B of the AHCCCS Operations Manual, Policy 103. The AdSS can use the sample provided under Attachment B for guidance on how to present such compliance activities. The AdSS's written Corporate Compliance Plan must be submitted to the Division annually as specified in Section F3, Contractor Chart of Deliverables.

3. Have Corporate Compliance Plan that includes a program integrity audit/review program designed to identify fraud, waste, and abuse.

   This program must ensure that the AdSS tracks inadequate billing practices and identifies emerging trends in an effort to provide technical assistance to contracted providers and avoid future occurrences of problematic billing.

4. Provide the external auditing schedule and executive summary of all individual provider audits to the Division as specified in Section F3, Contractor Chart of Deliverables.

   a. The External Audit Plan shall include the following information using Attachment C:

      i. Provider Name,

      ii. AHCCCS ID #,

      iii. Location,

iv. Provider Type,

v. Audit Type,

vi. Planned Audit Date,

vii. Audit Look-Back Period

viii. Total number of In-Network Providers, and

ix. Number of Providers to be audited

b. The External Audit Plan shall include the following information using Attachment C:

i. Location,

ii. Agency Name/Provider,

iii. Date(s) of Audit,

iv. AHCCCS ID,

v. Provider Type,

vi. Audit Type, and

vii. New/Follow-up Audit.

c. The Executive Summary shall include at a minimum:

i. A summary statement regarding audits, trends, and any countermeasures implemented by the contractor,

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

iii. In the event that an audit was not timely completed, the Executive Summary shall include a reason why the audit was not completed and a date when the audit will be completed in the future, and

iv. Estimated dollar amount at risk.

5. Obtain and disclose the information regarding ownership and control, and disclosure of information on persons convicted of crimes in accordance with 42 CFR 455.100-106, 42 CFR 455.436, State Medicaid Director Letters 08-003 and 09-001, and the contractual provisions contained in the contract.

The AdSS must also obtain and disclose the same information regarding its subcontractors. The results of the Disclosure of Ownership and Control and the Disclosure of Information on Persons Convicted of Crimes must be held by the AdSS. The AdSS must disclose to the Division the identity of any person excluded from participation in federal healthcare programs.

6. Submit annually Attachment A in the AHCCCS Operations Manual, Chapter 103, Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime, as specified in Section F3, Contractor Chart of Deliverables, attesting that the information has been obtained and verified by the AdSS, or upon request, provide this information to the Division.

7. Comply with Section 6032 of the Deficit Reduction Act.

8. Ensure all employees, subcontracted providers, and members receive adequate training and ongoing education on all of the following aspects of the Federal False Claims Act provisions:

   a. The administrative remedies for false claims and statements

   b. Any state laws relating to civil or criminal penalties for false claims and statements

   c. The whistleblower protections under such laws.

9. Ensure adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees, contracted providers, and members to report fraud, waste, and abuse without fear of retaliation.

10. Ensure an internal reporting process that is well defined and made known to all employees.

11. Conduct research and proactively identify changes for program integrity that are relevant to their program, and periodically review and revise the fraud, waste, and abuse policies or guidance from the Division or AHCCCS to reflect such changes due to rules, regulations, or new initiatives.

12. Regularly attend and participate in Division work group meetings.

13. Respond promptly and no later than 30 days to requests for information from the Division.

14. Cooperate with the Division regarding any allegation of member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702.

15. Have a method of verifying with Division members that the Division members received the services billed by providers, to identify potential service/claim fraud. The AdSS must perform periodic audits through member contact and to report the results of these audits to the Division as described in this Manual, Policy 424.

16. Be in compliance with all state and federal laws and regulations related to fraud, waste, and abuse, even if not directly detailed in this policy.

C. Reporting Responsibilities

1. Fraud, Waste, and Abuse

   a. If an AdSS discovers, or is made aware, that an incident of alleged fraud,

waste, or abuse has occurred, the AdSS must immediately report the incident to AHCCCS-OIG within ten business days, by completing and submitting the reporting form available on the AHCCCS-OIG webpage under Report Suspected Fraud or Abuse of the Program. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.

b. If the AdSS identifies an incident that warrants self-disclosure, the incident must be reported within ten business days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.

c. Once the AdSS has referred a case of alleged fraud, waste, or abuse to AHCCCS-OIG, the AdSS must take no action to recoup or otherwise offset any suspected overpayments.

d. In the event AHCCCS-OIG feels it would be beneficial to seek additional and/or clarifying details regarding a referral from the AdSS, AHCCCS-OIG may first choose to request preliminary review work from the AdSS in order to expand the allegation and to obtain further documentation that will support an investigation by AHCCCS-OIG.

e. If AHCCCS-OIG chooses to seek additional and/or clarifying details regarding a referral from the AdSS, the AdSS will have 30 business days or more to provide the requested documentation, or provide an update as to the status of completing such request.

f. Once AHCCCS-OIG receives a referral, it will conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

g. AHCCCS-OIG will notify the AdSS when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation.

h. If it is determined by AHCCCS-OIG not to be a fraud, waste, or abuse case, AHCCCS-OIG will return the matter to the AdSS for disposition in accordance with any applicable laws and/or contracts.

i. The AdSS agrees that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste, or abuse. The AdSS assigns to AHCCCS the right to recoup any amounts overpaid to a provider as a result of fraud, waste, or abuse. If the AdSS receives anything of value that could be construed to represent the repayment of any amount expended due to fraud, waste or abuse, the AdSS must forward that recovery to AHCCCS-OIG within 30 days of its receipt. The AdSS relinquishes any and all claims to any monies, received by AHCCCS as a result of any program integrity efforts, that include, but are not limited to:

    i. Civil monetary penalties and/or assessments

    ii. Civil settlements and/or judgments

iii. Criminal restitution.

j. The AdSS must also report to AHCCCS, as specified in Contract, Division Medical Policy 950, any credentialing denials including, but not limited to:

i. Those which are the result of licensure issues

ii. Quality of care concerns

iii. Excluded providers

iv. Alleged fraud, waste, or abuse.

D. The Division's Corporate Compliance Responsibilities Related to Fraud, Waste, and Abuse

1. Conduct pre-fact findings of viable allegations of member and provider fraud.

2. Oversee, monitor, and be the focal point for, the Division's compliance program, with the authority to review all documents and functions as they relate to fraud, waste and abuse prevention, detection and reporting.

3. Maintain and monitor a tracking system of fraud, waste, and abuse investigations.

4. Ensure all employees, AdSS, providers, and members receive adequate training and information regarding fraud, waste and abuse prevention, identification and reporting. Assure employees, AdSS, providers, and members that they can report fraud, waste, and abuse without fear of retaliation.

5. Take contract action to include, but not be limited to, enrollment suspense of provider payments when there is a credible allegation of fraud.

6. Develop and maintain open channels of communication with AdSS to combat fraud, waste, and abuse at all levels in the system.

7. Develop and maintain open channels of communication with AHCCCS OIG in the prevention and detection of fraud, waste, and abuse.

8. Refer to AHCCCS OIG cases of potential member billing in violation of A.R.S. § 36-2903.01(L) and A.A.C. R9-22-702.

9. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of AdSS and providers to ensure their compliance.

10. Ensure the Division is in compliance with its federal obligations regarding 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.

104 CONTINUITY OF OPERATIONS AND RECOVERY PLAN

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.207 and 42 CFR 438.208; Business Continuity and Recovery Plan Checklist (ACOM 104-Attachment A); Contract Section F, Deliverables

DELIVERABLES: Continuity of Operations and Recovery Plan Summary

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division requires in the contract that each of its AdSS have a Continuity of Operations and Recovery Plan to ensure restoration of business operations following unexpected events, or the threat of such events, which impact their ability to adequately serve members. The purpose of this policy is to outline the required components of the Continuity and Recovery Plan. Refer to the Resources section of this policy for more information in developing an emergency management plan.

Definitions

A. Administrative Services Subcontracts - 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. Credentialing, including those for only primary source verification
3. Management Service Agreements
4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

B. Continuity of Operations Programs (COOP) - An effort within the individual executive departments and agencies to ensure that essential functions continue to be performed during a wide range of emergencies.

The Division is mandated to provide health care benefits to its AHCCCS-eligible members. In order to provide benefits, the AdSS must be able to recover from any disruption in services as quickly as possible. This recovery can be accomplished by the development of a Business Continuity and Recovery Plan that contains strategies for recovery. The Continuity and Recovery Plan is part of the Federal Government's Continuity of Operations Programs (COOP) requirements.

AdSS Responsibilities

The AdSS must develop, maintain, and update annually a Continuity and Recovery Plan that assures the Division that the provision of covered services will occur as stated in the contract (42 CFR 438.207 and 42 CFR 438.208). As specified in contract Section F, Deliverables, a comprehensive summary of the AdSS's Continuity and Recovery Plan must be evaluated, updated, and submitted with a Continuity and Recovery Plan Checklist (AHCCCS Contractor Operations Manual Policy 104-Attachment A). The summary must be no longer than five pages and must address all Continuity and Recovery Plan requirements outlined below.

Continuity and Recovery Plan Requirements

A. The Continuity and Recovery Plan (Plan) must be reviewed and tested at least annually to manage unexpected events that may negatively and significantly impact the ability to deliver services to members and must be updated as needed by the AdSS.

B. The AdSS must ensure that all staff are trained and familiar with the Plan, and understand their respective roles.

C. The Plan must be specific to the AdSS's operations in Arizona and reference local resources. Generic plans that do not reference operations in Arizona and the AdSS's relationship to the Division are not acceptable.

D. The Plan must contain a listing of key customer priorities and key factors that could cause disruption and timelines for when the AdSS will be able to resume critical customer services when a disruption occurs.

E. These priorities include but are not limited to:

1. Providers receipt of prior authorization approvals and denials
2. Members receiving transportation
3. Timely claims payments.

F. The AdSS must also include any additional priorities as identified by the AdSS to be critical key priorities or factors.

G. The Plan must contain specific timelines for resumption of services as well as the percentage of recovery at certain hours, and the key actions required meeting those timelines.

Example: Telephone service restored to prior authorization unit within four hours, to Member Services within 24 hours, to all phones in 24 hours.

H. The Plan must contain, at a minimum, planning and training for:

1. Electronic/telephonic failure
2. Complete loss of use of the main site and any satellite offices in and out of State
3. Loss of primary computer system/records
4. Extreme weather conditions
5. How the AdSS will communicate with the Division during a business disruption (the name and phone number of a specific contact in the Division of Health Care Management is preferred)

   The Plan must direct the AdSS staff to contact the Division at 602-542-0419 in the event of a disruption outside of normal business hours.

6. Periodic testing, at least annually. Results of the test must be documented.

I. The AdSS must designate a staff person as Continuity Planning Coordinator and furnish the Division with contact information as part of the Plan.

J. The AdSS must require its subcontractors to develop and maintain a Continuity and Recovery Plan.

Resources

The Federal Emergency Management Agency (FEMA) website contains more information on continuity planning, including checklists for reviewing a Plan. The Division encourages the AdSS to use relevant parts of these checklists in the evaluation and testing of its own

Continuity Plan. The AdSS can also reference the Ready.gov website for supplementary information.

106 CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE-AHCCCS MEMBERS

EFFECTIVE DATE: October 1, 2019
REFERENCES: Social Security Act §1876

This Policy applies to the Division's Administrative Services Subcontractors (AdSS) pursuing and becoming Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan) serving dual eligible Medicaid and Medicare members. This Policy outlines the steps necessary to gain Medicare Advantage state certification by AHCCCS and the ongoing requirements to stay certified.

State certification is required as part of the CMS Medicare Advantage application. Under Arizona state law, certification of an AdSS serving persons who are eligible for Medicaid, including persons eligible for both Medicare and Medicaid (dual eligible members), can be completed by AHCCCS or through state licensure by the Arizona Department of Insurance (DOI).

AdSS serving dual eligible members can choose to be licensed by DOI, rather than certified by AHCCCS, if desired. However, if an AdSS does serve more than dually eligible Medicare and Medicaid members under its Medicare Plan, the AdSS must obtain certification by DOI and not AHCCCS. For current AdSS who have a MA Plan that serves members enrolled in the Arizona Long Term Care System Developmentally Disabled program, certification can be extended to include this population.

AHCCCS will only provide certification to AdSS if they are currently a Medicaid Contractor. . However, due to the timing of the MA Plan application process, AHCCCS may provide a conditional certification that would allow an AdSS to start the process of becoming an MA Plan during the Division bid process for a new contracting cycle. The certification would be conditional upon being awarded a contract for the new contracting period. Likewise, conditional approval will be made final if the Offeror is awarded a contract.

Definitions

A. Dual Eligible Member (for Purposes of this Policy) - A member enrolled with a Division's AdSS for Medicaid services who is also a Medicare beneficiary. These persons are considered full *dual* eligible members. A full dual eligible member does not include persons who are members of the Medicare Cost Sharing populations: Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).

B. Equity per Member - Net assets that are not designated or restricted for specific purposes divided by the number of Medicare Advantage Dual Eligible Members. Refer to the AdSS Operations Manual Policy 305 for further clarification.

C. Medicare Advantage Plan - An organization that provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.

D. Medicare Advantage- Prescription Drug/Special Needs Plan (MA-PD/SNP) - An organization that provides the full Medicare benefit, including prescription drugs, to a very specific group of Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act. Specific groups served may include members eligible for Medicare and Medicaid (dual eligibles) and/or members residing in nursing facilities.

E. Performance Bond - In general, a performance bond is an instrument that provides a financial guarantee in an amount of one month's capitation or an established amount per enrolled member.

AdSS Responsibilities

AdSS pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Request form to the AHCCCS Division of Health Care Management (DHCM), Medicare Administrator, at least 30 days prior to the date the certification must be sent to the Center for Medicare and Medicaid Services (CMS). The State Certification Request form can be obtained from the Medicare Advantage application on the CMS website at www.cms.gov.

In addition to the State Certification Request, AdSS must submit the following in narrative form:

A. Timing of start-up

B. Description of service area

C. Projected enrollment at start up and at the end of year one.

D. Projected amount and description of how equity per member requirements will be met initially and ongoing

E. Projected amount, and description of how performance bond requirements will be met initially and ongoing (refer to AdSS Operations Manual Policy 305 for performance bond requirements)

F. Statement of understanding regarding ongoing monitoring and reporting.

AHCCCS Process

A. Within two weeks of receipt of the State Certification Request, DHCM will notify the plan of the specific financial viability requirements and/or determine if additional information is necessary to approve the request.

B. Prior to the approval, DHCM will verify that the plan will be able to comply with the requirements by obtaining a specific plan of action addressing how the standards will be met.

C. Upon review and acceptance of the plan of action noted in B above, DHCM will forward a recommendation and the Certification Request to the AHCCCS Office of the Director for final signature and then back to the Contractor to be sent to CMS to continue the application process.

Financial Viability Standards and Reporting

To receive certification, the AdSS must be in compliance with current financial viability, claims, and administrative standards per the Division contract.

A. Performance Bond - The Division requires that the AdSS obtain and maintain a performance bond specifically for the purpose of the MA Plan in accordance with AdSS Operations Manual Policy 305.

B. Equity per Member - The Division requires that the AdSS maintain equity per MA Dual Eligible Member in accordance with AdSS Operations Manual Policy 305.

C. Ongoing Monitoring - The AdSS must self-monitor their compliance with the equity per member and performance bond requirements and to report to the Division when approaching non-compliance along with a corrective action plan. The Division reserves the right to investigate issues brought to the agency's attention related to the MA Plan.

D. Financial Reporting - The AdSS will be required to submit quarterly financial statements and an annual audit report and supplemental financial schedules reporting on the MA Plan line of business separately.

The AdSS must report financial data to the Division using the appropriate Division Financial Reporting Guide for the line of business to which the MA Plan is related.

108 AHCCCS SECURITY RULE COMPLIANCE

EFFECTIVE DATE: October 1, 2019

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

DELIVERABLES: AHCCCS Security Rule Compliance Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

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; or
- 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 employer; and
- Regarding a person who has been deceased more than 50 years.

G. 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. 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 to meet the general security standards.

Data Security Audit

The AdSS 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 AdSS must have a security audit performed by an independent third party annually. If an AdSS 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. AdSS policies and procedures to verify that appropriate security requirements have been adequately incorporated into the AdSS's business practices, and the production processing systems. The AdSS'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 AdSS must submit the AHCCCS Security Rule Compliance Report to the Division annually as described in Section F3, Contractor Chart of Deliverables. 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 AdSS'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. 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."*

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. Risk Management

   The required implementation specification at 45 CFR 164.308(a)(1)(ii)(B), for 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)]."* 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

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes processes and AdSS requirements 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 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 date of admission through discharge, but not including the date of discharge unless the member expires.

General

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

AdSS Requirements

A. Members remain enrolled and eligible for all medically necessary services during the entire IMD Stay whether or not the stay exceeds 15 cumulative days during a calendar month. The AdSS is responsible for payment of these services.

B. For any IMD stay which 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 AdSS responsible for behavioral health services must complete and submit *ACOM 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 AdSS resulting in an adjustment to the Capitation.

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

F. The AdSS must maintain a network of providers adequate to provide members with adequate access to behavioral health services and to ensure the member is receiving 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 AdSS'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. If two different AdSSs are responsible for physical health services and behavioral health services for the member, AHCCCS must recoup the entire monthly capitation payment from both AdSSs.

D. The capitation recoupment will occur whether or not the AdSS pays the IMD.

E. This recoupment applies whether or not the member is dual eligible or the member has third party insurance coverage.

F. The AdSS 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 AdSS(s) 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 who is 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 AdSS 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 days of the IMD Stay when the member is 65 must not be counted against the limit.

The AdSS 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, the Division will make a capitation payment to the AdSS(s) 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

EFFECTIVE DATE: October 1, 2019

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). This Policy outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

For Fee-For Service (FFS) members who are receiving part of their services through an AdSS, the Division will facilitate mental health parity requirements.

Definitions

A. 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).

B. 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.

C. Benefit Package - A benefit package includes all benefits provided to a specific population group or targeted residents (e.g. individuals determined to have a serious mental illness) regardless of the Health Care Delivery System.

D. 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.

E. 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 AdSSs or via fee-for-service arrangements).

F. Medical/Surgical Benefits - 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.

G. 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.

H. 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.

I. 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 nonquantitative 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

If the AdSS is responsible for the delivery of all MH/SUD and M/S services in a benefit package, the AdSS is responsible for performing the initial and ongoing parity analyses. If some MH/SUD or M/S benefits are provided to members through another Health Care Delivery System, the Division is responsible for completing the parity analysis. The Division is responsible for ensuring compliance for all AdSSs.

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

2. The parity analysis must be conducted and assessed annually for each Health Care Delivery System administering a benefit package.

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 a specific population;

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

c. A benefit package may be provided using one or more Health Care Delivery Systems.

C. Standard Parity Requirements

1. Benefit Packages

Benefit packages and Health Care Delivery Systems are defined as Title XIX adults and children; Title XXI adults and children; Title XIX SMI adults; Title XXI SMI adults; Title XIX DDD children and adults; EPD Title XIX adults and children; Medicare cost sharing; and members that are American Indians. Title XIX and XXI members up to the age of 21 are designated as children.

The AdSS must adhere to all applicable established benefit packages and service Health Care Delivery Systems when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

In addition to the established benefit packages and identified populations, the Division identified the following additional special populations applicable to the analysis that necessitated separate benefit packages:

a. Transitional Medical Assistance,

b. AHCCCS for Families with Children (1931),

c. Young Adult Transitional Insurance (YATI),

d. State Adoption Assistance for Special Needs Children who are being adopted,

e. Supplemental Security Income (SSI),

f. SSI Medical Assistance Only (SSI MAO), and

g. Freedom to Work (FTW).

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. Sub-chapter 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. 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.

AdSSs must utilize the Division's 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, AdSS must apply 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. AdSSs must apply the established benefit mapping when conducting the parity analysis. Refer to AHCCCS Contractor Operations Manual (ACOM), Chapter 100, Policy 110, Attachment A for the benefit mapping for year 2016-2017. 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 (ED) 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).

AdSSs must apply 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, AdSSs must conduct limit testing as part of the initial parity analysis and must 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 MH 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. Financial requirements include copays, coinsurance, deductibles, out of pocket maximums (does not include aggregate lifetime or annual dollar limits),

      i. The AdSS must ensure that cumulative financial requirements (i.e. deductibles) do not accumulate separately for MH/SUD benefits.

      ii. Individuals eligible for AHCCCS may be charged nominal copays, unless they are receiving a covered service that is exempt from copays or the individual is in a group that cannot be charged copays. Nominal copays are also referred to as optional copays. If a member has a nominal copay, then a provider cannot deny the service if the member states that the member is unable to pay the copay. There are specific populations that are exempt from any nominal copayments,

      iii. During the initial MH parity analysis ((Contract Year (CY) 2017)) and presently ((Fiscal Year (FY) 2019)), the Division requires all outpatient office visits in all benefit packages to have a copayment, with the exception of members and services exempted from copayments. Because all outpatient office visits

have a copayment, the Division concluded without testing that these are the respective predominant limits. Similarly, for prescription drugs, a copayment applies to all prescription drugs for both M/S and MH/SUD conditions. This is considered the predominant limit, and

iv. The AdSS must adhere to ACOM Policy 431 regarding copayment requirements, including the populations subject to a copayment, the amount of the copayment, populations and services exempt from copayments, as well as the out-of-pocket maximum.

c. 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 AdSS must 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 occupational therapy services in the outpatient classification are permissible under the parity requirements.

d. 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. AdSSs must not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the AdSS 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 AdSS must 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 and AdSS Specific Requirements

1. AdSSs responsible for administering a fully integrated contract must perform a parity analysis anytime a benefit package, utilization requirements, including both NTQL and QTL, Health Care Delivery System changes, or when there is a change in the AdSS' operations that may impact parity compliance. AdSSs that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package must perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis must be submitted to the Division as specified in Contract.

2. In the event of a contract modification, amendment, novation, or other legal act changes, limits, or impacts compliance with the mental health parity requirement, the AdSS must conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, 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 AdSS must certify compliance with parity requirements prior to the effective date of the contract changes.

3. The AdSS must report mental health parity deficiencies as specified in Contract and develop a corrective action plan to be in compliance within the same quarter as the submission.

4. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the AdSS' parity analysis.

5. The AdSS may utilize 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 AdSS must analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

6. If there have been no substantive changes to the AdSS's benefit package, utilization, or Health Care Delivery Systems, the AdSS must submit an annual attestation (Attachment B) and NQTL Summary (Attachment C) along with documentation supporting compliance with mental health parity certifying ongoing compliance with parity requirements as specified in Contract.

7. The AdSS must make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. AdSSs must also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

8. The AdSS may be required to participate with and respond to inquiries from AHCCCS or an AHCCCS contracted consultant regarding AdSS policies and procedures requiring review to determine compliance with mental health parity regulations.

201 MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-22-201 et seq, A.A.C. R9-22-702, R9-22-705, R9-28-201 et seq, A.A.C. R9-29-101, A.A.C. R9-29-301 et seq, A.A.C. R9-29-302, A.A.C. R9-29-303

DELIVERABLES: AHCCCS Notification to Waive Medicare Part D Co-Payments

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to:

- Define cost sharing responsibilities for members who are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan.
- Maximize cost avoidance efforts by the AdSS and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

Definitions

A. Cost Sharing - The AdSS's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

B. Dual Eligible Medicare Beneficiaries (Duals) – A member who is eligible for the Division and both Medicaid and Medicare services. There are two types of Dual Eligible members: Qualified Medicare Beneficiary (QMB) Duals and Non-QMB Duals (Full Benefit Dual Eligible [FBDE], Specified Low Income Medicare Beneficiary [SLMB], QMB)

C. Full Benefit Dual Eligible (FBDE) - An AHCCCS member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.

D. In-Network Provider - A provider that is contracted with the AdSS to provide services.

E. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and local and Regional Preferred Provider Organizations (RPPOs).

F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.

H. Medicare Part D - Medicare prescription drug coverage.

I. Non-Qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in A.A.C. R9-29-101.

J. Out of Network Provider - A provider that is neither contracted with nor authorized by the AdSS to provide services to its members.

K. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB Dual person receiving both Medicare and Medicaid services and cost sharing assistance.

L. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

M. For QMB Duals and Non-QMB Duals, the AdSS's cost sharing payment responsibilities are dependent upon whether:

1. Service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid.

2. Services are received in or out of network (the AdSS only has responsibility to make payments to AHCCCS-registered providers).

3. Services are emergency services.

4. AdSS refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. R9-29-301 et seq.

An exception to the AdSS's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the AdSS must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For AdSS responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division's Operations Manual, Policy 434.

QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their AHCCCS Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C. 9-22 or A.A.C. 9-28 from a registered provider is not liable for any Medicare copayment, coinsurance, or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

AdSS Payment Responsibilities

A. The AdSS is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this policy (see Division Medical Policy Manual Chapter 300). These services include:

1. Chiropractic services for adults
2. Outpatient occupational and speech therapy coverage for adults
3. Orthotic devices for adults
4. Cochlear implants for adults
5. Services by a podiatrist
6. Any services covered by or added to the Medicare program not covered by Medicaid.

B. The AdSS only has responsibility to make payments to AHCCCS-registered providers.

C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the AdSS's network or prior authorization has been obtained.

D. The AdSS must have no cost sharing obligation if the Medicare payment exceeds the AdSS's contracted rate for the services. The AdSS's liability for cost sharing plus the amount of Medicare's payment must not exceed the AdSS's contracted rate for the service. There is no cost sharing obligation if the AdSS has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the AdSS must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if the AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS-registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS

QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST PAY:** *(Subject to the limits outlined in this policy)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: **a.** The Medicare copay, coinsurance or deductible, **or** b. The difference between the AdSS's contracted rate and the Medicare paid amount.

Figure 1 – QMB DUAL Cost Sharing - Examples

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *Subject to the limits outlined in this policy*			
	EXAMPLE 1	**EXAMPLE 2**	**EXAMPLE 3**
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100
Medicaid rate for Medicare service (AdSS's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
AdSS PAYS	**$20**	**$10**	**$50**

Non-QMB DUALS

A Non-QMB Dual eligible member who receives covered services under A.A.C. R9-22-201 et seq or A.A.C. R9-28-201 et seq from a provider within the AdSS's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22-201 et seq. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

AdSS Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-201 et seq, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: Non-QMB Duals (In Network)

NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST NOT PAY:**
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	**THE AdSS MUST PAY:** *Subject to the limits outlined in this Policy*
Medicaid Only	The provider in accordance with the contract
Both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): **a.** The Medicare copay, coinsurance or deductible, **or** b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (AdSS's contracted rate).

AdSS Payment Responsibilites (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracting provider the following applies (Table 3):

Table 3: NON-QMB Duals (Out of Network)

NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE AdSS** *Subject to the limits outlined in this Policy*
Medicare Only	Has no responsibility for payment.
Medicaid only and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the AdSS **has** referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the AdSS **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the AdSS has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay the lesser of: **a.** The Medicare copay, coinsurance or deductible, **or** b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

Prior Authorization

The AdSS can require prior authorization. If the Medicare provider determines that a service is medically necessary, the AdSS is responsible for Medicare cost sharing if the member is a QMB Dual, even if the AdSS determines the service is not medically

necessary. If Medicare denies a service for lack of medical necessity, the AdSS must apply its own criteria to determine medical necessity. If criteria support medical necessity, the AdSS must cover the cost of the service for QMB Duals.

Part D Covered Drugs

For QMB and Non-QMB Duals, federal and state laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.

203 CLAIMS PROCESSING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2903.01.G, 36-2904.G; 42 CFR 438.242(a), 45 CFR 160.101 et seq., 162.100 et seq., and 164.102 et seq., Section F3 Contractor Chart of Deliverables
DELIVERABLES: Claims Dashboard

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It stipulates requirements for the adjudication and payment of claims. See Section F3, Contractor Chart of Deliverables.

Definitions

A. Administrative Services Subcontracts - An Administrative Services Subcontract is a contract that delegates any of the requirements of the Division's contract with AHCCCS, including, but not limited to:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification
3. Management Service Agreements
4. Service Level Agreements with any Division
5. Subsidiary of a corporate parent owner claims process.

B. Clean Claim – 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.

C. Subcontractor –

1. A provider of health care who agrees to furnish covered services to members
2. A person, agency or organization with which the Administrative Services Subcontractor (AdSS) has contracted or delegated some of its management/administrative functions or responsibilities
3. 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 the Division agreement.

Claims Processes and Systems

The AdSS must develop and maintain claims processes and systems that ensure the correct collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in information on areas including, but not limited to, service utilization, claim disputes, and appeals.

The AdSS must have a mechanism to inform providers of the place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

Receipt Date

The receipt date of the claim is the date of the date stamp on the claim or the date on which the claim is electronically received. The receipt date is the day on which the claim is received at the AdSS specified claim mailing address, received through direct electronic submission, or received by the AdSS designated clearinghouse.

Claim Submission Timeliness

A. Unless a contract specifies otherwise, the AdSS ensures that, for each form type, 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim. The AdSS must track and report the following monthly:

1. Percentage of clean claims that reach PAID status on a provider's first billing submission

   The AdSS will ensure that 95% of all clean claims reach PAID status on the provider's first billing submission. *The AdSS will highlight field and provide an explanation if this falls below contract performance minimum.*

2. Percentage of claims that are DENIED

   i. *The AdSS will highlight field and provide an explanation if the total percentage reported is above 20% OR*

   ii. *The AdSS will highlight field and provide an explanation if there is a 15% increase from the previous reporting month.*

   For example, if the previous month's percent claims denied was 10%, the AdSS must provide an explanation if the current month's percent is 11.5% or greater.

   Percentage of claims denied:

$$\frac{\text{Total number of claims denied in the month}}{\text{Total number of claims processed in the month}}$$

B. In addition, 95% of clean claims will be paid on first submission and less than 20% of second submission claims will be denied.

C. The AdSS must refer to ATTACHMENT B of the DDD Claims Dashboard Reporting Guide for additional information on reporting guidelines.

The AdSS must not pay:

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.

When any payor recoups a claim because the claim is the payment responsibility of another payor (responsible payor), the provider may file a claim for payment with the responsible payor. The provider must submit a clean claim to the responsible payor no later than the latest of the following dates:

A. 60 days from the date of the recoupment

B. 12 months from the date of service

C. 12 months from date that eligibility is posted.

The payor must not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

Discounts

The AdSS must apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the clean claim was received.

Interest Payments

The AdSS must pay interest on late payments and report the interest as required.

For hospital, clean claims, the AdSS must pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest must be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.

For authorized services submitted by a licensed skilled nursing facility, the AdSS must pay interest on payments made after 30 days of receipt of the clean claim. Interest is paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment.

For non-hospital clean claims the AdSS must pay interest on payments made after 45 days of receipt of the clean claim. Interest is paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

The AdSS must 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).

Electronic Processing and Remittance Advices

A. The AdSS must accept and generate required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission. Accepted electronic submissions include eligibility verifications, claims, claims status verifications, and prior authorization requests.

B. The AdSS must make claim payments via electronic funds transfer (EFT) and accept electronic claim attachments.

C. The AdSS must generate an electronic remittance that includes:

1. The reason(s) for denials and adjustments
2. A detailed explanation/description of all denials and adjustments
3. The amount billed
4. The amount paid
5. Application of Coordination of Benefits (COB) and copays
6. Providers rights for claim disputes
7. Instructions and timeframes for the submission of claim disputes and corrected claims.

D. The AdSS must send electronic remittance advice with the payment, unless the payment is made by EFT. The AdSS must either direct providers to the link where this information is explained or include a supplemental file where this information is explained. Any remittance advice related to an EFT is sent no later than the date of the EFT.

General Claims Processing

The AdSS must follow all general claims processing requirements as described below.

A. The AdSS must use nationally recognized methodologies to correctly pay claims; these methodologies include but are not limited to:

1. National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgery Centers, and Outpatient Services
2. Multiple Procedure/Surgical Reductions
3. Global Day E & M Bundling Standards.

B. The AdSS claims payment system must assess and apply data-related edits including but not limited to:

1. Benefit Package Variations

2. Timeliness Standards

3. Data Accuracy

4. Adherence to Division and AHCCCS policy

5. Provider Qualifications

6. Member Eligibility and Enrollment

7. Overutilization Standards.

C. If a claim dispute is overturned, in full or in part, the AdSS reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.

D. The AdSS claims payment system must not require a recoupment of a previously paid amount when the provider's claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made. The AdSS must ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.

E. The AdSS must adhere to the following:

1. COB and Third Party Liability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual

2. Claims processing requirements per contract and the Claims Dashboard Reporting Guide

3. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.

F. When the AdSS contractor cost avoids a claim, the following payment provisions apply:

1. Claims from providers CONTRACTED with the AdSS: Unless a subcontract with the provider specifies otherwise, the AdSS must pay the difference between the AdSS Contracted Rate and the Primary Insurance Paid amount, not to exceed the AdSS Contracted Rate.

2. Claims from providers NOT CONTRACTED with the AdSS: The AdSS must 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 Service.

Claims Processing By AdSS Contractors

A. The AdSS must obtain prior approval from the Division for subcontracts regarding claims processing to be performed by or under the direction of a subcontractor.

B. The AdSS remains responsible for the complete, accurate, and timely payment of

all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of administrative service arrangements.

C. The AdSS must forward all claims received to the subcontractor responsible for claims adjudicating.

D. The AdSS must require the subcontractor to submit a monthly claims aging summary to the AdSS to ensure compliance with claims payment timeliness standards.

E. The AdSS must monitor the subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.

1. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan.

2. The results of the performance review and the correction plan must be communicated to the Division upon completion.

F. The AdSS must monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.

205 GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT REQUIREMENTS FOR NON-CONTRACTED PROVIDERS

EFFECTIVE DATE: October 1, 2019

Purpose

This Policy applies to the Division of Developmental Disabilities Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide ground ambulance transportation reimbursement requirements. It is limited to AdSS and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Definitions

For purposes of this policy the following definitions apply:

A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS as either transportation by ground ambulance vehicle, that has medically necessary supplies and services, and the treatment includes 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 ALS procedure:

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

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

C. Basic Life Support (BLS) - 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 an individual who is qualified in accordance with State and local laws as described in 42 CFR 414.605.

D. Emergency Ambulance Services - Emergency ambulance services are as described in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

E. Emergency Ambulance Transportation - Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility.

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 AHCCCS 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 are used by the AdSS 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 are used by the AdSS.

Emergency Ground Ambulance Claims are Subject to Medical Review

Claims are submitted with documentation of medical necessity and a copy of the trip report evidencing:

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

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

C. Supplies

D. Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial. The AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS 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. To reimburse Ambulance services at the ALS level, all the following criteria must be satisfied**:**

   a. The Ambulance must 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.

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

B. Basic Life Support (BLS) level

1. To reimburse Ambulance services at the BLS level, all the following criteria must be satisfied:

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 AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS 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 AdSS. Medical necessity criteria are based on the medical condition of the member. Non-emergent transportation by an 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 AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the AdSS 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 AdSS 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.

305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155
DELIVERABLES: Performance Bond or Bond Substitute, ACOM 305 Attachment A

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this Policy is to establish standards to meet the performance bonding and equity per member requirements. These standards will continue to ensure an AdSS ability to meet its claims payment obligations, while addressing the individual differences among AdSS and enrollment growth.

Definitions

A. Equity - Net Assets that are not designated or restricted for specific purposes.

B. 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.

C. Surety Bond - An agreement between the Division, the AdSS, and the Surety where the surety provides a financial guarantee to the Division.

Policy

The Division requires the posting of a Performance Bond or Bond Substitute in addition to the initial minimum capitalization and equity per member requirements as described below. This is to guarantee payment of the AdSS obligations under the Contract including, but not limited obligations or payments to providers and non-contracting providers and any other entity that subcontracts for the performance of the AdSS obligations under this Contract whether related to coverage for services to members or for the administration of this Contract.

The Division will inform the AdSS of the required initial amount of the Performance Bond or Bond Substitute, as determined by the Division, prior to or at the beginning of each contract cycle. This requirement must be satisfied by the AdSS no later than 30 days after notification by the Division of the initial amount required.

After the initial performance bond or Bond Substitute is satisfied, the Division will evaluate each AdSS enrollment statistics and/or monthly capitation payments and determine if adjustments are necessary in accordance with this Policy.

Annually on October 1, the AdSS provides a written attestation, consistent with 42 C.F.R. 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful. See Attachment A.

Performance Bond Requirements and Bond Substitutes

A. The Performance Bond must be in a form acceptable to the Division as described in Section III B of this Policy. The AdSS must request an approval from the Division before a Bond Substitute is established.

B. The AdSS must not change the amount, duration, scope, or type of the performance bond of Bond Substitute without prior written approval from the Division's Finance unit.

C. The AdSS must not pledge any Bond Substitute as collateral or security for any other loan, debt, or obligation of the AdSS or pledge the Bond Substitute as security to creditors.

D. The Performance Bond or Bond Substitute maintains after the contract term until outstanding and contingent liabilities greater are less than $50,000, or 15 months following the termination date of the contract with the Division, whichever is later and will be in the amount and for the term determined by the Division.

E. Any security agreement must be disclosed.

F. An AdSS that fails to maintain or renew the Performance Bond or Bond Substitute as required by the Contract with the Division and as outlined in this Policy, is considered in material breach of the Contract with the Division.

G. Following a merger/acquisition of an AdSS or an AdSS parent company, the Division reserves the right to require additional Performance Bond assurances on behalf of the new entity, including, but not limited to, expanding the Performance Bond or Bond Substitute to include service dates prior to the merger/acquisition.

H. In the event of a default by the AdSS, the Division will, in addition to any other remedies it may have under the Contract, obtain payment under the Performance Bond or Bond Substitute to remedy the breach, including but not limited to one or more of the following purposes:

1. Paying any damages sustained by providers, and other subcontractors because of a breach of the AdSS obligations under this Contract.

2. Reimbursing the Division for any payments made by the Division on behalf of the AdSS.

3. Reimbursing the Division for any administrative expenses incurred because of a breach of the AdSS obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract. Terminations pursuant to Section E, Termination for Convenience, of the Contract do not require reimbursement to the Division for administrative expenses.

4. Reimbursing expenditures incurred by the Division in the direct operation of the AdSS under Section E.

5. Paying any sanctions imposed under Section D, to the extent the sanctions

are not offset against payments due from the Division to the AdSS as provided for under Section G2, Right of Offset of the Contract.

Performance Bonds and Types of Bond Substitute

A. Performance Bond

1. Establishment of Bond

a. The AdSS must send a copy of the completed Performance Bond form to the Division's Finance Department, 30 days prior to the execution of the bond agreement. The Division will review the agreement and advise the AdSS in writing of the acceptance of the Performance Bond form to be executed or that changes are necessary. The Division review will only be for the sufficiency of the agreement to meet the Division Performance Bond requirements section.

b. Performance Bond Form includes the following requirements

i. Issued by a Surety

ii. The Performance Bond must be in an amount that meets or exceeds the Performance Bond dollar requirement.

iii. The Performance Bond guarantees performance by the AdSS for all obligations, including post-award obligations that precede the beginning of the first contract year and "wind down" obligations that follow termination of the contract.

iv. The Performance Bond includes a statement that the Performance Bond cannot be changed in the amount, duration, or scope or discontinued without the written authorization of the Division Finance Department. Any changes in the Surety or the terms of the Performance Bond is approved in writing by the Division Finance Department at least 30 days prior to the anticipated change date.

v. The Performance Bond includes a contact person at the financial institution issuing the Performance Bond and a contact phone number.

2. After the Performance Bond Form is executed, the Division sends the original completed Performance Bond Form to the Division Finance Department signed, and notarized by the AdSS and the Surety.

3. The Division will hold the original Performance Bond Form in safe keeping until the agreement ends or is terminated by the parties.

4. The AdSS is not required to submit a separate Surety Bond to support the Performance Bond Form. If a supporting Surety Bond exists, to the extent the

terms of a Surety Bond conflict with the terms of the Performance Bond Form, the terms of the Performance Bond Form are controlling.

5. Return of Performance Bond Form original

The original Performance Bond Form will be returned to the originators upon:

a. The later of 15 months after the termination of the Contract or when the AdSS actual and contingent liabilities after the termination of the Contract are less than $50,000.

b. Satisfying the Performance Bond requirement with a Bond Substitute(s) as outlined and approved by the Division.

B. Types of Bond Substitutes

With the prior written approval of the Division Finance Department, the AdSS may provide one or more of the following Bond Substitutes in lieu of a Performance Bond:

Cash Deposits, Irrevocable Letter of Credit, Certificate of Deposit, and any other type of security agreed to by the Division.

C. Cash Deposit

1. Deposit of Funds

a. Any funds to be deposited with the State Treasurer must be sent to the Division in the form of a check or a wire transfer of funds to the State Treasurer. Reference *ACOM 305 Attachment A Instructions for Wire/ ACH Transfers of Funds to AHCCCS via Arizona State Treasurer*.

b. Additionally, a letter should be sent to the Division describing:

i. The application of funds

ii. A contact person at the AdSS and contact phone number, for any issues concerning the deposit, and a wire number if the funds were sent via a bank wire.

c. The Division will "claim" the funds by submitting a copy of the AdSS letter and a "Securities Safekeeping" form to the State Treasurer's Office. After the funds, have been claimed, the Division will send a confirmation that the funds were received and claimed.

2. Withdrawal of Funds

a. To withdraw principal funds, send a letter to the Division requesting the withdrawal. The letter must include:

i. The amount of the withdrawal

ii. The program from which the funds are being withdrawn

iii. The date that the funds should be withdrawn (allow a minimum of 10 working days)

iv. The manner the warrant from the State Treasurer's office is to be handled:

- Mailed by the US Postal Service
- Courier pick-up (please include a phone number of the primary contact so prompt notice can be given)
- Wiring instructions.

b. The Division will submit to the State Treasurer's Office a copy of the AdSS letter and a "Securities Safekeeping" form to release the funds. The Division will forward the warrant to the AdSS in the manner requested in the withdrawal letter.

D. Irrevocable Letter of Credit

1. Establishment of Irrevocable Letter of Credit

a. Before a Letter of Credit can be accepted in lieu of performance bond it must be approved by the Division for form and amount. Requirements include:

i. Be of standard commercial scope and issued by a bank, insured by the Federal Deposit Insurance Corporation, credit union insured by the National Credit Union Administration or savings and loans association insured by Federal Savings and Loan Insurance Corporation and authorized to do business in the State of Arizona.

ii. For an amount that meets or exceeds the Bond Substitute dollar requirement.

iii. Payable to the Division for the benefit of covered members, providers and certain third parties

iv. A statement that the Letter of Credit cannot be changed in the amount, duration, or scope, or discontinued without the written authorization from the Division.

b. The AdSS must send a copy of the Letter of Credit to the Division Finance Department to 30 working days prior to the execution of the Letter of Credit. The Division will review the Letter of Credit and advise the AdSS in writing whether it is accepted or that changes are necessary including but not limited to, expiration date and amount. The Division review will only be for issues that are necessary for the

Division Letter of Credit. It will not include review for any other matters.

c. After the agreement is executed, the AdSS must send the original to the Division. The original will be held in safe keeping until the agreement ends or is terminated by the parties.

d. The AdSS must send notification of a contact person at the financial institution issuing the letter of credit and contact phone number to the Division Finance Manager.

2. Return of the original Letter of Credit

The original Letter of Credit will be returned to the originators upon:

a. Termination of the Letter of Credit

b. Termination of the Division Contract

c. Satisfying the Performance Bond or Bond Substitute requirement with another acceptable form as outlined by the Division.

Certificate of Deposits

Certificates of Deposit are acceptable only by a bank, savings and loan, or credit union that is insured by the appropriate Federal institution.

A. Types of Certificate of Deposits

1. Only Certificates of Deposit from banks

2. Savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the performance bond.

B. Assignment to Arizona State Treasurer

C. All Certificates of Deposit must be assigned to the Arizona State Treasurer in compliance with A.R.S. §35-155. Division finance personnel completes this by submission of the "Assignment to Arizona State Treasurer" form.

D. Deposit of the Certificate of Deposit.

1. The AdSS must send or deliver the original Certificate of Deposit (or receipt for the Certificate of Deposit if a certificate is not issued) and the Assignment form to the Division. A letter should accompany the Certificate of Deposit describing the contract or line of business (e.g., Acute Care, DDD, CRS, ALTCS/EPD, or MA) the Certificate of Deposit is satisfying and a contact person.

2. After the Certificate of Deposit has been sent to the State Treasurer, the Division will send a copy of the State Treasurer's "Securities Safekeeping" form to the Treasurer to record the deposit of the

Certificate of Deposit.

3. After the Certificate of Deposit has been deposited with the State Treasurer, the AdSS must monitor the maturity date. No notification should be expected from the State Treasurer's office or the Division. Evidence of the renewal of each CD must be sent to the Division within five business days prior to the renewal date.

4. The AdSS must send notification of a contact person at the AdSS and contact phone number to the Division Finance Manager.

E. Withdrawal of a Certificate of Deposit

The AdSS must send a letter to the Division requesting the release of a specific Certificate of Deposit providing:

1. The name of the institution that issued the Certificate of Deposit

2. The certificate number

3. The amount of the Certificate of Deposit

4. The programs from which the Certificate of Deposit is being withdrawn

5. The manner the Certificate of Deposit is to be returned to the Plan

6. A contact person.

The Division submits to the State Treasurer's Office a copy of the AdSS letter and a "Securities Safekeeping" form to release the funds. The Division forwards the warrant to the AdSS in the manner requested in the withdrawal letter.

F. Any Other Type of Substitute Securities

1. The Division may accept a substitute security or securities in lieu of the surety bond or bond substitute forms discussed above. The AdSS must obtain prior approval from AHCCCS for any Substitute Securities.

   a. The AdSS agrees to perform all acts and execute any and all documents including, but not limited to, security agreements and necessary filings pursuant to the Arizona Uniform Commercial Code, necessary to grant the Division an enforceable security interest in such substitute security to secure performance of the AdSS obligations under the Contract.

   b. The AdSS is solely responsible for establishing the credit-worthiness of all forms of substitute security.

2. The Division may, after written notice to the AdSS, withdraw its permission for a substitute security or securities, in which case the AdSS must provide the Division with Performance Bond or an alternate form of Bond Substitute

discussed above.

Performance Bond and Bond Substitute Requirement for a Terminated AdSS

A. The Performance Bond or Bond Substitute amount must be maintained after the contract term in an amount sufficient to cover the Terminated AdSS outstanding and contingent liabilities greater than $50,000, or 15 months following the termination date of their contract, whichever is later, to guarantee payment of the AdSS obligations to providers, non-providers, and other subcontractors and performance by the AdSS of its obligations under the Contract with the Division.

B. The Performance Bond or Bond Substitute must be in a form acceptable to the Division.

C. Annually, on October 1, the AdSS must provide a written attestation, consistent with 42 C.F.R. ~~§§~~ 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful.

D. A terminated AdSS may request a reduction in the Performance Bond or Bond Substitute amount sufficient to cover all outstanding liabilities, including liabilities greater than $50,000, subject to the Divisions' approval. A Terminated Contractor AdSS may not change the amount, duration, scope, or type of the Performance Bond or Bond Substitute without prior written approval from the Division Finance. Any modification in the Performance Bond or Bond Substitute must be approved by the Division Finance at least 30 days before the revision of the Performance Bond or Bond Substitute has been executed.

Equity per Member Requirements

A. Formula

Unrestricted equity, less on-balance sheet performance bond or bond substitute, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted by the Division, divided by the number of members enrolled at the end of the period.

B. Requirement

CYE2020: At least $450 per member

CYE2021: At least $500 per member

CYE2022 and thereafter: At least $500 per member

C. Division Certified Medicare Advantage Plan Requirement:

$350 per member upon commencement of the plan.

Remediation When an AdSS Fails to Meet the Equity per Member Requirement

If an AdSS equity per member falls below the requirement, the Division will review the

causes for the lack of compliance. The Division may require the AdSS to comply with one or more of the following measures:

A. Capital infusion, within 30 days of non-compliance, in an amount sufficient to not only bring equity into compliance, but also to maintain compliance.

B. Submission of corrective action plan to increase equity

C. Monthly financial reporting, if not already required

D. Increase the amount of the Performance Bond or Bond Substitute

E. Sanctions and/or Enrollment Cap, if applicable.

If the AdSS fails to comply with the above requirements, the Division may apply sanctions as delineated in *AdSS Operations Manual, Policy 408*.

Restrictions on Equity

The following asset types will constitute restricted assets, and therefore will be subtracted from AdSS equity when calculating the equity per member ratio:

A. Assets recorded as "due from affiliates." The AdSS may request a waiver from the Division to include the prorated portion of the due from affiliates balance resulting from Division approved cash/bank account sweep arrangements.

B. Goodwill and adjustments to other assets resulting from a purchase, including those resulting from purchases and revaluations recorded in accordance with FASB Accounting Standards Codification Topic 105 - Generally Accepted Accounting Principles and FASB Accounting Standards Codification Topic 350 - Intangibles — Goodwill and Other

C. Guarantees of debt, pledges, and assignments.

D. On balance sheet Performance Bonds or Bond Substitute

E. Other assets determined to be restricted by the Division.

Requirements for AdSS with Restricted Equity

If AdSS equity is not supported by unrestricted cash or investments, and the AdSS does not meet the equity per member requirements, then the AdSS may be required to maintain a Performance Bond or Bond Substitute in an amount greater than 100% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

Fund Balance and Capitalization Requirements

If the AdSS equity becomes a fund deficit, the AdSS and its owners must fund the deficit through capital contributions in a form acceptable to the Division. The capital contributions must be for the period in which the deficit is reported and must occur within 30 days of the financial statement due to the Division. The Division at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. The Division may,

at its option, impose enrollment caps ~~and~~/or sanction the AdSS because of an accumulated deficit, even if unaudited.

Division Monitoring Responsibilities

A. The Division's Finance Unit monitors compliance with equity per member requirements on a quarterly basis. Analyses will be performed to determine the equity per member. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will be required to submit a plan to increase the equity and/or capitalization within 30 days.

B. The Division's Finance Unit monitors compliance with Performance Bond or Bond Substitute requirements on a monthly basis. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will have 30 days to comply with new requirements.

307 ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE-BASED PAYMENTS INCENTIVE

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 306, ACOM Policy 307, Attachments A and B

DELIVERABLES: Alternative Payment Model (APM) Strategies Certification (Final), Structured Payment File, and APM indicator; Alternative Payment Model APM Strategies Certification (Initial)

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this Alternative Payment Model (APM) Initiative is to encourage AdSS activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the AdSS and provider through APM strategies.

Definitions

A. Alternative Payment Model Strategies (In LAN-APM Category Order) - A model that aligns payments between payers and providers to incentivize quality, health outcomes and value over volume, to achieve the goals of better care, smarter spending, and healthier people.

The APM strategies discussed in this initiative originate from the Learning Action Network APM Framework (LAN-APM), which include the following categories and strategies:

- Fee-For-Service – No Link To Quality & Value
- Fee-For-Service – Link To Quality & Value (Foundational Payments for Infrastructure & Operations, Pay for Reporting, Pay for Performance)
- APMs Built on Fee-For-Service Architecture (APMs with Shared Savings, APMs with Shared Savings and Downside Risk)
- Population Based Payment (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance & Delivery Systems).

See ACOM Policy 307, Attachment A to view the LAN-APM strategies.

B. Pay for Performance - Purchasing strategy in which providers are rewarded for performing well on quality metrics. It can also include penalties for providers who do not perform well on quality metrics. In this strategy, specific providers are responsible for the cost and quality associated with a particular set of procedures or services. Payments are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures.(LAN-APM Category 2C).

C. APMs Built On Fee for Service Architecture (LAN-APM Category 3)

1. APMS with Shared Savings - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A).

2. APMs with Shared Savings and Downside Risk - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B).

D. Population Based Payment (LAN-APM Category 4)

1. Condition-Specific Population-Based Payment - Purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes per member per month payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN- APM Category 4A).

2. Integrated Finance and Delivery Systems - Purchasing strategy of prospective, population-based payments structured to encourage providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C).

3. Encounter - For the purposes of this policy, all encounters must be in an adjudicated and approved status.

4. Performance Based Payment - A payment from an AdSS to a provider upon successful completion, or expectation of successful completion, of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment usually occurs after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

General

The AdSS must meet the APM strategies qualifying criteria in in "A" and "C" of AdSS Responsibilities (below), and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in

AdSS Responsibilities

A. A minimum percentage of total Title XIX payments (both APM and non-APM, whether contracted or non-contracted), must be governed by APM strategies for the contract year.

The Division intends that the minimum value threshold will grow each year according to the schedule below.

	DDD Choice Plan
CYE 19 Anticipated	35%
CYE 20 Anticipated	50%
CYE 21 Anticipated	60%

Strategies for this initiative may not include:

- Block Purchase Payment Arrangement Methodology with no link to quality and value
- Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1)
- Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A).

Strategies that incorporate the Pay for Reporting strategy (LAN-APM Category 2B) are considered by the Division to meet the qualifying criteria on a case-by-case basis, and prior approval is required:

- The Division only considers approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally used for APM arrangements.
- The Division expects to consider approval only on a short-term basis.

Strategies used must meet the definitions provided in the Definitions section of this policy. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

AHCCCS will have a requirement beginning in CYE19 for specific usage of strategies in LAN-APM Categories 3 and 4; this information will be determined based upon a review of contractor deliverables and will be released in a Public Notice published in or after January 2018. AHCCCS intends that the required percentage of strategies in LAN-APM Category 3 and Category 4 grow each year.

The AdSS is responsible for identifying which strategy applies to each APM contract and whether each contract applies to a limited cost of care, where the provider can only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members' total medical costs and only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars must not be counted under multiple contracts. Additionally, one contract must not be counted under multiple strategies.

The AdSS may use quality measures other than the measures identified in this policy as part of the AdSS's APM strategies.

To count towards meeting the qualifying criteria, strategies must be evidenced by written contracts. For those contracts executed before February 1 of each contract year, the Division counts the strategies for the time period in the contract year for which the contract is in effect. For those contracts executed after February 1 of each contract year, the Division counts the strategies for the time period from the execution date forward for which the contract is in effect.

B. The AdSS must certify to the Division that these requirements will be met, by submitting an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in below under "Structured Payment File and Post Adjudicated/Post Submitted File."

1. An initial APM strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager within 60 days of the start of the contract year, and

2. A final APM Strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager, and the Structured Payment File, due 270 days after the end of the contract year.

   The Division will submit the APM Strategies Certifications on behalf of the AdSSs.

   In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

Failure to certify to the APM strategies qualifying criteria in a particular contract year will result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions listed under General (above)

The Division reserves the right to request an audit of the Certifications included in ACOM Policy 307, Attachment B. The AdSS, upon the request of the Division, must provide documentation of APM contracts and payments to providers for performance based payments.

Division Responsibilities

A. The performance-based payments made by the AdSS to providers will be paid by the Division through a lump sum payment through a future monthly capitation payment. Upon receipt and review of the final APM Strategies Certification discussed in AdSS Responsibilites, The Division will perform testing of the performance-based payment amounts reported by the AdSS prior to payment of the incentive, including review of AdSS documentation of APM contracting and payments to providers for performance-based payments. The performance-based payment incentive will be adjusted for premium tax.

The AdSS must report the performance-based payments on an accrual basis. The Division reserves the right to perform a look-back and true-up of the previous year's accrual in a subsequent year's payment.

B. For any APM contract that is effective for a period other than the measurement year, The Division will allow performance-based payments to be included in the year to which the lump sum performance-based payments incentive is attributable. For example, a contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X lump sum payment and six months (October 1, 201X – March 31, 201Y) in the 201Y lump sum payment.

The AdSS is not required to meet the APM strategies qualifying criteria in AdSS Responsibilites in order for the performance-based payments incentive to be paid to the AdSS.

The Division will test the total amount of performance-based payments incentive due to the AdSS to ensure that the federal limit of 5% of annual prospective gross capitation is met. Any amount over the limit must be reduced to bring the final due payment within the federal requirement. Federal regulation requires that all incentive payments combined not exceed this 5% limit; thus the test of the 5% limit will include both the performance-based payment incentives included in this policy and the Quality Measure Performance Incentive payments described in ACOM Policy 306.

Structured Payment File and Post Adjudicated/Post Submitted Files

A. The Division has developed a Structured Payment File to automate the APM Strategies Certification Excel file. The AdSS must submit this file annually. (See AdSS Responsibilites)

B. To link encounters to the Structured Payment File, the AdSS must add an APM Indicator to encounters paid under an APM contract. If the AdSS knows upfront that the encounter is tied to a member/provider under APM contract, the AdSS should include the APM Indicator in the original encounter submission.

If the AdSS does not know upfront that the encounter is tied to a member/provider under APM contract, the AdSS must add the APM Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The AdSS may choose to only use the post adjudication adjustment process to add the APM Indicator to adjudicated encounters, if desired.

All applicable encounters should have the APM Indicator included 270 days following the contract year end.

311 CYE 20 AND FORWARD – TIERED CAPITATION RECONCILIATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2905, AHCCCS Financial Reporting Guide; Section 9010 of the Patient Protection and Affordable Care Act, Section F3, Contractor Chart of Deliverables

This Policy applies to the Division's Administrative Services Subcontractor (AdSS). The purpose of this Policy is to outline the process and AdSS requirements regarding the DDD Health Plan Tiered Prospective Reconciliation. The reconciliation applies to dates of service effective on and after October 1, 2019 and is based upon total medical expenses and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS profit or loss for all risk groups as described below using a tiered approach. 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.

Definitions

A. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) awarded to the AdSS including any administrative adjustments deemed necessary by the Division during the capitation rate setting process multiplied by the actual prospective member months for the contract year being reconciled. For any rates that are not bid by the AdSS, but are set by the Division, the administrative component is equal to the administrative PMPM built into the capitation rates multiplied by the actual prospective member months for the contract year being reconciled.

B. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS'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.

C. Non-Capped Newborn Expenses - In accordance with the contract, AdSS must notify the Division of a newborn born to an ALTCS mother within one day of the date of birth. When notification is received timely, the AdSS receives capitation retroactive to the birth date. When notification is received late, the AdSS receives capitation beginning on the date of notification, but expenses must be covered by the AdSS back to the date of birth. Encounters for dates of services from the date of birth to the day before a tardy notification are considered non-capped expenses and are excluded from capitation rate development and reconciliations.

D. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. §36- 2905 for all payments made to AdSS for the contract year.

E. Prospective and Prior Period Coverage Medical Expense - Prospective expenses reported through fully adjudicated encounters and subcapitated/block purchase expense incurred by the AdSS for covered services with dates of service during the contract year (including expenses incurred during the Prior Period Coverage (PPC) time period) being reconciled.

F. Net Capitation – Prospective and PPC capitation, risk adjusted if applicable, plus Delivery Supplemental payments, less the administrative component, the health insurer fee capitation adjustment and the premium tax component.

G. Reinsurance - For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the AdSS as the result of prospective medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

H. Subcapitated/Block Purchase Expense - Expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated /block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

General

A. The tiered prospective reconciliation shall be based on net capitation less prospective and PPC medical expense plus reinsurance payments. The amount due from or due to the AdSS as the result of this reconciliation will be based on aggregated profits and losses across all of the tiered reconciliation 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.

B. The reconciliation will limit the AdSS profits and losses to the percent of net capitation according to the following schedule:

PROFIT	AdSS SHARE	STATE SHARE	MAX AdSS PROFIT	CUMULATIVE AdSS PROFIT
<= 1%	100%	0%	1%	1%
>1%	0%	100%	0%	1%

LOSS	AdSS SHARE	STATE SHARE	MAX AdSS LOSS	CUMULATIVE AdSS LOSS
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Note: Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.

Division Responsibilities

A. No sooner than six months after the end of the period to be reconciled, the Division shall perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

Profit/Loss to be reconciled = Net Capitation – Total Medical Expenses – Subcapitated/block purchase Expense + Reinsurance payments.

Profit/Loss % = Profit/Loss to be reconciled divided by Net Capitation.

Note: ACOM 311, Attachment A provides an example of the tiered reconciliation calculation.

B. The Division will utilize only total medical expense supported by fully adjudicated encounters and subcapitated expense reported by the AdSS to determine the expenses subject to reconciliation. The enhanced portion of a payment for 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.

C. The Division will utilize amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self- reported subcapitated/block purchase expense included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines 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 future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline 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.

G. 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.

H. The Division may include adjustments to the reconciliations to account for completion factors.

AdSS Responsibilities

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

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

C. The AdSS must monitor the estimated program tiered reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide and as specified in *Contract, Contractor Chart of Deliverables*.

D. It is the AdSS responsibility to identify to the Division any encounter data issues, or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

E. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

F. The AdSS must report all subcapitated/block purchase expense in a format requested by the Division.

G. If the AdSS performs recoupments/refunds/recoveries on prospective claims, the related encounters must be adjusted (voided or void/replaced) pursuant to AdSS Operations Manual, 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 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.

312 CHILDREN'S REHABILITATIVE SERVICES PROGRAM RECONCILIATION

EFFECTIVE DATE: 10/1/2018
REFERENCES: A.R.S. §36-2905, 9 A.A.C. 22 Article 1, ACOM Policy 325, ACOM Policy 412,

Patient Protection and Affordable Care Act Section 9010, AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

The Children's Rehabilitative Services (CRS) Program Reconciliation is based on adjudicated medical expense and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS's profit or loss for the CRS program 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.

Definitions

A. Administrative Component – an amount equal to the administrative. Per member Per Month (PMPM) awarded to the AdSS, including any administrative adjustments deemed necessary by the Division during the capitation rate setting process, multiplied by the actual member months for the contract year being reconciled.

B. Access to Professional Services Initiative (APSI) - effective October 1, 2017 and forward, is an initiative where AHCCCS seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona 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 Division's rates for professional services provided by qualified physicians and non-physician professional affiliated with designated hospitals who meet the definition outlines in ACOM Policy 325.

C. Health Insurer Fee Capitation Adjustment - an amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS'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. Medical Expense - expenses reported through fully adjudicated encounters and subcapitated/block purchase expenses incurred by the AdSS for covered services with dates of service during the contract year. This will exclude APSI expenses.

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

F. Premium Tax Component - is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to the AdSS for the contract year.

G. Prior Period Coverage (PPC) - 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 (usually the first day of the month of application) until the date the member is enrolled with the AdSS. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the AdSS only on a prospective basis.

H. Reinsurance - for purposes of this reconciliation, the actual reinsurance payments received by the AdSS as the result of medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

I. Subcapitated/Block Purchase Expenses - expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated/block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

J. Reconciliation Population - all CRS members, except State Only Transplant members, subject to this reconciliation.

General

The CRS reconciliation must be based on net capitation less medical expense plus reinsurance payments. The amount due from, or due to, the AdSS as the result of this reconciliation will be based on aggregated profits and losses across the reconciliation population. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to Division 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 325 will also be excluded from this reconciliation.

The reconciliation will limit the AdSS's profits and losses to the percent of net capitation according to the following schedule, per contract year as noted:

Profit	AdSS Share	State Share	Max AdSS	Cumulative AdSS Profit
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Loss	AdSS Share	State Share	Max AdSS	Cumulative AdSS Loss
<= 1%	100%	0%	1%	1%
> 1%	0%	100%	0%	1%

Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.

Division Responsibilities

A. No sooner than six months after the end of the period to be reconciled, the Division will perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

Profit/Loss to be reconciled = Net Capitation – Medical Expense – Subcapitated Expense/Block Purchase Expenses + Reinsurance payments.

Profit/Loss % = Profit/Loss to be reconciled divided by Net Capitation.

B. The Division will use only medical expense supported by fully adjudicated encounters and subcapitated/block purchase expenses reported by the AdSS to determine the expense subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to Division cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

C. The Division will use amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/ block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self-reported subcapitated or block purchase expenses included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines 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 future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline 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. 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.

G. The Division may include adjustments to the reconciliations to account for completion factors.

AdSS Responsibilities

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

B. The AdSS must maintain financial statements that separately identify all CRS transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor.

C. The AdSS must monitor the estimated CRS program reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide for the Children's Rehabilitative Services (CRS) Contractor.

D. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data submitted for reconciliations by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

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

F. The AdSS must report all subcapitated/block purchase expenses in a format requested by the Division. Subcapitated and block purchase encounters should have a CN 1 code of 05 and a paid amount of $0 for all non-PCP rate parity encounters. All subcapitated encounters that have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures. This includes all subcapitated amounts greater than $0 for PCP Rate Parity that are subject to Division cost settlement.

G. If the AdSS performs recoupments/refunds/recoveries on the related 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.

314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019
REFERENCES: Administrative Services Contract

This policy describes the method used to auto-assign members to an AdSS.

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

1. Prior to the start of the contract (choice period), current members will be given 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 member will be reassigned 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 member will be auto-reassigned 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 members will be given a choice to select an AdSS prior to the start of the contract.

B. 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

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 101-106; ACOM Policy 438, 103; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Change in Contractor Organizational Structure: Notification; Change in Contractor Oorganizational Structure: Transition Plan Final Documents; Change in Contractor Organizational Structure: Transition Plan Initial Documents; Completed Change in Contractor Organizational Structure: Documents required after AHCCCS Approval

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes the procedure for approval of AdSS changes in Organizational Structure as defined below, including changes in a Management Service Agreement (MSA) 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 AdSSs.

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 owner of an AdSS delegates all or substantially all management and administrative services necessary for the operation of the AdSS.

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 AdSS's Organizational Structure

A change in AdSS organizational structure requires notification and prior approval of the Division. When submitting for prior approval, the Division will review documentation to ensure the following:

A. Uninterrupted services and ongoing adequate access to care and choice for members

B. The new entity's ability to maintain and support the contract requirements including the commitments in the proposal submitted to the Division during the procurement process

C. Major functions of the AdSS's organization, as well as Division-funded services, are not adversely affected

D. The integrity of a fair, competitive, procurement process for AdSS contracts.

The Division reserves the right to obtain stakeholder input on the proposed ownership change through a public notice and feedback process, and to temporarily suspend an AdSS's new-member enrollment pending the Division's review and final determination regarding an AdSS's change in organizational structure. The AdSS must submit a written notification to the Division of any proposed merger, acquisition, reorganization, or change in ownership, 180 days before the effective date. This notification must include:

A. A detailed description of the type of change or new corporate structure and the purpose thereof

B. A detailed transition plan as outlined below.

Transition Plan

The AdSS must submit the transition plan 180 days before the effective date. Items for which information is not yet available for submission, or is still considered draft, must be noted and must be submitted or resubmitted no later than 90 days before the effective date.

All transition plan documents must be submitted electronically to the Division via the secured File Transfer Protocol (FTP) server.

A. The AdSS must submit the following as part of the transition plan, as applicable:

1. A letter of explanation that includes the following information:

a. The type of entity if a new entity will be formed and/or any changes to existing entity

b. Any material change to operations as specified in Policy 439 of this Manual and contract

2. Documents including the following:

   a. The formal name and any proposed logo used by the resulting organization

   b. The organizational chart of the new resulting organization or proposed changes to the existing organizational chart if a new entity is not being formed

   c. Current audited financial statements of current AdSS and merging entity

   d. Pro forma financial statements of entity resulting from the change in organizational structure that include, at a minimum: a balance sheet, statement of revenues and expenses, and statement of cash flows for the subsequent three years, and enrollment projections and footnotes detailing assumptions. The format can be the same as the audit format; however the Division lines of business should be detailed separately just as is required in the annual audit report.

3. A description of the following:

   a. An assessment of any potential interruption of services to members, and steps the AdSS is taking to ensure there are no interruptions

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

   c. Any changes to existing Administrative Services Subcontracts

   d. Any changes to the administration of critical components of the organizations, including but not limited to information systems, prior authorization, claims processing or grievances

   e. The AdSS's plan for communicating the change to members, including a draft notification to be distributed to affected members and providers

   f. The AdSS's plan for changes to critical member information, including the website, member and provider handbook and member ID card

   g. Any anticipated changes to the network.

B. Upon Division approval of the transition plan, the following documents must be submitted within 120 days of the change:

1. The Articles of Incorporation, if applicable, including copies of all affiliation agreements

   An affiliate is an entity that directly or indirectly controls, is controlled by, or is under common control with another entity; also, a party with which

the entity may deal if one party has the ability to exercise significant influence over the other's operating and financial policies. The affiliation agreement (also referred to as a member agreement) defines and governs the affiliate relationship.

2. Any proposed change to the Employer Identification Number/Tax Identification Number (EIN/TIN)

3. Any additional information requested by the Division.

Additional Submission Requirements

The AdSS must submit the following to the Division no later than 45 days before the effective date of the change in organizational structure and commencement of operations under the new structure:

A. Automatic Clearing House (ACH) Vendor Authorization Form

The ACH form is to be submitted as directed on the form in order for the AdSS to begin receiving reimbursement.

B. Information regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime in accordance with the 42 CFR 101 through 106, the Corporate Compliance Contractual Provisions, and Division Policy Manuals

The information is to be submitted via secured FTP server to the Division.

For a change of MSA Subcontractor, the AdSS must also follow the process for the review and approval of the new subcontract as outlined in Division Operations Manual Policy 438.

The Division reserves the right to request additional items deemed necessary to complete the evaluation.

Divison Disposition of Request

The Division will review and respond to the AdSS within 30 days of the Notification and submission of the Transition Plan. Incomplete submissions may require additional information before approval. Upon completion of the review, the Division may:

A. Approve the proposal without conditions.

B. Approve the proposal with conditions that may include, but are not limited to:

1. Allowing an open enrollment for plan membership

2. More rigorous oversight for a specified period of time

3. A cap on enrollment.

C. Deny the proposal.

If the Division denies the proposal, and if the AdSS moves forward, the Division may terminate some or all of the Geographic Service Areas that are part of the contract.

320 HEALTH INSURER FEE (Health Insurance Provider Fee)

EFFECTIVE DATE: October 1, 2019

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

DELIVERABLES: Health Insurance Providers Fee: Federal and State Income Tax Filings; Health Insurance Providers Fee: Liability Reporting Template; Health Insurance Providers Fee: Report of Health Insurance Provider Information (IRS Form 8963)

This policy applies to Division's Administrative Services Subcontractors (AdSS). AHCCCS provides funding to the Division for the Health Insurance Provider Fee (HIPF) and associated taxes. The purpose of this policy is to define what the AdSS submits to AHCCCS and the process by which the Division reimburses the AdSS for the HIPF.

Definitions

A. Affordable Care Act (ACA) - Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (ACA).

B. Fee Year - The calendar year in which the fee must be paid.

C. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 for all payments made to contractors for the contract year.

HIPF Requirements and Exclusions

Section 9010 of the ACA requires that the AdSS, if applicable, pay an HIPF annually, beginning in calendar year 2014, based on its respective market share of premium revenues from the preceding calendar year. Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance. Certain entities will be excluded. Excluded entities include, but are not limited to:

A. Government entities, including independent nonprofit county-organized system entities that contract with state Medicaid agencies

B. Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations, including Medicare, Medicaid, State Children's Health Insurance Plan (SCHIP), and dual eligible plans.

Additionally, certain entities can exclude 50% of their net premium for the HIPF calculation because of their status as a public charity, social welfare organization, high-risk health insurance pool, or Consumer Operated and Oriented Plan (CO-OP).

Every health insurer must report its national net premiums written to the IRS annually by

April 15 of the fee year on IRS *Form 8963, Report of Health Insurance Provider Information*. The health insurer is responsible for allocating its national net premiums written to the entities recorded on its *Form 8963*. The allocation for each fee year is based on the prior

calendar year's revenue. The IRS will then send each health insurer a notice of preliminary fee calculation each fee year. The regulations provide that the IRS will send each health insurer its final fee calculation for a fee year no later than August 31 of that fee year, and that the health insurer must pay the fee to the IRS by electronic funds transfer by September 30.

AHCCCS Responsibilities

A. Subject to receipt and review of documentation from the AdSS as described below, AHCCCS will make a retroactive capitation rate adjustment to the Division consistent with the methodology approved by the Centers for Medicare and Medicaid Services (CMS).

   For CMS-approved methodology to approximate the cost associated with the HIPF Premium tax, see AHCCCS Contractor Operations Manual (ACOM) *Policy 320 Attachment A, CMS Approved Retroactive Capitation Rate Adjustment Methodology – One Month Method of Payment of Health Insurer Fee (HIPF)*.

B. For Fee Year 20 and forward, the retroactive capitation rate adjustment for the AdSS in "A" above will include the provision to approximate the federal income tax liability and Arizona state income tax liability incurred related to the HIPF, if applicable.

AdSS Responsibilities

A. The AdSS must submit to the AHCCCS Division of Health Care Management (DHCM) Finance Manager with a copy to the Division's Business Administrator, a copy of its entity's IRS *Form 8963, Report of Health Insurance Provider Information* filed with the IRS to report net premium along with its final fee estimate by September 30 of each fee year.

B. The AdSS must complete ACOM *Policy 320 Attachment B, Health Insurer Fee Liability Reporting Template* and submit both an executed copy and an electronic copy in an Excel format to the DHCM Finance Manager and the Division's Business Administrator by September 30 of each fee year, Since the template includes all lines of business, an AdSS with multiple lines of business only needs to make one submission. The AdSS must include Title XIX only. The AHCCCS fee liability must be allocated to line of business based on the allocation of revenue reported in *Attachment B*. AHCCCS will verify the reasonableness of the data. In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

C. If no fee is due, the AdSS must submit to the DHCM Finance Manager and the

   Division's Business Administrator a written statement indicating no fee is due and the

   reason for the exemption.

D. The AdSS must submit to the DHCM Finance Manager and the Division's Business Administrator a copy of its entity's federal and Arizona state income tax filings by

April 30 of the year following the fee year. The AdSS must notify the DHCM Finance Manager and the Division's Business Administrator of the federal and Arizona state income tax rates that apply to the AdSS.

E. If the AdSS requested a tax filing extension, the AdSS must submit its anticipated federal and Arizona state income tax rates that apply to the AdSS to the DHCM Finance Manager and the Division's Business Administrator by April 30 of the year following the fee year. Within 30 days after submitting tax filing, the AdSS must submit copies of the federal and Arizona state income tax filings.

F. AHCCCS may adjust a capitation rate that was previously adjusted for tax liability purposes if the resulting tax liability is materially different from the anticipated tax rates reported.

G. The AdSS deliverables due to AHCCCS, including IRS Form 8963, Attachment B, and Federal and State Income Tax filings will be waived, should the Federal Government place a suspension on the HIPF, for the fee year in which the HIPF would have been due. See Section F3, Contractor Chart of Deliverables.

321 PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to define parameters for the Payment Reform-E-Prescribing Initiative.

Definitions

A. Electronic Prescription or E-Prescription - Electronic Prescriptions or E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.

B. Origin Code **-** The field located in the National Council for Prescription Drug Programs (NCPDP) standardized code set known as the Prescription Origin Code and also referred to as the NCPDP Prescription Origin Code.

General

E-Prescribing is a recognized and proven effective tool to improve members' health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, patient adherence, and increased prescription accuracy.

The following parameters must apply for the Payment Reform - E-Prescribing Initiative:

A. Only those prescriptions that meet the definition of an E-Prescription (see definition above) must be included for the purpose of the initiative. The initiative must not include other electronic methods of transmitting prescriptions, e.g., computer-generated paper prescriptions or facsimiles or telephone-generated prescriptions. The initiative also must not include E-Prescriptions converted to computer-generated facsimile when the E-Prescription is sent via an intermediary that is unable to complete the transaction.

B. Refills retain the origin of the prescription. Each time a prescription that meets the definition of an E-Prescription is refilled, it counts as an E-Prescription. Consequently, refills must not be counted as electronic originations for this initiative, as they overstate the number of prescriptions generated in this manner.

C. Controlled substances can be E**-**Prescribed and therefore may be counted as an E-Prescription if the electronic origination meets the definition of an E-Prescription.

D. Prescriptions generated by nurse practitioners and physician assistants may be counted as electronic originations if they meet the definition of an E-Prescription.

The Division may sanction the AdSS for failure to meet the requirements in the AdSS Responsibilities section of this policy.

AdSS Responsibilities

For CYE 16: The AdSS must increase the percent of prescriptions originating through E-Prescribing by 20% of the difference between the CYE 15 baseline percentage of original prescriptions generated as E-Prescriptions by line of business and the goal percentage of original prescriptions generated as E-Prescriptions as defined below, using the CYE 16 peak quarter to determine compliance with the E-Prescribing Initiative.

Goal (Percentage of Original Prescriptions Generated as E-Prescriptions)

DDD, including AdSS: 65%

The required increase in the percent of prescriptions originating through E-Prescribing will be calculated as follows:

- G = E-Prescribing percentage Goal
- B = CYE 15 Baseline E-Prescribing percentage
- R = Required E-Prescribing percentage increase from CYE 15 Baseline E-Prescribing percentage per AdSS
- T = Target E-Prescribing percentage per AdSS
- P = CYE 16 Peak Quarter E-Prescribing percentage

Calculation	Example
(G – B) * 20% = R	(60% - 45%) * 20% = 3%
B + R = T	45% + 3% = 48%
P >= T	49% > 48%

Prescription origination data must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.

The Prescription Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.

325 ACCESS TO PROFESSIONAL SERVICES INITIATIVE AND RECONCILLIATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 48-5501 et seq., Division Operations Manual Policy 412

Purpose: To establish guidelines for Administrative Services Subcontractors (AdSS) regarding the Access to Professional Services Initiative (APSI) and related reconciliation.

Policy: The Division of Developmental Disabilities (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 rates for professional services provided by qualified practitioners affiliated with designated hospitals.

Due to uncertainty regarding actual use of qualified practitioners, and because the state share of the capitation paid to the AdSS will be funded using Inter-Governmental Transfer funds for this specific purpose, the Division intends to eliminate the financial risk to its AdSS. The Division will isolate the APSI revenue and expenses, and reconcile AdSS prospective and Prior Period Coverage (PPC) profits and losses to 0%. A risk pool will be used to capture unexpended funds.

Definitions

APSI Expense: The PPC and Prospective Expenses incurred by the AdSS for the 40% rate increase to providers. APSI Expenses excludes Subcapitated/Block Purchase Expenses.

APSI Revenue: The amount of additional PPC and Prospective capitation provided for the 40% rate increase to providers.

Designated Hospitals: For purposes of this Policy, designated hospitals include:

- A hospital facility with an Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching program and which is operated pursuant to the authority in A.R.S. Title 48, Chapter 31 (A.R.S. § 48-5501 et seq.); or
- A hospital facility with:
  - An ACGME-accredited teaching program with a state university, and
  - AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2019; or
  - A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than 100 licensed pediatric beds, excluding nursery beds.

Qualified Practitioner: For purposes of this policy, qualified practitioners are providers who bill for services under one of the Group National Provider Identifier numbers that are affiliated with one of the Designated Hospitals identified in Section A.1. of this policy, and includes the following practitioners:

- Physicians, including doctors of medicine and doctors of osteopathic medicine
- Certified Registered Nurse Anesthetists
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dentists
- Optometrists

A. Designated Hospitals

1. Designated Hospitals participating in APSI effective October 1, 2019, include the following:

    a. Banner University Medical Center Phoenix

    b. Banner University Medical Center Tucson

    c. Banner University Medical Center South

    d. Cardon Children's Medical Center at Banner Desert Medical Center

    e. Maricopa Medical Center

    f. Phoenix Children's Hospital

    g. St. Joseph's Hospital and Medical Center

    h. Tucson Medical Center

B. Reconciliation

1. The reconciliation must relate solely to the APSI portion of encounters for fully adjudicated prospective and PPC medical expenses, excluding services provided under subcapitated/block purchase arrangements, for Qualified Practitioners. The amount due from or due to the AdSS as a result of this reconciliation will be based on aggregated profits and losses from APSI

Revenue and Expenses across both prospective and PPC risk groups.

2. The reconciliation will limit the AdSS's profits and losses from APSI Revenue and APSI Expenses to 0%. Any losses in excess of 0% will be reimbursed to the AdSS and, likewise, profits in excess of 0% will be recouped.

C. <u>Administrative Services Subcontractors' Responsibilities</u>

1. Effective with dates of service on and after October 1, 2019, the AdSS will provide a 40% increase to the otherwise contracted rates to Qualified Practitioners for all claims for which the Division is the primary payer.

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

3. The AdSS must maintain financial records that separately identify all APSI-related prospective and PPC transactions, and submit such information through a footnote in the financial statements as required by Contract and as specified in the AHCCCS Financial Reporting Guide.

4. The AdSS must monitor the estimated APSI reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide.

5. It is the AdSS's responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

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

7. If the AdSS performs recoupments/refunds/recoveries on any APSI 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 APSI reconciliation results for the impact of the revised encounters and recoup any amounts due 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.

D. 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: Profit/Loss to be reconciled = APSI Capitation.

2. The Division will use only expenses supported by fully adjudicated encounters reported by the AdSS to determine the expenses subject to reconciliation.

3. The Division will compare fully adjudicated encounters to AdSS financial statements and other AdSS submitted files for reasonableness.

4. The Division will provide to the AdSS the data used for the initial APSI 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.

5. A final APSI reconciliation will be performed no sooner than 15 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 to the AdSS the data used for the final reconciliation and provide a set time period for review and comment by the AdSS.

6. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

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

8. The Division may include adjustments to the initial APSI reconciliation to account for completion factors.

9. The Division will create and use an APSI risk pool to capture recouped funds. The monies included in the risk pool will be used to reimburse AdSS with losses in excess of 0%.

401 CHANGE OF DDD HEALTH PLAN AND ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 401- Attachment A, AHCCCS Acute Care Change of Contractor Form

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes requirements and timeframes for how, when and by whom AdSS change requests will be processed for members eligible for the Division outside of the AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This policy describes the rights, obligations, and responsibilities of the following parties when such changes are made:

- The Member
- The Relinquishing AdSS
- The Receiving AdSS
- The Division of Developmental Disabilities (DDD or the Division).

Definitions

A. Annual Enrollment Choice (AEC) - The opportunity for a member to change the DDD Health Plan and AdSS every twelve months.

B. Auto Assignment - The process by which members who do not exercise their right to choose an AdSS and members who are not assigned an AdSS based on family continuity rules are assigned to an AdSS through an auto assignment algorithm. The algorithm is a mathematical formula used to assign members to the various AdSSs in a manner that is predictable and consistent with Division goals.

C. Business Day -. A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

D. Freedom of Choice - The opportunity given to each member who does not specify an AdSS preference at the time of enrollment to choose between the AdSSs available.

E. Receiving AdSS - The AdSS with which the member will become enrolled as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

F. Relinquishing AdSS - The AdSS in which the member will be leaving as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

Policy

A. Criteria for Change of AdSS Outside of Initial Enrollment or AEC Period

AdSS change requests outside of the initial enrollment period or the member's AEC period will be granted for members if certain conditions are met. These conditions include:

1. Administrative Actions That May Merit an AdSS Change:

   a. A member was entitled to Freedom of Choice but was not sent a choice letter.

   b. A member was entitled to participate in an AEC but:

      i. Was not sent an choice letter, or

      ii. Was sent a choice letter but was unable to participate in the AEC due to circumstances beyond the member's control.

   c. Family members were inadvertently enrolled with a different AdSSs. A member who is enrolled with an AdSS through the Auto Assignment process may inadvertently be enrolled with a different AdSS than other family members. Upon receipt of notification by the Division, the member who was inadvertently enrolled will be disenrolled from the AdSS of assignment and enrolled with the AdSS where the other family members are enrolled. Other family members will not be permitted to change to the AdSS to which the new member was auto-assigned. This process must not apply if a member was afforded an enrollment choice during their AEC period.

   d. A member loses eligibility and regains eligibility within 90 days. The member shall be reenrolled with the AdSS that the member was enrolled with prior to the loss of eligibility. If this does not occur, the Division, upon notification, will enroll the member with the previous AdSS.

   e. A Title XIX eligible member who is entitled to Freedom of Choice but becomes eligible and is auto assigned prior to having the full choice period of 90 days will be given an opportunity to request an AdSS change following Auto Assignment. The member will be given 90 days from the date of the choice letter to request an AdSS change. A member who does not make a selection within 90 days will remain with the auto assigned AdSS.

2. Medical Continuity of Care

   In unique situations, AdSS changes may be approved on a case-by-case basis if necessary, to ensure the member access to medical/health care.

   A plan change for medical continuity is not an automatic process. The member's Primary Care Provider (PCP), or other medical provider, must provide documentation to both the Receiving and Relinquishing AdSSs that supports the need for an AdSS change. The AdSSs must be reasonable in

the request for documentation. However, the burden of proof that an AdSS change is necessary rests with the member's medical provider. The AdSS change must be approved by both AdSS's Medical Directors.

A pregnant member who is enrolled with an AdSS Auto Assignment or Freedom of Choice and is currently receiving or has previously received prenatal care from a provider who is affiliated with another AdSS, may be granted a medical continuity AdSS change if agreed to by the Medical Directors of both AdSSs. The member must be transitions within the requirements and protocols in AdSS Operation Manual Policy 402 and in Division Medical Policy Manual chapter 500.

When the Medical Directors of both the receiving and relinquishing AdSS have discussed the request and have not been able to come to an agreement, the relinquishing AdSS must submit the request to the Division's Chief Medical Officer (CMO) or designee. Within 14 calendar days from the date of the original request, the Relinquishing AdSS must submit Attachment A and the supporting documentation to the Division for review.

The results of the review will be shared with both Medical Directors. The relinquishing AdSS will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing AdSS will send the member in writing. .The letter will also advise the member of the Division Grievance and Appeal System policy and include timeframes for filing a grievance.

Upon approval of a change in AdSS for medical continuity, the member must be transitioned within the requirements and protocols in AdSS Operations Manual Policy 402 and the Division Medical Policy Manual Chapter 520.

B. AdSS Responsibilities When an AdSS Change is Not Warranted

The current AdSS has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care or delivery issues that may have caused an AdSS change request to be initiated. These issues include, but are not limited to:

1. Quality of care delivery
2. Case management responsiveness
3. Transportation convenience and service availability
4. Institutional care issues
5. Physician or provider preference
6. Physician or provider recommendation
7. Physician or provider office hours

8. Timing of appointments and services

9. Office waiting time

10. Network limitations and restrictions.

When quality of care and delivery of care and service issues raised by the member are identified, the AdSS shall refer the issue for review by the Division's Quality Management Department, who will follow the Division's established Quality Management process for timely resolution.

Additionally, the AdSS must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

The delivery of covered services remains the responsibility of the current AdSS if an AdSS change for medical continuity of prenatal or other medical care is not approved.

The current AdSS must notify the member, in writing, that an AdSS change is not warranted. If the AdSS change request was the result of a member concern, as defined in this Policy, the letter must include the AdSS's resolution of this concern. The letter must also advise the member of the Division and AdSS Grievance and Appeal System policy and include timeframes for filing a grievance.

AdSSs may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

C. Relinquishing AdSS, Receiving AdSS And Division Responsibilities When an AdSS Change is Warranted

1. Relinquishing AdSS Responsibilities

If a member contacts the current AdSS, verbally or in writing, and states that the reason for the plan change request is due to situations defined in this Policy, the relinquishing AdSS must advise the member to telephone the Division Customer Service at 1-844-770-9500 and follow the prompts for health plan changes and questions, in order for the Division to process the change.

If the member contacts the relinquishing AdSS, verbally or in writing, to request a plan change for medical continuity of care as defined in this policy, the following steps must be taken:

a. The relinquishing AdSS will contact the receiving AdSS to discuss the request. If a plan change is indicated for medical continuity of care, ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form must be completed. All members impacted by the

change request must be indicated on the form. The form must be signed by the Medical Directors of both AdSSs. The signed form must be submitted to the Division Chief Medical Officer,

b. To facilitate continuity of prenatal care for the member, the AdSS must sign off and submit the ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form to the Division Chief Medical Officer within two business days of the member's AdSS change request. The timeframe for other continuity of care changes is as expeditiously as the member's health care condition requires, or no later than 10 business days, and

c. The Division Chief Medical Officer will review the AdSS change documentation and process accordingly.

2. Receiving AdSS Responsibilities

The member must be transitioned within the requirements and protocols in AdSS Manual Policy 402 and in the Division Medical Policy Manual Chapter 500.

3. Division Responsibilities

The Division must process change of AdSS requests that are listed in Section A (1) and must send notification of the change via the daily recipient roster to the relinquishing and receiving AdSSs. It is the AdSS's responsibility to identify members from the daily recipient roster who are leaving the AdSS.

If the Division denies a change of AdSS request, the Division will send the member a denial letter. The member will be given 60 days to file a grievance.

If the Division receives a letter or verbal request from a member requesting an AdSS change, for reasons defined in this Policy, that also references other concerns (e.g., transportation, accessibility or availability of services), that information will be sent to the current AdSS who must follow the Policy requirements as outlined above.

402 MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE AND ELIGIBILITY CHANGES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-101

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines, criteria, and timeframes for how members are to be transitioned between AdSSs and how AdSSs are notified for Annual Enrollment Choice (AEC) and eligibility changes. This policy explains the rights, obligations, and responsibilities of the member's current (relinquishing) AdSS and the requested (receiving) AdSS. The AdSS and the Division work together to ensure the smooth transition of members as they change from one AdSS to another. Maintenance of continuity and the quality of care are the overriding considerations for member transitions (the process during which members change from one AdSS to another).

This policy does not include requirements for the following member transitions:

A. Transitions due to AdSS Award, AdSS Termination, or material change to the AdSS's network

B. Transitions due to member request for AdSS change outside of AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period

C. Member transition between ALTCS/Elderly and Physically Disabled (EPD) and Division contractors. Members may be transitioned between an ALTCS/EPD contractor and Division. Transfers between an ALTCS/EPD contractor and the Division are the result of a change in Division eligibility, as determined by the Division.

Definitions

A. Annual Enrollment Choice (AEC) - the opportunity for a member to change the model and AdSS during the Division's open enrollment period.

B. Enrollment Transition Information (ETI) - member-specific information the relinquishing AdSS must complete and transmit to the receiving AdSS for those members requiring coordination of services as a result of transitioning to another contractor (see Division Medical Manual Chapter 500).

C. Health Care Professional - physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

D. Geographic Service Area (GSA) - an area designated by the Division within which a contractor of record provides, directly or through subcontract, covered health care

service to a member enrolled with that contractor of record, as defined in A.A.C. R9-22-101.

E. Potential Plan Listing (PPL) - a file which provides the Division with the basic demographic information of all members who may be joining or leaving.

F. Receiving AdSS - contractor with which the member will become enrolled as a result of AEC, open enrollment, a contractor change or a change in eligibility.

G. Relinquishing AdSS - contractor from which the member will be leaving as a result of AEC, open enrollment, a contractor change or a change in eligibility.

Policy

A. Transitions

1. AEC

a. Members residing in a county with choice of model and AdSS may change enrollment once a year.

i. The Division provides notice to members regarding annual enrollment 60 days before the member's AEC date.

ii. The member may choose a new model and AdSS by contacting the Division to complete the enrollment process.

iii. Members who notify the Division of their choice of model and AdSS prior to AEC will transition to the requested model or AdSS (receiving AdSS) on the first day of the new enrollment period. Members will receive services from their requested AdSS (receiving AdSS) on the first day of the new enrollment period.

b. If the member does not participate in the AEC, no change of model and AdSS will be made.

c. Members must maintain eligibility as a condition of enrollment in the Division and ALTCS.

i. If a member loses eligibility after making an AEC and regains eligibility within 90 days, the member's AEC will be honored.

ii. If the member regains eligibility after 90 days, members who make a choice of model and AdSS will be enrolled with the model and AdSS of choice, if a choice is not made, the member will be auto-assigned to an available AdSS.

iii. The Division sends a choice notice to the member, after the member is auto-assigned, allowing the member 90 days to choose an available AdSS.

2. Eligibility Changes

Member transitions due to eligibility changes include, but are not limited to, Acute Care to the Division.

Members who become eligible for the Division will be transitioned as outlined in this policy, and Division Medical Manual Chapter 500.

B. Division Enrollment Notification to AdSS

1. Final notification data containing the member's choice of AdSS is provided via the 834 file.

2. Enrollment notification data is provided daily and monthly as follows:

   i. Daily Enrollment Notification (834 File) is completed by the Division between 8:00 p.m. and 11:59 p.m. each night for that day's activity.

   ii. Monthly Enrollment Notification (834 File) occurs three days before the first of the next month for each Division AdSS.

C. AdSS Transition Policy

The AdSS must develop and implement policies and procedures for the acceptance and transfer of members in accordance with contract and Division policy.

D. Transition Coordinator

The AdSS must identify a representative to serve as Transition Coordinator. The Transition Coordinator must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all transition issues, responsibilities, and activities.

The role of the Transition Coordinator includes:

1. Ensuring the transition activities are accomplished in accordance with Division and AdSS policies and procedures

2. Acting as an advocate for members leaving and joining the AdSS

3. Facilitating communication between AdSSs and the Division

4. Assisting Primary Care Providers (PCPs), internal AdSS departments, and other contracted providers with the coordination of care for transitioning members

5. Ensuring continuity of care is maintained during transitions

6. Participating in Division transition meetings.

E. Relinquishing AdSS Responsibilities

The relinquishing AdSS must complete and transmit ETI to the appropriate parties no later than 10 business days of receipt of the Division notification described above for each member who has special circumstances. The AdSS must comply with the notification requirements specified in Division policy for all member transitions.

Special circumstances include, but are not limited to, medical conditions or circumstances such as pregnancy, major organ or tissue transplantation services which are in process, Serious Mental Illness, chronic illness which has placed the member in a high-risk category, and other conditions, circumstances, and all members eligible for the Division.

The relinquishing AdSS must:

1. Coordinate care for members with special health care needs with the receiving AdSS to ensure that services are not interrupted.

2. Be responsible for timely notification to the receiving AdSS of pertinent information related to any special needs of transitioning members.

3. Notify the receiving AdSS.

   Relinquishing AdSSs, who fail to notify receiving AdSSs about members that meet the Division transition notification requirements specified in Division Medical Policy Manual Chapter 500, will be responsible for the cost of medically necessary services received by the member for the first 30 days. The scope and responsibility for such cases will be reviewed and determined by the Division.

   If the Division determines that the relinquishing AdSS is responsible for payment of services following the transition date, the Division will require the receiving AdSS to provide the Division with information about all costs incurred by the member during the period determined by the Division. Failure to timely provide the requested information to the Division will void the receiving AdSS's claim to reimbursement in that case.

4. Notify the hospital before transitioning a member who is hospitalized on the date of transition and comply with the requirements of the Division Medical Policy Manual Chapter 500.

5. Be responsible for ensuring that a transitioning member's medical records are copied and transmitted when requested by the member's new PCP or designated office staff.

   In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing AdSS is responsible for the cost of copying and postage.

   The member is never required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving AdSS.

6. Ensure coverage and provision of medically necessary services to their

assigned members through the date of transition.

An AdSS must never cancel, postpone, or deny a service based on the fact that a member will be transitioning to another AdSS.

7. Be responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the relinquishing AdSS's duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

8. Remain responsible for adjudicating all pending member grievances and appeals that are filed before the member's transition.

F. Receiving AdSS Responsibilities

Receiving AdSSs which fail to timely act upon ETI or fail to timely coordinate or provide the necessary covered services to transitioning members after being properly notified will be subject to sanctions as outlined in contract and AdSS Operations Manual Policy 408.

The receiving AdSS must perform the following:

1. Coordinate care for members with special health care needs with the relinquishing AdSS so that services are not interrupted, and provide the new member with AdSS and service information, emergency numbers and instructions about how to obtain services.

2. Do not delay the timely process of a transition because of missing or incomplete information.

   If notification of a transition is received before a relinquishing AdSS's ETI, the receiving AdSS must begin care coordination efforts immediately upon notification.

3. Extend previously approved prior authorizations for a minimum period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's representative.

4. Provide at a minimum a 90-day transition period, for children who have an established relationship with a PCP that does not participate in the AdSS's provider network, during which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the AdSS, and/or Support Coordinator finds an alternative PCP within the AdSS's provider network.

5. Allow members who are in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

6. Provide new members with member information within timeframes outlined in AdSS Operations Manual Policy 404.

7. Ensure that transitioning members are assigned to a PCP and can obtain routine, urgent, and emergent medical care in accordance with Division standards.

8. Be responsible for the payment of obstetrical and delivery services when a pregnant woman who is considered high-risk, is in her third trimester, or is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery. If the member's current physician and/or facility selected as her delivery site are not within the receiving AdSS's provider network, the receiving AdSS must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving AdSS's contracted network.

404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C R9-22-504; 42 CFR 438.10; 42 CFR 438.310(d)(3); ACOM Chapter 404; ACOM 404, Attachment A – Organizations Recognized by AHCCCS, ACOM 404, Attachment B - Contractor Website Certification Checklist, and ACOM 404, Attachment C - Member Information Attestation Statement; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Member Information Attestation Statement; Member Newsletter

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes requirements for AdSSs regarding Member Information and the approval process for Member Information Materials developed by or used by the AdSS. This policy pertains to oral and written communication disseminated to an AdSS's enrolled Members and to the content of an AdSS's website.

The AdSS must obtain approval from the Division and AHCCCS for all member informational materials (messages) including, but not limited to, print, e-mail, and voice-recorded information messages.

This policy includes references to exhibits and attachments in the AHCCCS Contractor's Operations Manual (ACOM) that have been adopted by the Division for use by the AdSS.

Definitions

A. File and Use - 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.

B. Incentive Item – Items that are used to encourage behavior changes in the AdSS's enrolled members or Health promotion incentives to motivate members to adopt a healthy lifestyle and/or obtain health care services.

C. Member Information Materials - Any materials given to the AdSS's 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.

D. Retention Materials – Member information materials sent to members prior to and during Annual Enrollment Choice (AEC) for the purposes of retaining members as an enrollee with the AdSS.

E. 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

1. The AdSS must comply with the requirements in this Policy for all member information materials. In addition, refer to the requirements outlined in:

   a. AdSS Operations Policy 405 for requirements regarding Cultural Competency, Language Access Plan and Family/Patient Centered Care,

   b. AdSS Operations Policy 406 for requirements regarding the Member Handbook and Provider Directory,

   c. AdSS Operations Policy 425 for requirements regarding Social Networking activities,

   d. AdSS Operations Policy 433 for requirements regarding Member ID Cards,

   e. AdSS Operations Policy 414 for sample Notice of Adverse Benefit Determination and Notice of Extension notice, and

   f. The Division Grievance and Appeal System standards

   g. ACOM Policy 406, Attachment B CMS Required Definitions regarding definitions for AHCCCS members pursuant to 42 CFR 438.10

2. The AdSS must attest it is in compliance with Member Information requirements by signing and submitting ACOM 404 Attachment C, Member Information Attestation Statement, as specified in the Contract.

3. The AdSS 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.

4. The AdSS 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.

5. The AdSS must use state developed Member notices as indicated in Contract and Policy [42 CFR 438.10(c)(4)(ii)].

B. Language, Readability, and Oral Interpretation Requirements

All member information materials must include taglines in the prevalent non-English languages in Arizona and include large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services with the AdSS's toll free and TTY/TDY telephone numbers for customer service which must be available during normal business hours. In addition, the AdSS must provide members the AdSS toll free and TTY/TDY nurse triage line telephone number which must be available 24hr/7days a week.

1. Vital materials must be made available in the prevalent non-English language spoken for each LEP population [42 CFR 438.310(d)(3)]. Oral interpretation services must not substitute for written translation of vital materials. The AdSS is not required to submit to the Division the translated member materials to AHCCCS translated into a language other than English14. It is the Contractor's obligation to ensure that the translation is accurate and culturally appropriate.

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

3. Readability - The AdSS must make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The AdSS should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale. The AdSS must use a font size no smaller than 12 point. Member Information Materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have other disabilities, or who have limited reading proficiency. Large print materials must be made available using a font size no smaller than 18 point

4. Oral Interpretation - The AdSS must make oral interpretation services available to its Members at no cost. This applies to American Sign Language and all non-English languages, not just those identified as prevalent. The AdSS must ensure interpretative services including the use of auxiliary aids such as TTY/TDY are made available.[42 CFR 438.10(d)(4)].

C. Incentives

The AdSS may offer Incentive Items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to Members to participate in health-related promotions, but total value of the items may not exceed $75.00 per Member annually. Incentives may not be given to Members to influence continued enrollment with the AdSS, as specified in A.A.C R9-22-504.

D. Materials not Requiring Submission to the Division

1. Customized letters for individual Members need not be submitted to the Division as described in this Policy. Information sent by the AdSS to Members enrolled in an AdSS's Medicare Dual Special Needs Plan (D-SNP) that clearly

and exclusively relate to their Medicare benefits and services do not require submission to the Division.

2. Health related brochures developed by a nationally recognized organization included in ACOM Policy 404 Attachment A-Organizations Recognized by AHCCCS, do not require submission to the Division. However, in the event the informational material provided by an approved organization references services that are not medically necessary, or are not Division covered benefits, or do not align with Division policy, the AdSS may not distribute the organization's informational materials to Members. In these instances, the AdSS may use the organization's material only as a reference to develop its own Member Information Materials specific to Division recipients.

3. The AdSS must refer to this Policy for updates when considering using information from organizations listed in ACOM Policy 404 Attachment A-Organizations Recognized by AHCCCS. The AdSS will be held accountable for the content of materials developed by the organizations listed in Attachment A. The AdSS must review the materials to ensure that:

   a. The services are covered by the Division.

   b. The information is accurate.

   c. The information is culturally sensitive.

It is important to note that in all instances where the AdSS is required by its Contract with the Division to educate its Members, brochures developed by outside entities must be supplemented or replaced with informational materials developed by the AdSS which are customized for the Medicaid population.

E. <u>Member Newsletter Content and Requirements</u>

1. The AdSS must develop and distribute, at a minimum, two Member newsletters during each contract year. Newsletters must be submitted 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 and must be submitted as specified in the Contract. Member newsletters will be reviewed in accordance with this Policy. The Member Newsletter does not fall under the 15-day File and Use review process.

2. At a minimum, the Member newsletter must include the following 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. AdSS contact information and Crisis Hotline information (in each newsletter),

k. Resources to assist with Social Determinants of Health,

l. Information on the AdSS's integration efforts to improve overall Member outcomes, as applicable (e.g. behavioral health and physical health services), and

m. Other information required by the Division or AHCCCS.

F. <u>Website</u>

The AdSS's website must contain all the information required in ACOM Policy 404-Attachment B, Contractor Website Certification Checklist and Attestation. The AdSS must submit Attachment B as specified in Contract. All of the information must be located on the AdSS's website in a manner that Members can easily find and navigate (e.g. "Consumer, Enrollee, Member or Recipient Page") from the AdSS's home page. Information should be in a format that can be retained and printed by the Member.

Websites must be specific to the AdSS's Medicaid program and must not include links or references to private insurance. The website may contain links and references to the AdSS's Medicare programs and services exclusively to promote coordination of care for Members enrolled in both Medicaid and Medicare. For the approval process for additional information added to the AdSS's website that is directly related to Members or Potential Members, see refer to requirements outlined in this Policy.

The Division will review the content of the AdSS's website to ensure the AdSS is in compliance with this Policy and the Division Contract.

G. <u>Submission, Requirements and Restrictions for All Other Materials</u>

1. The AdSS must inform all members of any changes considered to be significant by the Division 30 calendar days prior to the implementation date of the change. These changes include, but are not limited to:

   a. Cost Sharing

b. Prior Authorization

c. Service Delivery

d. Covered Services.

In addition, the AdSS must make a good faith effort to give written notice to Members within 15 calendar days after receipt or issuance of a provider termination notice to each Member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

The Division has adopted a File and Use review process for all other Member Information Materials developed by the AdSS. All other Member Information Materials disseminated by the AdSS to its Members must be submitted, as specified in Contract 15 calendar days before it is to be released. If a 15-day notice is not possible, the AdSS may request an expedited review, but the request must be clearly marked as expedited and also indicate the reason for the shortened timeframe. The Division reserves the right to determine if the request for an expedited review is warranted

2. The AdSS must submit the following information to the Division prior to releasing Member Information Materials:

   b. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its Members or Potential Members. Translations of the material into other languages as required by this policy are not required to be submitted. A cover letter containing a description of the purpose, the process the AdSS will use to disseminating the material

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

The AdSS may disseminate the member information as indicated in their request upon the expiration of the 15-day time period, unless the Division notifies the AdSS otherwise. Member materials submitted outside of standard business hours will be considered received the following Business Day. State Holidays that fall on business days are not counted as part of the 15-day review period.

Member Information Materials that are a component of new initiatives, special projects, (e.g. new Member portal, health education initiatives), or are comprised of a bulk submission (e.g. booklet, magazine, multiple submissions in a short time frame) may require additional review time.

The Division reserves the right to require any necessary changes to the material. The Division may also conduct audits and/or operational reviews to ensure compliance.

Member Information Materials can also be used for marketing purposes as defined in Division Operations Manual, Policy 101. In these cases, the materials must receive prior approval from the Division as outlined in Policy 101. In addition, for social

networking applications and content requirement, refer to Division Operations Manual, Policy 425.

3. The AdSS must ensure:

   a. All materials must be labeled with the AdSS's name and/or logo; this includes Member material that is located on the AdSS's website, e-mail messages, and voice or text -recorded phone messages delivered to the Member's phone.

   b. Information contained within the material is accurate, updated regularly, and appropriately based on changes in benefits, Contract, policy, or other relevant updates.

   c. Updated Member information is re-submitted for approval, including the date the material was previously approved, the reason for the update and clearly identify all content revisions,

   d. A log is kept for all Member material distributed each year; the log must identify the date the materials was originally submitted to the Division as described in this policy, as well as resubmission dates,

   e. The log is made available to the Division upon request,

   f. Member Information Materials do not directly or indirectly refer to the offering of private insurance, do not include inaccurate, misleading, confusing or negative information about AHCCCS, the Division or the AdSS, 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.

Member Information Materials developed for services under contract with the Division are not considered proprietary to the AdSS.

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

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 405, Attachment A, Cultural Competency Plan, Assessment, Language Access Plan, and Family-Member Centered Care Reporting Checklist; 42 CFR 438.206(c)(2); Section F3, Contractor Chart of Deliverables

DELIVERABLES: Cultural Competency Plan Assessment

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to outline the requirement that AdSS offer accessible and high-quality services in a culturally competent manner and provide family/patient-centered care, as applicable.

Definitions

A. Competent - Properly or well qualified and capable.

B. Cultural Competency - 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. 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. 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.

C. Culture - The integrated pattern of human behavior that includes language, thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

D. Family-Centered - Care that:

- Recognizes and respects the pivotal role of the family in ensuring the health and well-being of children and family members of all ages
- Supports families in their natural caregiving roles, and acknowledges that emotional, social, and developmental supports are integral components of health care
- Seeks mutually beneficial partnerships among health care providers, patients, and families
- Ensures family collaboration in the development of policies and programs, and promotes choice in the provision of services to the member.

E. Interpretation - The conversion of oral communication from English into the member's preferred language while maintaining the original intent.

F. Limited English Proficiency (LEP) - 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 language assistance with respect to a particular type or service, benefit or encounter.

G. Linguistic Need - For the purposes of this policy, linguistic need is defined as the necessity of providing services in the member's primary or preferred language, including sign language, and the provision of interpretive and translation services.

H. Translation - The conversion of written communication from English into the member's preferred language while maintaining the original intent.

I. Vital Materials **–** 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:

1. Member handbooks
2. Notices of Adverse Benefit Determinations
3. Notices of Appeal Resolution
4. Consent forms
5. Member notices
6. Communications requiring a response from the member
7. Grievance, appeal, and request for state fair hearing information
8. Written notices informing members of their right to interpretation and translation services.

Cultural Competency Plan

The AdSS must have a comprehensive cultural competency program that includes those with limited English proficiency and diverse cultural backgrounds, and the AdSS must develop a written Cultural Competency Plan (CCP).

The CCP must describe how care and services will be delivered in a culturally competent manner [42 CFR 438.206(C)(2)] and must include all information provided in ACOM Policy 405, Attachment A, Cultural Competency Plan, Assessment, Language Access Plan, and Family-Member Centered Care Reporting Checklist, which is located in the AHCCCS Operations Manual.

The AdSS must identify a staff member responsible for implementation and oversight of all requirements for the cultural competency program and plan. The AdSS must employ a Cultural Competency Administrator as a key staff position. If there is a change in the staff member responsible for the cultural competency program and plan, the AdSS must notify the Division. The CCP must address the following:

A. Education and Training

1. The education program consists of the methods the AdSS will use to train its staff to ensure that services are provided in a culturally competent manner to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.

2. The education program consists of methods the AdSS will use for providers and other subcontractors with direct member contact. The education program must be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner and understanding of health literacy. The AdSS must also make additional efforts to train or assist providers and subcontractors with how to provide culturally competent services.

   The AdSS must ensure all staff receives Cultural Competency training during new employee orientation and annually thereafter.

3. Culturally Competent Services and Translation/Interpretation Services

   The AdSS must describe the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the AdSS evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It should also describe the provision and coordination needed for linguistic and disability-related services.

   The availability and accessibility of translation/interpretation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation/interpretation service. AdSSs, at any point of contact, must make members aware that translation/interpretation services are available and provide written notice informing members of the right to translation/interpretation services in their preferred language. Additionally, the AdSS must ensure access to oral interpretation, translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request. The services offered must be provided by an individual who is proficient and skilled in translation/interpretation. Translation/interpretation services must be provided at no cost to members.

Translations must be provided in the following manner:

a. All member materials must be translated when the AdSS is aware that a language is spoken by 3,000 or 10% (whichever is less) of the AdSS's members who also have Limited English Proficiency (LEP). However, those materials that are considered to be vital materials must be translated when the AdSS is aware that a language is spoken by 1,000 or 5% (whichever is less) of the AdSS's members who also have LEP.

b. All written notices informing members of their right to interpretation and translation services in a language, must be translated when the AdSS is aware that 1,000 or 5% (whichever is less) of the AdSS's members speak that language and have LEP.

c. The AdSS must make oral interpretation services available at no cost to the member. This applies to sign language and all non-English languages, not just those identified as prevalent. The AdSS must also provide information on which providers speak languages other than English. Refer to AdSS Operations Policy 404 for more information regarding language, readability, and oral interpretation requirements.

4. The AdSS must provide easy-to-understand print and member information materials as well as signage in the languages commonly used by the populations in the service area. This includes the production of materials with consideration of members with LEP or limited reading skills, those with diverse cultural and ethnic backgrounds, and those with visual or auditory limitations.

5. The AdSS and its subcontractors must:

a. Use licensed interpreters for the Deaf and the Hard of Hearing.

b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to persons with hearing loss.

6. 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.

B. CCP Assessment Reporting

The AdSS must assess its CCP for effectiveness, at a minimum on an annual basis, including modifications based on the assessment. The assessment should consider:

linguistic need, comparative member satisfaction surveys, outcomes for certain cultural groups, translator/interpretive services and use, member complaints, grievances, provider feedback and/or employee surveys. Identified issues must be tracked and trended, and actions taken to resolve the issue(s). The CCP should also address how the AdSS communicates its progress in implementing and sustaining the CCP goals to all stakeholders, members and the general public.

The CCP Assessment must be submitted with Attachment A, as specified in Section F3, Contractor Chart of Deliverables.

Language Access Plan

The AdSS must submit a Language Access Plan annually that indicates how the needs of members with Limited English Proficiency are met. The plan must be submitted with ACOM 405 Attachment A, as specified in the Contract. The plan must 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 AdSS's capacity to meet these needs according to the elements of this plan

B. Oral Language Assistance Services

Processes for providing oral language help (such as qualified interpreters or staff whose proficiency in non-English languages has been documented), in both face-to-face and telephone encounters, that addresses the needs as specified in assessment above. The AdSS must provide the established point of contact for members with LEP, such as an office, official, or phone number. The AdSS must include the process used to ensure that the interpreters used are qualified to provide the service and understand interpreter ethics and client 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, AdSS Operations Manual, Policy 404, and ACOM Policy 406,

D. Policies and Procedures

Written policies and procedures that ensure members with LEP have **meaningful access** to programs and activities

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

Processes to inform members with LEP that language help is available at no cost. The AdSS must take steps to ensure meaningful access to its programs, including notifying current and potential members with LEP about the availability of free

language help. Notification methods may include multilingual taglines in member materials, and 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. Staff Training

Description of employee training to ensure management and staff understand and can implement the policies and procedures of this 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
- 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 customer need
- Evaluate progress on an ongoing basis

I. Subcontractor Assurance and Compliance

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

Children's Rehabilitative Services (CRS) Family-Centered and Culturally Competent Care

The CRS AdSS provides family-centered care in all aspects of the service delivery system (as specified in Division Medical Manual Policy 330). The additional responsibilities of the CRS AdSS for support of family-centered care include, but are not limited to:

A. Recognizing the family as the primary source of support for the member's health care decision-making process; service systems and personnel should be made available to support the family's role as decision makers

B. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:

   1. Care of the member

   2. Development, implementation, evaluation of programs

   3. Policy development

C. Promoting a complete exchange of unbiased information between recipients, families, and health care professionals in a supportive manner at all times

D. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families

E. Implementing practices and policies that support the needs of recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs

F. Participating in Family-Centered Cultural Competence Trainings

G. Facilitating family-to-family support and networking

H. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family

I. Acknowledging that families are essential to the members' health and well-being and are crucial allies for quality within the service delivery system

J. Appreciating and recognizing the unique nature of each recipient and their family.

406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10, 42 CFR 438.102(a)(2); ACOM Policy 404, Attachment C, ACOM 406 Attachment A; ACOM 406 Attachment B; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Member Handbook; Member Handbook Request for Approval to Forgo Issuing Hard Copy; Website Certification

Purpose

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines regarding member handbooks and provider directories.

Definitions

A. Business Day - A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

B. Multi-Specialty Interdisciplinary Clinic (MSIC) - A facility where specialists from more than one specialty meet with members and their families in order to provide interdisciplinary services to treat members.

General Requirements

A. The AdSS must provide annually a Member Handbook to members.

B. The AdSS must provide annually a Provider Directory to members.

C. The member handbook must contain all information required, as identified in AHCCCS ACOM 406 Attachment A, Model Member Handbook Checklist, including definitions as required by Centers for Medicare and Medicaid Services specified in AHCCCS ACOM 406 Attachment B, Definitions for AHCCCS Members. The required information must be incorporated into the AdSS's Member Handbook in the order identified on the Checklist.

D. The Member Handbook must be submitted as described in the section "Member Handbook Review Process" below.

E. The Division may require the AdSS to publish information modifying or expanding the contents of the AdSS's Member Handbook, and to distribute this information in the form of inserts and supply these inserts with subsequently distributed Member Handbooks.

F. The AdSS must update paper provider directories at least monthly [42 CFR 438.10(h)(3)],

G. The AdSS must ensure the electronic versions of the Member Handbook and Provider Directory meet the following requirements [42 CFR 438.10]:

1. The format is readily accessible.

2. The information is located in a place on the AdSS's website that is prominent and readily accessible.

3. The information is provided in an electronic form which can be electronically retained and printed.

4. The information is consistent with federal content and language requirements.

5. The member is informed that the information is available in paper form upon request at no cost and it is provided within five business days

6. Adhere to the requirements identified in Policy 416 in this Policy Manual. [42 CFR 438.10(h)(3)].

H. Language and format requirements are as outlined in Policy 404 in this Policy Manual.

Member Handbooks

A. Member Handbook Review Process

The AdSS's Member Handbook, along with a redlined version, must be submitted annually as specified in Section F3, Chart of Deliverables, or as directed by the Division. A copy of the Member Handbook must be submitted to the Division after the Division has given final approval, as specified in Section F3, Contractor Chart of Deliverables. The Division is responsible for the Member Handbooks and Provider Directories issued by its AdSS.

B. Distribution Requirements

1. Electronic-Only Member Handbooks

If a hard copy member handbook will not be provided:

a. Submit a request for approval to forego providing the hard copy of the handbook and include a statement of intent to notify members as specified in Section F3, Contractor Chart of Deliverables.

Ensure the written notification gives the member the option to obtain a printed version of the member handbook.

b. Acquire approval of the member notification in accordance with Administrative Services Subcontractors Operations Manual, Policy 404.

c. Send the written notification to members within the member handbook timeframes as outlined above [42 CFR 438.102(a)(2)].

2. Providing Member Handbooks to Members

   a. Provide to the member either a hard copy of the member handbook or an electronic version of the member handbook (or both versions) as follows:

      i. Hard Copy

         Provide the member handbook in hard copy format with the new member packet or inform the member that the information is available in paper form upon request at no cost and provide it within five business days.

      ii. Electronic

         Via electronic mail or postal mailing, provide notification of how to access the information in the member handbook on the AdSS website, to each member/representative or household within 10 business days of receipt of:

         - Notification of the enrollment date [42 CFR 438.102(a)(2)]
         - When member is determined medically eligible for CRS covered services [42 CFR 438.102(a)(2)]

   b. Annually, provide the member handbook, or notification of how to access the information in the member handbook, to each member/representative or household.

C. Other Requirements

1. The Division may, at its discretion, require the AdSS to provide written notification that the AdSS's member handbook is available on the subcontractor's website, or upon request via electronic mail or by postal mailing.

2. The AdSS must, when providing behavioral health services, make available copies of the member handbook to known consumer and family advocacy organizations and other human service organizations.

3. Member Handbook Inserts – the Division may require the AdSS to update its Member Handbooks throughout the contract year to address program changes for inclusion in the member handbook.

   a. These changes must be incorporated in subsequently distributed handbooks through inserts until the handbooks are updated with the new information.

   b. The AdSS must also post the content of the insert on its website.

Provider Directory

A. Creating, Revising, and Maintaining Provider Directories

The AdSS must:

1. Update paper provider directory at least monthly [42 CFR 438.10(h)(3)].

2. Ensure the electronic version of the provider directory is searchable (including specialists for referrals) and meets the following requirements [42 CFR 438.10] (see ACOM Policy 404, Attachment C).

   a. Format is readily accessible and user friendly.

   b. Information is placed in a location on the AdSS's website that is prominent and readily accessible.

   c. Information is provided in an electronic form which can be electronically retained and printed.

   d. Information is consistent with federal content and language requirements.

   e. Language and formatting comply with Division Administrative Services Subcontractors Operations Manual Policy 404. [42 CFR 438.10]

3. Adhere to the requirements identified in AdSS Operations Policy Manual, Policy 416 [42 CFR 438.10(h)(3)].

4. Ensure the provider directory (hard copy and electronic) includes:

   Note: See 42 CFR 438.10.

   a. Provider name as well as any group affiliation

   b. Provider address

   c. Provider telephone number

   d. Web site 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 following provider types:

      i. Physicians, including specialists

      ii. Hospitals

iii. Pharmacies

iv. Behavioral Health Providers

v. Skilled Nursing Facilities

vi. Emergency Alert System

vii. Physical Therapy for members age 21 and over

viii. Community-based, peer and family support providers throughout the State, and

ix. MSICs

i. 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, and whether the provider has completed cultural competence training

j. Locations 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 for identifying provider locations that meet the AdSS's criteria for accommodating members with physical or cognitive disabilities and a description of how the members can obtain details of the accessibility features for specific providers with this designation.

l. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide Multi-Specialty, Interdisciplinary Care when needed in other areas of the State.

m. The following provider and MSIC-specific information:

i. Specialty Provider and MSIC names

ii. Specialty Provider and MSIC address

iii. Specialty Provider and MSIC telephone number

iv. Non-English languages spoken by providers

v. Whether or not the specialty provider is accepting new patients

n. Any restrictions on the member's freedom of choice among network providers and MSICs (this information must be current and can be in the same form as typical correspondence to members).

o. For CRS provider directory, the additional following information:

i. Physicians (including adult and child psychiatrists), laboratory, x-ray and therapy services available onsite at the MSIC and through a network of community-based providers closer to members' homes

ii. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State

iii. Community-based, family support providers throughout the state.

B. Providing Provider Directories to Members

The AdSS must:

1. Inform the member that information is available in paper form upon request at no cost, and if the information is requested in paper form, provide it within five business days.

2. Provide to the member either a hard copy of the provider directory or an explanation of how to use the electronic version of the provider directory (or both versions) as follows:

a. Hard Copy

Provide the provider directory in hard copy format with the new member packet.

b. Electronic

Within 10 business days of receipt of notification of the enrollment date [42 CFR 438.102(a)(2)], inform each member/representative or household how to access the provider directory.

Via electronic mail, postal mailing, or inclusion in the member handbook, provide written notification of how the provider directory information is available to the member on the AdSS's website. This member notification must:

i. Be approved in accordance with this policy and with Division Administrative Services Subcontractors Operations Manual Policy 404

ii. Give the member the option to obtain a hard copy version of the provider directory.

D. Other Requirements

The Division may, at its discretion, require the AdSS to provide written notification that the AdSS's provider directory is available on the subcontractor's website, or upon request via electronic mail or by postal mailing.

407 WORKFORCE DEVELOPMENT

EFFECTIVE DATE: October 1, 2019

DELIVERABLES: Workforce Develolpment Plan; Workforce Development Plan Implementation Progress Report

This policy applies to the Division's Administrative Services Subcontractors (AdSS). Overseeing the development of the provider workforce is a function of the AdSS's network management responsibilities. The purpose of this policy is to describe the AdSS requirements to monitor and collect information about the workforce, collaboratively plan workforce development initiatives including the recruitment and employment of members eligible for the Division into healthcare roles, and when necessary, provide direct assistance to providers in order to develop the workforce.

Definitions

Competency Requirement - A requirement mandating personnel to behaviorally demonstrate to a qualified staff member that they have acquired specific information or skill and or that they are capable of routinely using the information or skill in the performance of their duties.

Training Requirement - A requirement mandating personnel to participate in a specific training course or program.

A. General

The Division, AHCCCS, providers and the AdSS work together to ensure members receive services from a workforce that is qualified, capable and sufficiently staffed,

1. Providers are responsible for acquiring, developing and deploying a sufficiently staffed and qualified workforce that capably delivers services to members.

2. AHCCCS and the Division are responsible for generating policies that shape worker, workplace and workforce development practices. AHCCCS's Office of Workforce Policy analyzes current and future healthcare trends; forecasts the workforce capacities and capabilities needed to address these trends, and assists Contractors and providers by mobilizing governmental and community resources as necessary to strengthen Arizona's healthcare workforce.

3. AdSS are responsible for ensuring that provider workforce management and development processes are aligned with the Division's workplace and workforce development policies. The AdSS monitors the performance of the network, collects information about the workforce, develops plans to strengthen the workforce, and when necessary, directly assist providers to develop and maintain a qualified, capable and sufficiently capacitated workforce.

The AdSS must ensure that subcontracted provider organizations are deploying a qualified, sufficiently staffed workforce that capably provides services to members eligible for the Division in an interpersonally, clinically, culturally and technically effective manner.

B. Maintain A Workforce Policy Management Function

The AdSS must perform specific workforce monitoring, data collection, planning and technical assistance as follows:

1. Maintain a workforce policy management function to implement the requirements of this policy.

2. Designate a staff member with experience and expertise in workforce development to oversee the AdSS's workforce development responsibilities.

3. Ensure that resources are available to monitor provider workforce development activities, collect workforce data, produce a workforce development plan, ensure subcontracted personnel are receiving the training required by Division policy, and provide technical assistance to provider organizations to improve their workforce development programs if determined necessary.

C. Workforce Development Plan And Progress Report

The AdSS must produce a Workforce Development Plan (WFD) in collaboration with providers, members eligible for the Division and their families and other stakeholders including but limited to Division staff, other Division Administrative Services Subcontractors, and industry, education and community groups. The WFD Plan must describe the goals, objectives, tasks and timelines to develop the workforce. The WFD Plan must be submitted as specified in Contract.

The WFD Plan must include the following:

1. Short and long term strategic WFD capacity and capability requirements (e.g. addressing health professional shortage areas, and integrated care)

2. Forecast of anticipated workforce capacity (size, job types etc.) and capability (skills and workplace support) needs

3. Specific WFD goals

4. Description of the actions to be taken to implement WFD initiatives, such as programs to recruit members eligible for the Division to seek employment in various roles within the AHCCCS healthcare system, and

5. How stakeholders, members, families and the general public will be involved in the development and implementation of the WFD Plan.

The AdSS must maintain a general assessment of the progress of the WFD Plan and must formally assess and submit a written WFD Progress Report of overall progress as specified in Contract. The WFD Progress Report(s) must include:

1. Progress being made toward the achievement of statewide WFD goals as well as AdSS specific – provider network identified WFD goals, and

2. A summary of technical assistance activities provided to provider organizations.

D. Monitor Provider Workforce Development Activities

Division and AHCCCS policies, guidance documents, manuals and plans may include training and or competency requirements. As part of the routine audit and compliance monitoring process the Contractor must ensure the following:

1. All required training content or competency descriptions are incorporated into the appropriate orientation, education or training program and evaluation processes and are being made available to provider personnel.

2. Providers have processes for documenting training, verifying the qualifications, skills and knowledge of personnel, and retaining required training and competency transcripts and records

3. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

E. Workforce Data

The AdSS must collect and analyze required and ad hoc workforce data. This process must include, but is not limited to, the following:

1. Proactively identifying potential challenges and threats to the viability of the workforce

2. Conducting analysis of the potential impact of the challenges and threats to access to care for members

3. Developing and implementing interventions to prevent or mitigate threats to workforce viability

4. Developing indicators to measure and monitor workforce sustainability.

The AdSS must also assist the Division to develop forecasts and plans concerning the WFD needs of Arizona's healthcare system.

F. Provider Technical Assistance

On an as needed basis, the AdSS must provide technical assistance to providers to develop, implement and improve workforce recruitment, selection, evaluation, education, training and retention programs. The Contractor must determine the need, scope (all, segments or individual providers), and the most effective and efficient methods for providing technical assistance to providers. Potential examples of technical assistance include, but are not limited to, the following:

1. Workforce development planning
2. Talent identification and acquisition
3. Competency based training and development programs and systems
4. Workforce retention and promotion strategies
5. Workplace culture development.

The AdSS's technical assistance activities must be reported on the WFD Progress Report(s).

408 SANCTIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §36-2903.01(B)(4); 42 CFR 438.700 et sq.

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy specifies the sanctions that may be imposed by the Division o in accordance with federal and state laws, regulations and the contract with the Division. This policy does not limit the authority of the Division or AHCCCS Office of the Inspector General to investigate fraud, waste and abuse, conduct audits, and pursue any legal remedies arising from the findings of those investigations and audits.

Definitions

A. Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks 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 AdSS and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency

B. Notice to Cure (NTC) - A formal written notice to an AdSS regarding specific non-compliance. The NTC contains specific timelines for meeting performance standards and possible penalties for continued non-compliance. An NTC may contain specific activities or reporting requirements that must be adhered to as the AdSS works toward compliance. Failure to achieve compliance as the result of a Notice to Cure may result in the imposition of a Sanction

C. Sanction - A monetary and/or non-monetary penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility. Non-monetary penalties may include, but are not limited to any or all the following:

1. Appointment of temporary management for the AdSS, granting the AdSS enrollees the right to terminate enrollment with the AdSS

2. Suspension of auto-assignment and/or new enrollment

3. Suspension of payment to the AdSS until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

General

The Division expects the AdSS to align its performance of the Contract with the AHCCCS and Division mission and vision and implement program innovation and best practices on a continual basis while adding value to the ALTCS program.

If the AdSS fails to demonstrate compliance with contractual requirements, the Division may elect to impose an administrative action. The Division reserves the right to issue an administrative action for any occurrence of non-compliance. Each occurrence of non-compliance will be evaluated for determination and issuance of potential administrative

action. Administrative actions may include issuance of any or all the following: Notice of Concern, Notice to Cure, a mandate for a Corrective Action Plan, and Sanctions. The administrative actions described in this policy are non-exclusive; that is, the issuance of an administrative action or the imposition of any sanction by the Division does not preclude the Division from pursuing any other remedy available in law or contract arising from the same conduct.

To promote transparency, administrative actions and related documentation may be published on the Division website.

Division Compliance Committee

A. Except for encounter-related sanctions for aged, pended encounters as outlined in the Division Encounter Manual, the Division Compliance Committee will evaluate recommendations for proposed sanctions and will determine the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee, however, will regularly review encounter-related sanctions to ensure just and consistent application of such sanctions. The Compliance Committee may, but is not required to, review administrative actions that do not include a sanction such as issuing a Notice of Concern, a Notice to Cure, or requiring a Corrective Action Plan.

B. The Division's Health Plan Compliance Committee is comprised of the following individuals, or their designees:

- Medical Director
- Compliance Officer
- Quality Management Manager
- Performance/Quality Improvement Coordinator
- Maternal Child Health/EPSDT Coordinator
- Medical Management Manager
- Network Manager
- Behavioral Health Coordinator
- Policy Manager

C. All Compliance Committee members listed above, or their designee, must be present at each Committee meeting. Sanctions will be approved based on a majority vote.

D. The Division's Health Plan Compliance Committee may consult with subject matter experts as appropriate and will consider the following in its decision making:

1. Applicable statutes and rules and contractual requirements

2. Application of consistent standards for determination of sanction type administrative actions

3. The goals and objectives of the agency

4. Aggravating or mitigating factors such as:

a. Quality of care or safety concerns for members

b. Repeated/continual deficiencies

c. Previous administrative actions

d. Intentional non-compliance

e. Self-identification of deficiencies and remediation

f. Risk to the financial viability of the AdSS

g. Non-compliance with key staffing requirements

h. Financial implications for providers,

i. Financial harm to the state.

E. Upon the Committee's decision regarding the sanction, the Division will provide written notification to the AdSS which explains the basis and nature of the sanction, and any applicable appeal rights [42 CFR 438.710(a)(1)].

Basis for Imposition of Sanctions

The Division may impose sanctions for any breach of the Contract, or any failure to comply with applicable state or federal laws or regulations including but not limited to any conduct described in 42 CFR 438.700 et seq.

Types of Sanctions

The Division may impose the following types of sanctions:

A. Member Enrollment Related Sanctions

the Division may sanction an AdSS by:

1. Granting members, the right to terminate enrollment without cause and notifying the affected members of their right to disenroll (If another AdSS is available)

2. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction (if another AdSS is available)

3. Suspending payment for members enrolled after the effective date of the sanction until CMS or the Division is satisfied that the reason for the sanction no longer exists and is not likely to recur.

Right to Appeal

The AdSS may file a grievance to dispute the decision to impose a sanction in accordance with A.R.S. §36-2903.01(B)(4).

Sanctions Imposed to AdSS

A. Sanctions imposed against the Division by AHCCCS for noncompliance with requirements for encounter data or reporting that would not have been imposed but for the AdSS action or lack thereof will be assessed to the AdSS as actual damages.

B. Any other sanctions imposed against the Division by AHCCCS in accordance with applicable AHCCCS rules, policies, and procedures that would not have been imposed but for the AdSS action or lack thereof will be assessed dollar for dollar to the Contractor as actual damages.

C. Sanctions imposed against the Division by AHCCCS for failure of AdSS to submit requested disclosure statements will be assessed dollar for dollar to the AdSS as actual damages.

412 CLAIMS RECOUPMENT

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2901, 35-214; A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq.; Deficit Reduction Act of 2005 (Public Law 109-171); 42 CFR 438.600 et seq.

DELIVERABLES: Claim Recoupments >12 Months from Original Payment; Data Processes for Recoupments; Single Claim Recoupments >$50,000

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It outlines the guidelines for claims recoupment and refund activities.

AdSS are responsible for reimbursing their providers and coordinating care for services provided to a member pursuant to state and federal regulations.

Definitions

A. Day - Calendar day unless otherwise specified.

B. Provider - Any person or entity that contracts with the AdSS for the provision of covered services to members according to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a provider delivering such services.

C. Recoupment - An action initiated by the AdSS to recover all or part of a previously paid claim(s). Recoupments include AdSS initiated/requested repayments, as well as overpayments identified by the provider where the AdSS seeks to actively withhold or withdraw funds to correct the overpayment from the provider. For purposes of this policy, a recoupment is a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days. An adjustment that is greater than $50,000 and is completed within 30 days is not considered a recoupment but must be tracked and made available to the Division 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.

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

Recoupments Over $50,000 Or One Year

A. Single Recoupment in Excess of $50,000

Prior to initiating any single recoupment in excess of $50,000 per provider Tax Identification Number (TIN), the AdSS must submit a written request for approval to the Division Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation that describes:

    a. How the need for recoupment was identified

b. The systemic causes resulting in the need for a recoupment

c. The process that will be used to recover the funds

d. Methods to notify the affected provider(s) prior to recoupment

e. The anticipated timeline for the project

f. The corrective actions that will be implemented to avoid future occurrences

g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted

h. Other recoupment action specific to this provider within the contract year.

2. An electronic file containing:

a. AHCCCS member ID

b. Date of service

c. AHCCCS original claim number

d. Date of payment

e. Amount paid

f. Amount to be recouped.

3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include, at a minimum:

a. How the need for the recoupment was identified

b. The process that will be used to recover the funds

c. The anticipated timeline for the recoupment

d. The provider's right to file a claim dispute

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

f. Listing of impacted claim numbers.

The written communication must be approved by Division prior to being sent to the provider(s).

B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment

The AdSS 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 approval is obtained from the Division. Retroactive third party recoveries for Third Party Liability (TPL) are not included in this discussion.

To request approval from the Division, the AdSS must submit a request in writing to the designated Division Compliance Officer with all the following information:

1. A detailed letter of explanation that describes:
    a. How the need for the recoupment was identified
    b. The systemic causes resulting in the need for recoupment
    c. The process that will be used to recover the funds
    d. Methods to notify the affected provider(s) prior to recoupment
    e. The anticipated timeline for the project
    f. The corrective actions that will be implemented to avoid future occurrences
    g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted.
2. An Electronic file containing:
    a. AHCCCS member ID
    b. Date of service
    c. AHCCCS original claim number
    d. Date of payment
    e. Amount paid
    f. Amount to be recouped.
3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include at a minimum:
    a. How the need for the recoupment was identified
    b. The process that will be used to recover the funds
    c. The anticipated timeline for the recoupment
    d. Total recoupment amount, total number of claims, and ranges of dates for the claims being recouped
    e. Listing of impacted claim numbers.

The written communication must be approved by the Division prior to being sent to the provider(s).

C. Cumulative Recoupment in Excess of $50,000 per Contract Year

The AdSS must continuously track 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 AdSS must report the cumulative recoupment monthly to the designated Division Compliance Officer as outlined in the Division Claims Dashboard Reporting Guide.

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

EFFECTIVE DATE: October 1, 2019

REFERENCES: Section F3, Contractor Chart of Deliverables; 42 CFR 438; 42 CFR 431.211; 42 U.S.C. 1396d(r)(5); A.A.C. R9-34-202, A.A.C. R9-22-213; ACOM Policy 414-Attachments A, B, and C

DELIVERABLE: Notice of Adverse Benefit Determination Audit

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This Policy provides clarification regarding required content of a Notice of Adverse Benefit Determination (NOA) relating to Title XIX/XXI coverage and authorization of services. The AdSS must follow all other requirements regarding Notice of Adverse Benefit Determination set forth in Contract and refer to as NOA throughout.

Definitions

A. Adverse Benefit Determination - The denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.

B. Appeal - A request for review of an Adverse Benefit Determination.

C. Calendar days - Every day of the week including weekends and holidays.

D. Computation of time in calendar days - Computation of time in calendar days that begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates only, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the "count" always begins on the day after the event.

E. Expedited service authorization request - A request for services in which either the requesting provider indicates, or the AdSS 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.

F. Legal holidays - Legal holidays as defined by the State of Arizona are:

- New Year's Day – January 1
- Martin Luther King Jr./Civil Rights Day – 3rd Monday in January
- Lincoln/Washington Presidents' Day – 3rd Monday in February
- Memorial Day – Last Monday in May

- Independence Day – July 4
- Labor Day – 1st Monday in September
- Columbus Day – 2nd Monday in October
- Veterans Day – November 11
- Thanksgiving Day – 4th Thursday in November
- 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.

G. Notice of Adverse Benefit Determination (NOA) – 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.

H. Notice of Extension (NOE) – 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 criteria for a service authorization extension are met.

I. Service authorization request - 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 AdSS.

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

- A legal holiday falls on one of these days; or
- A legal holiday falls on Saturday or Sunday and an AdSS is closed for business the prior Friday or following Monday.

Policy Overview

When the AdSS decides to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services, the AdSS must provide a written NOA to the member as described in 42 CFR 438.404.

A. The AdSS must use the AHCCCS-developed member NOA templates specified in 42 CFR 438.10(c)(4)(ii). The templates must not be altered except for the areas designated in the template that permit alteration and the removal of the header. Refer to AHCCCS Contractors Operations Manual (ACOM) 414 Attachment A-1 (Notice of Adverse Benefit Determination not Involving Medications Template) for the NOA template for service authorization requests that do not pertain to medications and AHCCCS Contractors Operations Manual (ACOM) 414 Attachment A-2 (Notice of

Adverse Benefit Determination Involving Medications Template) for the NOA template for service authorization requests that pertain to medications.

B. The AdSS Member Handbook informs members:

1. Of their right to make a complaint to the AdSS about an inadequate NOA.

2. That if the AdSS does not resolve the complaint about the NOA to the member's satisfaction, the member may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at MedicalManagement@azahcccs.gov; and

3. That the AdSS and its providers are prohibited from taking punitive action against members exercising their right to appeal.

Right to be represented

The AdSS acknowledges the member's right to be assisted by a third-party representative, including an attorney, during an appeal of an Adverse Benefit Determination. A list of legal aid services available to members is provided in ACOM Policy 414, Attachment B (Legal Services Program). The AdSS's appeals process registers the existence of the third-party and the AdSS ensures that the required communications related to the appeals process occur between the AdSS and the representative. The member's representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy laws, the AdSS must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member, however, if the AdSS questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

Notice of Adverse Benefit Determination Content Requirements

A. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the information necessary for the member to understand the Adverse Benefit Determination, the reason for the AdSS's determination such that the member may make an informed decision regarding appealing the determination, and how to appeal the decision. If the reason for the denial of a service authorization request is due to the lack of necessary information, the member must be clearly informed of that reason in order to be given the opportunity to provide the necessary information.

B. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the following information and must be consistent with 42 CFR 438.404:

1. The requested service;

2. The reason or purpose of the requested service;

3. The reasons for the Adverse Benefit Determination the AdSS has made or

intends to make (i.e. denial, limited authorization, reduction, suspension or termination) with respect to the requested service consistent with 42 CFR 438.404(b)(1);

4. The effective date of a service denial, limited authorization, reduction, suspension, or termination;

5. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member'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);

6. The legal basis for the Adverse Benefit Determination;

7. Where members can find copies of the legal basis, (e.g. the local public library and the web page with links to legal authorities). When a legal authority or an internal reference to the AdSS's policy manual is available online, the AdSS must provide the accurate URL site to enable the member to find the reference online;

8. A listing of legal aid resources;

9. The member's right to request an appeal and procedures for filing an appeal of the AdSS Adverse Benefit Determination, including information on exhausting the AdSS'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);

10. The procedures for exercising the member's rights as described in 42 CFR 438.404(b)(4);

11. The circumstances under which an appeal process can be expedited and how to request it; and

12. 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 member may be required to pay the costs of continued services if the appeal is denied [42 CFR 438.420(d)].

C. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically necessary. Failure to provide the reasons and explanation supporting the lack of medical necessity in the Adverse Benefit Determination will result in regulatory action by AHCCCS. Refer to ACOM 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination) for examples where medical necessity is appropriately used in denying or limiting services.

D. The NOA must state the reasons supporting the denial, reduction, limitation, suspension, or termination of a service. NOAs that do not provide explanation of

why the service has been denied, reduced, limited, suspended, or terminated and merely refer the member to a third party for more information are unacceptable. The AdSS may include a statement referring a member to a third party for more help when the third party can explain treatment alternatives in more detail.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

The AdSS must 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. The AdSS must explain in accordance with this Policy and the AdSS Medical Manual Policy 430 the denial, reduction, limitation, suspension, or termination of the requested EPSDT service.

In such circumstances, the AdSS must specify why the requested service does not meet the EPSDT criteria and is not covered and must 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.

Member Complaints Regarding the Adequacy or Understandability of the Notice of Adverse Benefit Determination

If a member complains about the adequacy of an NOA, the AdSS must review the initial NOA against the content requirements of this Policy. If the AdSS determines that the original NOA is inadequate or deficient, the AdSS must issue an amended NOA consistent with the requirements of this Policy. Should an amended NOA be required, the timeframe for the member to appeal and continuation of services must start from the date of the amended NOA.

Timeframes for Service Authorization Decisions

A. All references to "days" in this Policy mean "calendar days" unless otherwise specified.

B. When a service authorization request is submitted, the AdSS ensures completion and issuance of the service authorization decision within the following timeframes. Different timeframes apply depending upon whether or not the service authorization request is a standard request, an expedited request, and whether the service request relates to medications. The date/time the AdSS receives the request is considered the date/time of receipt, whichever is applicable. The date/time is used to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The AdSS may use electronic date stamps or manual stamping for logging the receipt. If the AdSS subcontracts prior authorization to a delegated entity, the date or time the delegated entity receives the request is used for establishing receipt of the request.

C. Standard and expedited authorization requests pertain to service requests that do not involve medications. Service authorization decisions pertaining to requests for medication must be completed within the timeframe specified below and do not follow the standard or expedited timeframes used for other service authorization requests.

D. An expedited authorization request is a request for a service that is not medication in which either the requesting provider indicates, or the AdSS determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. For expedited requests that meet these requirements, the authorization decision is prioritized and must be completed in the 72-hour expedited timeframe as described in this Section.

E. A standard authorization request is a request for a service that is not medication and does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the AdSS receives the request is considered the date of receipt and is used to determine the due date for completion of the decision.

F. For expedited service authorization requests and medication requests, the time the request is received is used to determine the completion time for the decision.

G. Service Authorization Decision Timeframe for Medications

1. The AdSS must issues service authorization decision for medication no later than 24 hours from receipt of the submitted request for PA regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. If the prior authorization request lacks sufficient information for the AdSS to render a decision for the medication, the AdSS must send a request for additional information to the prescriber no later than 24 hours from receipt of the request. The AdSS must issue a final decision no later than seven working days from the initial date of request. Refer to 42 CFR 438.3(s).

H. Standard Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications

1. The AdSS must 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.

2. The AdSS may issue an NOE of up to 14 additional calendar days, utilizing ACOM 414 Attachment D, if the criteria for a service authorization extension are met as specified in this Policy.

I. Expedited Service Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications

1. The AdSS must 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.

2. The Division may issue an NOE of up to 14 additional calendar days, utilizing ACOM 414 Attachment D, if the criteria for a service authorization extension are met as specified in this Policy.

J. Expedited Service Authorization Request Treated as a Standard Request:

When the AdSS receives an expedited request for a service authorization and the service request fails to meet the requirements for expedited consideration, the AdSS may treat the expedited authorization request as a standard request. The AdSS must have a process included in the AdSS's policy for Prior Authorization (PA) that describes how the member will be notified of the downgrade change to a standard authorization request and be given an opportunity to provide additional information (Refer to Division of Developmental Disabilities Provider Policy Manual, Chapter 17). The requesting provider must be permitted to send additional documentation supporting the need for an expedited authorization.

K. Service Authorization Decisions Not Reached Within the Timeframes:

A service authorization decision that is not reached within the required timeframes for a standard, medication, or expedited request constitutes a denial. The AdSS must issue an NOA denying the request on the date that the timeframe expires.

L. Service Authorization Decisions Not Reached Within the Extended Timeframes:

A service authorization decision that is not reached within the timeframe noted in the NOE constitutes a denial. The AdSS must issue an NOA denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

<u>Timeframes for Completing Notices of Adverse Benefit Determinations</u>

The AdSS must mail the NOA within the following timeframes:

A. For termination, suspension, or reduction of a previously authorized service, the NOA must be mailed 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 AdSS must provide an NOA:

1. No later than 24 hours from the receipt of the request for authorization of medication regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. When the prior authorization request for a medication lacks sufficient information from the prescriber no later than 24 hours from receipt of the request. A final decision and an NOA must be rendered no later than seven working days from the initial date of the request.

2. For a non-medication request for authorization, 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 an 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)];

3. 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 an NOE. For extension timeframes, refer to NOE Requirements in this Policy.

Notice of Extension Requirements

NOE Timeframes

A. The AdSS may extend the timeframe to make a Service Authorization Decision for both standard and expedited service authorization requests when the member or provider (with written consent of the member) requests an extension, or when the AdSS justifies the need for additional information is in the member's best interest. The NOE must not be sent until the AdSS 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)];

B. For Standard Service Authorization requests (requests that do not involve medications), the AdSS 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 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;

C. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations (B)(2) in this Policy when the prior authorization requests lack sufficient information from the prescriber;

D. For an expedited Service Authorization Request (requests that do not involve medication), the AdSS 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;

E. Refer to Computation of Time in Calendar Days under "Definitions" for further information regarding when the end date falls on a weekend or legal holiday;

F. If the AdSS extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210(d)(1) the AdSS must:

1. Give the member written notice of the reason for the decision to extend the timeframe in easily understood language, at 6th grade or below reading level;

2. Include what information is needed in order to make a determination.

3. Inform the member of the right to file a grievance (complaint) if the member 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

4. 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); and

G. For examples of easily understood NOA language, refer to ACOM Policy 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination).

415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 415, 417, and 439, ACOM 415 Attachments A, B, D, E, F, Ga, Gb, ACOM 417 Attachment A; 9 A.A.C. R9-22-101, R9- 22-1201; A.R.S. §§ 36-2901, 36-3407; 42 CFR 438.207(b), Section F3, Contractor Chart of Deliverables

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; Value-Based Providers/Centers of Excellence Attachment to Provider Network Development and Management Plan

Network Development and Management Plan

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS provider networks must be a foundation that supports an individual's needs as well as the membership in general. This policy establishes guidelines for the submission of the Network Development and Management Plan to the Division.

The AdSS must develop and maintain a provider Network Development and Management Plan, which assures the Division that the provision of covered services will occur as stated in the contract [42 CFR 438.207(b)]. The Network Development and Management Plan must outline the AdSS's 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 satisfy all service delivery requirements.

The Network Development and Management Plan must be evaluated, updated, and submitted along with the following, as specified in Section F3, Contractor Chart of Deliverables:

A. ACOM 415 Attachment A, Network Attestation Statement

B. ACOM 415 Attachment B, Network Development and Management Plan Checklist

C. ACOM 417 Attachment A, Appointment Availability Provider Report.

The AdSS must notify the Division in writing when there has been a material change that would affect network capacity and services as outlined in contract and AdSS Operations Manual, Policy 439. The changes include, but are not limited to, changes in services, geographic service areas, and payments.

Provider/Network Changes Due to Rates Report

The AdSS must submit, as specified in Section F3, Contractor Chart Deliverables, a Provider/Network Changes Due to Rates Report, which consists of ACOM 415 Attachment D and E.

A. ACOM 415 Attachment D, Provider Terminations Due to Rates, documents providers who have terminated their contract due to rates. Submission of ACOM 415 Attachment D is required for each Geographical Service Area (GSA) even when the AdSS does not have any terminations to report.

B. ACOM 415 Attachment E, Providers That Diminished Their Scope of Services and/or Closed Their Panel Due to Rates, documents providers that have diminished their scope of service and/or closed their panel due to rates. Submission of ACOM 415 Attachment E is required for each GSA even when the AdSS does not have any providers to report.

Value-Based Providers/Centers of Excellence Report

The Centers of Excellence attachment shall outline the Contractor's process to develop, maintain and monitor activities for Centers of Excellence. The Attachment shall be limited to no more than two pages and include at a minimum:

A. Description of the Contractor's initiatives to encourage member utilization

B. Goals and outcome measures for the Contract Year

C. Description of monitoring activities to occur throughout the year

D. Evaluation of the effectiveness of the previous year's initiatives

E. Summary of lessons learned and any implemented changes

F. Description of the most significant barriers

G. Plan for next Contract Year.

416 PROVIDER NETWORK INFORMATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12, 42 CFR 438.100, 42 CFR 438.102

This Policy applies to the Division's Administrative Services Subcontractors. This Policy establishes guidelines for AdSS regarding provider information requirements and the content of a AdSS's website.

Definitions

A. Material Change to the Provider Network - Any change that affects, or can reasonably be foreseen to affect, the AdSS's ability to meet the performance and/or provider network standards as required in contract including, but not limited to, any change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

B. Provider - Any person or entity that contracts with the Division, AHCCCS, or an AdSS 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.

C. Subcontractor –

1. A provider of health care who agrees to furnish covered services to members.

2. A person, agency or organization with which the AdSS has contracted or delegated some of its management/ administrative functions or responsibilities.

3. 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 Division agreement.

The Contract contains multiple requirements for communications between AdSS and the AdSS's provider network. The information below instructs the AdSS on content and timing of these communications. The information below does not supersede any additional requirements that may be outlined in Contract.

Provider Manual

The AdSS must develop, distribute, and maintain a provider manual. The AdSS must ensure that each contracted provider is made aware of the provider manual available on the AdSS's website or, if requested, issued a hard copy of the provider manual. The AdSS is encouraged to distribute a provider manual to any individual or group that submits claim and encounter data.

The AdSS remains liable for ensuring that all providers, whether contracted or not, meet the applicable Division and AHCCCS requirements with regard to covered services, billing, etc.

At a minimum, the AdSS's provider manual must contain information on the following:

A. The ability of the member's PCP to treat behavioral health conditions within the scope of their practice.

B. Introduction to the AdSS which explains the AdSS's organization and administrative structure,

C. Provider responsibility and the AdSS's expectation of the provider,

D. Overview of the AdSS's Provider Services department and its function, including but not limited to the expected response times for provider calls,

E. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services,

F. Emergency Department use (appropriate and non-appropriate use of the emergency department),

G. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must 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/Family Planning services,

J. Criteria and process for referrals to specialists and other providers, including access to behavioral health services,

K. Grievance system process and procedures for providers and enrollees,

L. Billing and encounter submission information,

M. AdSS policies and procedures relevant to the providers including, but not limited to:

1. Utilization management,
2. Claims submission,
3. Criteria for identifying provider locations that accommodate members with physical or cognitive disabilities, and
4. Primary Care Provider (PCP) assignments.

N. Division Policies relevant to providers including, but not limited to:

1. Payment responsibilities as outlined in AdSS Operations Policy 432
2. Description of the Change of Contractor policies. See AdSS Operations Policy 401, and
3. Nursing Facility and Alternative Home and Community Based Service (HCBS) Setting contract termination procedures. See AdSS Operations Policy 421.

O. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e., Members who have Medicare and Medicaid),

P. Cost sharing responsibility,

Q. Explanation of remittance advice,

R. Criteria for the disclosure of member health information,

S. Medical record standards,

T. Prior authorization and notification requirements, including a listing of services that require authorization,

U. Requirements for behavioral health out of state placements for children and young adults,

V. Claims medical review,

W. Concurrent review,

X. 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,

Y. Credentialing and re-credentialing activities,

Z. Fraud, waste and abuse as specified in AdSS Operations Policy 103,

AA. Prescribing and monitoring psychotropic medications, including specific protocols for opiods and psychotropic medications, including, at a minimum, prior authorization and limits specified in AdSS Medical Policy 310-V, the AdSS

monitoring process for prescribers in AdSS Medical Policy 310-FF, and informed consent requirements in AdSS Medical Policy 320-Q.

BB. The AHCCCS Drug List and the AHCCCS Behavioral Health Drug List information available in a machine readable file and format, including:

1. How to access the drug lists electronically or by hard copy upon request,

2. How and when updates to these lists are communicated

CC. Division and AHCCCS appointment standards,

DD. Requirements pertaining to duty to warn and duty to report as outlined in Division Medical Manual, Policy 960,

EE. Information for behavioral health providers on their responsibilities for submitting to the Division demographic information according to the AHCCCS Demographic and Outcomes Data Set User Guide.

FF. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable,

GG. Ho to notify the AdSS and the Division when the provider changes address, contact information or other demographic information.

HH. Eligibility verification,

II. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English, including Sign Language, as specified in AdSS Operations Policy 405.

JJ. Peer review and the dispute process,

KK. Medication management services as specified in the Contract,

LL. A member's right to be treated with dignity and respect, as specified in 42 CFR 438.100, which includes the right to:

1. Be treated with dignity and respect

2. Receive information on availabile treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand

3. Participate in treatment decisions regarding his or her health care, including the right to refuse treatment

4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

5. Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and

applicable state law

6. Exercise his or her rights without adversely affecting service delivery to the member.

MM. That the AdSS has no policies that prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102,

NN. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions,

OO. General and informed consent for treatment requirements,

PP. Advanced directives,

QQ. Transition of members,

RR. Encounter validation studies,

SS. Pre-petition screening, court ordered evaluations, and court ordered treatment,

TT. Behavioral health assessment and service planning requirements and Serious Mental Illness (SMI) eligibility determination,

UU. Housing criteria for individuals determined to have SMI,

VV. How providers assist members in obtaining a Member Handbook and other new member materials,

WW. Outreach, engagement, re-engagement and closure activities,

XX. Requirements for grant funded services provided to Special Populations,

YY. Behavioral health crisis intervention service requirements,

ZZ. Partnership requirements with families and family-run organizations in the children and adult behavioral health system,

AAA. Seclusion, restraint, and emergency response reporting requirements,

BBB. Incidents, accidents, and deaths reporting requirements,

CCC. Training requirements, and

DDD. Peer support/recovery training, certification, and clinical supervision requirements.

417 APPOINTMENT AVAILABILITY, MONITORING AND REPORTING

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-512.01; 42 CFR 438.206; ACOM 417 Attachment A

DELIVERABLES: Appointment Availability Review; Appointment Availability Review Methods; Appointment Availability, Monitoring and Reporting - Annual Summary

PURPOSE: This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes a common process for the AdSS to monitor and report appointment accessibility and availability in order to ensure compliance with Division network sufficiency standards. This policy does not apply to emergency conditions.

Definitions

1800 Report - An AHCCCS-generated document, provided quarterly, that identifies Primary Care Providers (PCPs) with a panel of more than 1,800 AHCCCS members.

Established Patient - A member who has received professional services from the physician or any other physician with that specific subspecialty that belongs to the same group practice within the past three years from the date of appointment.

New Patient - A member who has not received any professional services from the physician or another physician with that specific specialty and subspecialty that belongs to the same group practice within the past three years from the date of appointment.

Urgent Care Appointment – An appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

Monitoring Appointment Standards

A. The AdSS must provide services that are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. To ensure this, the AdSS must provide a comprehensive provider network that provides access to all services covered under the contract for all members. If the AdSS' network cannot provide medically necessary services required under contract, the AdSS must adequately and timely cover these services through an out-of-network provider until a network provider is contracted.

B. The AdSS must ensure the following contractual appointment and accessibility standards are met (42 CFR 438.206).

C. The AdSS must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department use.

D. The AdSS must have written policies and procedures educating its provider network regarding appointment time requirements. The AdSS must develop a corrective action plan when appointment standards are not met. In addition, the AdSS must develop a corrective action plan in conjunction with the provider when appropriate

[42 CFR 438.206(c)(1)(iv), (v) and (vi)].

General Appointment Standards for All Contractors

A. Primary Care Provider Appointments:

1. Urgent care appointments as expeditiously as the member's health condition requires but no later than two business days of request.

2. Routine care appointments within 21 calendar days of request.

B. Specialty Provider Appointments, including Dental Specialty:

1. Urgent care appointments as expeditiously as the member's health condition requires but no later than three business days of referral

2. Routine care appointments within 45 calendar days of referral.

C. Dental Provider Appointments:

1. Urgent appointments as expeditiously as the member's health condition requires, but no later than three business days of request

2. Routine care appointments within 45 calendar days of request.

D. Maternity Care Provider Appointments (Initial prenatal care appointments):

1. First trimester within 14 calendar days of request

2. Second trimester within seven calendar days of request

3. Third trimester within three business days of request

4. High-risk pregnancies as expeditiously as the member's health condition requires but no later than three business days of identification of high risk by the AdSS or maternity care provider, or immediately if an emergency exists.

General Behavioral Health Appointment Standards for AdSS and TRBHA Contractors

A. Behavioral Health Provider Appointments:

1. Urgent Need appointments as expeditiously as the member's health condition requires but within 24 hours from identification of need.

2. Routine care appointments:

a. Initial assessment within seven calendar days of referral or request for service.

b. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but no later

than 23 calendar days after the initial assessment

c. All subsequent behavioral health services as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

B. Referrals for Psychotropic Medications:

1. Assess the urgency of the need immediately.

2. If clinically indicated, provide an appointment with a Behavioral Health Medical Professional within a timeframe that ensures the member does not run out of needed medications, or does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 days from the identification of need.

Provider Appointment Availability Review

On a quarterly basis, the AdSS must conduct provider appointment availability reviews to assess the availability of Routine and Urgent appointments for Primary Care, Specialist, Dental, and Behavioral Health providers. The AdSS must also review these standards for Maternity Care providers relating to the first, second and third trimesters, as well as high-risk pregnancies.

The AdSS must conduct provider appointment availability reviews in sufficient quantity to ensure results are meaningful and representative of the AdSS' network. Appropriate methods include:

A. Appointment schedule review where the AdSS independently validate appointment availability;

B. Secret shopper phone calls where the AdSS anonymously validate appointment availability; and

C. Other methods approved by the Division.

The AdSS may supplement these efforts by targeting specific providers identified through performance monitoring systems such as:

- The 1800 report generated by AHCCCS that identifies PCPs with a panel of more than 1,800 AHCCCS members
- Quality of care concerns
- Complaints, grievances and the credentialing process

To obtain approval for any additional methods the AdSS must submit a request for approval outlining details (including scope, selection criteria, and any tools used to collect the information) to the Division prior to implementing the proposed method.

Tracking and Reporting

Providers in compliance with AHCCCS appointment standards when survey is delivered receive a pass for their survey result. The overall goal for compliance percentage must meet 90% or above when all passing surveys are totaled per provider type:

- PCP, Specialists, Dental: urgent appointments and routine appointments
- Maternity Care
- Behavioral Health

On a quarterly basis the AdSS must:

A. Monitor and track provider compliance with appointment availability for all provider and appointment types using the AHCCCS reporting template, as adopted by the Division, ACOM 417 Attachment A, Appointment Availability Provider Report.

B. Submit this information as identified in Section F3, Contractor Chart of Deliverables.

C. Include a cover letter that, at a minimum:

1. Summarizes the data entered into the ACOM 417 Attachment A;
2. Describes how the survey methodology represents appointment standards across the AdSS' network;
3. Explains significant trending in either direction (positive or negative);
4. Describes any interventions applied to areas of concern (including corrective action plans);
5. Includes the Division's Appointment Availability Template which provides previous quarters overall passed survey compliance percentages by provider type and appointment type, current reporting of overall passed survey compliance percentages by provider type and appointment type, compliance percentage change between the previous and current quarter and arrow indicating an increase or decrease in meeting 90% passed survey standard; and
6. Explanation of the Divisions Appointment Availability Template addressing findings, root causes why 90% standard not met, identified root causes for increase or decrease over last quarter and any interventions to take place before the next quarter in order to meet compliance.

Appointment Availability Monitoring and Review					
(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
Category	**Goal**	**PASS Surveys %** (*Previous reporting quarter & year)*	***PASS Surveys %*** *(Current reporting quarter & year)*	**% change**	**Increase/Decrease**
PCP, Specialist, Dental *URGENT NEED*	90%				
PCP, Specialist, Dental *ROUTINE NEED*	90%				
Maternity	90%				
Behavioral Health	90%				

1. Column 2 enter DD Standard 90%
2. Columns 3 and 4 provide percentage of total survey's passed. Surveys passed total include:

   a. PCP, Specialists and Dental new and established for Urgent appointments and Routine appointments.
   b. Maternity Care first trimester, second trimester, third trimester and high-risk pregnancy.
   c. Behavioral Health urgent, routine (initial assessment), routine (subsequent Behavioral services) and referrals for psychotropic medications.

3. In order to obtain total surveys passed percentage, divide the number of surveys passed by the number of surveys taken in each section of the ACOM 417 Attachment A template. **Example**: 1,115 surveys, 950 surveys passed = 950/1,115 = 0.8520X100 = 85.20%.
4. Column 5 insert the percentage change from current quarter reporting percentage to previous quarter reporting percentage. **Example**: 94.00 (previous quarter total compliance percentage) minus 88.00 (current quarters total compliance percentage) = 6% increase over last quarter.
5. Column 6 enter arrows accordingly, ↑ if the percentage from current reporting quarter and previous reporting quarter has increased and ↓ if the percentage has decreased.
6. If the percentage change has decreased or DD standard is not being met, provide root cause and interventions to increase percentage next quarter.

D. Annually the AdSS must summarize the results, trends, and interventions as a component of the Network Development and Management Plan. See Division Operations Manual, Policy 415, for additional guidelines for the submission of the Network Development and Management Plan.

E. The AdSS' contractor submission of the Network Development and Management Plan to the Division must also include an attestation affirming the validity of the methodologies used and significance of the results, along with any planned changes to the methodologies for the coming year.

F. The Division may review AdSS monitoring and corrective action plans implemented as a result of provider non-compliance with appointment standards.

418 PROVIDER AND AFFILIATE ADVANCE AND LOAN REQUEST

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901
DELIVERABLES: Equity Distributions; Provider Advances and Loans

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It establishes guidelines for the provision of advances and loans by the AdSS to providers and affiliates (related parties), including another line of business or fund within the AdSS organization.

Definitions

A. Affiliate (Related Party) - 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 a contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the offeror 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 persons.

B. Advance – Includes, but is not limited to, payment to a provider or affiliate by a contractor that 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.

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, persons 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 persons.

D. Day - Calendar day unless otherwise specified.

E. Provider - Any person or entity that contracts with the AdSS for the provision of covered services to members consistent with A.R.S. § 36-2901, or any subcontractor of a provider delivering services consistent with A.R.S. § 36-2901.

Advances and Loans

A. Individual and Cumulative Provider Advances

The AdSS must submit a written request for approval to the Division for any individual or cumulative provider advances in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. All requests for prior

approval are to be submitted to the Division's Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

All requests for approval must be in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
    a. The provider(s) name(s) and AHCCCS Identification Number(s)
    b. The date the provider and AdSS initiated discussions relating to the need for the advance
    c. The systemic organizational causes resulting in the need for an advance
    d. The process that will be utilized to reconcile the funds against claims payments
    e. The anticipated timeline for the project
    f. The corrective action(s) that will be implemented to avoid future occurrences; and,
    g. The total advance 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.
2. A copy of the written communication that will serve as notification to the affected provider(s).
3. Upon completion of the advance(s), the Division may request that the AdSS make available within three working days a listing of the payments to be advanced, organized by provider TIN if multiple providers are affected, that includes the following:
    a. AHCCCS Member ID
    b. Date of Service
    c. Original AHCCCS Claim Number
    d. Date of payment
    e. Amount paid
    f. Amount advanced
    g. Balance Due to/from the provider.

B. Individual and Cumulative Provider Loans

The AdSS must submit written notification to the Division of any individual or cumulative provider loan equal to or in excess of $50,000 per provider TIN within a contract year. All requests for prior approval are to be submitted to Division's Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

1. All requests for approval must include:

   a. A detailed letter of explanation must be submitted that describes the:

      i. Provider(s) name(s) and AHCCCS Identification Number(s)

      ii. Date the provider and contractor initiated discussions relating to the need for the loan

      iii. Systemic organizational causes resulting in the need for a loan

      iv. Process that will be utilized to reconcile the funds against claims payments

      v. Anticipated timeline for the project

      vi. Corrective action(s) that will be implemented to avoid future occurrences

      vii. 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.

   b. A copy of the written communication that will serve as notification to the affected provider(s).

2. Upon completion of the loan(s), the Division may request that the AdSS make available within three working days a listing of the payment(s) loaned, organized by provider TIN if multiple providers are affected, that includes the following:

   a. AHCCCS Member ID

   b. Date of service

   c. Original AHCCCS Claim Number

   d. Date of payment

   e. Amount paid

   f. Amount loaned

g. Balance due to/from the provider

C. Routine/Scheduled Advances or 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 the Division for prior approval. The request for approval must be submitted to the Division's Compliance Unit.

The Division may request additional information or periodic reconciliations related to these advances.

D. Routine/Scheduled Advances, Distributions, Loans, Loan Guarantees or Affiliates

The AdSS must submit a written request for approval to the Division for any advances, equity distributions, loans, loan guarantees, or investments in/to related parties or affiliates, including to another fund or line 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 submitted in the format of a detailed letter of explanation that describes the:

a. Related Party or Affiliate name

b. Amount

c. Type of request

d. Purpose or reason for request

e. Expected date of investment or distribution.

Division Responsibility and Authority

The Division reserves the right to evaluate and present all proposed advances, loans, loan guarantees, distributions, and investments, to the affected providers(s), related parties, or affiliates, as part of the approval and/or notification process. Communication will be at the timing and discretion of the Division.

The Division evaluates all advance and loan requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. A written determination will be sent to the AdSS by electronic mail contingent upon receipt of all required information from the AdSS.

421 CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE HOME AND COMMUNITY BASED SETTINGS

EFFECTIVE DATE: October 1,2019

REFERENCES: A.A.C. R9-28-101 et seq.; 42 CFR 483; AMPM Chapter 1200, Section 1230

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). This policy is limited to, and defines, the relationship between a Nursing Facility (NF) and/or an Alternative Home and Community Based Setting (AHCBS) and an AdSS following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. This policy delineates how the AdSS, NF, and AHCBS collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

Definitions

A. Add-On **-** Generally refers to contract standards that an AdSS may have with a NF to establish criteria for additional payment to the Class 1, 2, or 3 levels determined by the Universal Assessment Tool (UAT).

B. Alternative Home and Community Based Setting - Under the Home and Community Based Services (HCBS) program, members may receive certain services while they are living in an alternative HCBS setting. HCBS settings as defined in A.A.C. R9-28-101 et seq., and AMPM Chapter 1200, Section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH), Behavioral Health Residential Facilities, and Behavioral Health Supportive Homes.

C. Bed Hold Day **-** A 24 hour per day unit of service that is authorized by the Division Support Coordinator or the AdSS, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and/or therapeutic leave.

1. Short Term Hospitalization Leave – This service may be authorized for members residing in a Nursing Facility (NF), Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID) or Residential Treatment Center (RTC) that is licensed as a Behavioral Health Inpatient Facility when short-term hospitalization is medically necessary. The total number of days available for each member per year is limited to 12 days per contract year except as in #3 below.

2. Therapeutic Leave – If included in the member's care plan, this service may be authorized for members residing in an NF, ICF/IID or RTC that is licensed as a Behavioral Health Inpatient Facility due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as a part of discharge planning. The total number of therapeutic leave days available for each member per year is limited to nine days per contract year except as in #3 below.

3. Members under 21 years of age may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per year.

D. Nursing Facility (NF) - A health care facility that is licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Contracted NFs are those facilities that have a contract with an AdSS. Non-contracted NFs are those facilities that do not have a contract with an AdSS.

E. Subacute or Specialty Care - Generally refers to contract standards that an AdSS may have with a NF to establish criteria for paying a rate higher than the Class 1, 2 and 3 levels determined by the UAT.

F. Uniform Assessment Tool (UAT) - A standardized tool that is used by the AdSS to assess the acuity of NF residents and commonly used for HCBS residents residing in Assisted Living Centers (ALC) or Assisted Living Homes (ALH) settings. The use of the UAT is not intended to impact how the AdSS determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management). This tool is located in Chapter 1600 of the AHCCCS Medical Policy Manual.

Policy

A. Member/Resident Options When an NF or AHCBS Contract is Terminated

Affected members residing in an NF and/or HCBS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available AdSS that is contracted with the facility, or move to a setting that is contracted with their current AdSS.

A meeting between the AdSS, NF and/or HCBS and the Division will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

The AdSS in collaboration with the NF and/or AHCBS and the Division must develop a member/representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The AdSS must receive approval of their member/representative communication plan from the Division.

The plan must be submitted to the Division within five business days of the termination decision. All member communications must be consistent with guidelines found in the AdSS Operations Manual, Policy 404.

B. Reimbursement

1. Nursing Facilities

The AdSS must reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, the AdSS must reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or the AdSS's previously contracted rates. Should AHCCCS reduce its fee schedule, the AdSS must reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

If the AdSS had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the AdSS must apply those rates. If AHCCCS adjusts its fee schedule, the AdSS will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Home and Community Based Settings

The AdSS must reimburse the Alternative Home and Community Based Setting at the previously contracted rate. If AHCCCS adjusts its HCBS Fee Schedule rates, the AdSS will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

C. Quality of Care

If an AdSS or other entity, such as Arizona Department of Health Services (ADHS) Licensure, the Division, or AHCCCS identifies instances where the overall quality of care delivered by an NF or AHCBS places residents in immediate jeopardy, the AdSS will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or AHCBS.

In some cases, ADHS, the Division, or AHCCCS may require that the AdSS find new placements for members. In such cases, the AdSS must work with the members/representative to identify an appropriate placement that meets the needs of the member. The Division may require the AdSS to increase monitoring of facilities identified as having health or safety issues until the Division is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or HCBS, the AdSS must notify the Division. In these instances, the AdSS should review the financial, health and safety status prior to placing a member in a placement owned by the same entity. If an AdSS identifies a member specific quality of care concern, the AdSS must identify the concern to the NF or ARS for resolution. The AdSS must also report to external entities and to the Division as required by Division Medical Policy Manual Chapter 900.

D. Admissions/Discharges/Readmissions

1. NFs or AHCBSs are not required to accept new admissions of members who are not enrolled with the AdSS.

2. NFs are required to otherwise follow admission, readmission, transfer, and discharge rights, as specified in 42 CFR 438.12.

3. The AdSS may authorize bed hold days up to the allowed limit as specified in 9 A.A.C. 28.

423 FINANCIAL RESPONSIBILITY FOR COURT ORDERED TREATMENT FOR DUI/DOMESTIC VIOLENCE OR OTHER CRIMINAL OFFENSES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 28-1301, 28-1381, 28-1382, or 28-1383; A.R.S. § 36-2021 et seq.
DELIVERABLES: Monthly Outpatient Court Ordered Treatment

This Policy applies to Division's Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide clarification regarding the financial responsibility for the provision of specific mental health treatment/care when such treatment is ordered because of a judicial ruling.

Definitions

Court-Ordered Alcohol Treatment - Detoxification services or treatment provided according to A.R.S. Title 36, Chapter 18, Article 2.

DUI Client -An individual who is ordered by the court to receive DUI screening, DUI education, or DUI treatment as a result of an arrest or conviction for a violation of A.R.S. §§28-1381,§28-1382, or §28-1383.

DUI Education - A program in which a person participates in at least sixteen hours of classroom instruction relating to alcohol or other drugs.

DUI Screening - A preliminary interview and assessment of an offender to determine if the offender requires alcohol or other drug education or treatment. (A.R.S. §28-1301)

DUI Services - DUI Screening, DUI education, or DUI treatment provided to a member eligible for the Division.

DUI Treatment - A program consisting of at least twenty hours of participation in a group setting dealing with alcohol or other drugs in addition to the sixteen hours of education. (A.R.S. §28-1301)

Driving Under The Influence (DUI)

The AdSS is responsible for covering and reimbursing for services when the services are Division or AHCCCS covered, medically necessary services described in Statute, Rule, Contract or Policy. A court order is not necessarily a substitute for the AdSS obligation to determine the amount, duration and scope of medically necessary services. The AdSS should not assume that a court or administrative agency ordering DUI screening, education or treatment services is aware of the scope of the Division or AHCCCS covered services or of how medical necessity is defined for purposes of the Medicaid program. Nevertheless, the AdSS may take into consideration, the medical information and factual findings of the court or administrative agency in making the AdSS determination of medical necessity.

When a DUI screening, education or treatment is ordered by the court for a person who has been charged for driving under the influence pursuant to A.R.S. §36-2027, the cost

of the screening, education and/or treatment is the responsibility of the county, city, town, or charter city whose court ordered the screening, education and/or

treatment. See A.R.S. §36-2027 (E). The county, city or town is a source of third party liability for any court ordered evaluation and/or treatment services that are also Division or AHCCCS covered services. Upon receipt of the claim, the AdSS should deny the claim and return it to the provider with directions to bill the responsible county, city or town.

Domestic Violence Offender Treatment

When a person is convicted of a misdemeanor domestic violence offense, pursuant to A.R.S. §13-3601, the sentencing judge must order the person to complete a domestic violence offender treatment program that is provided by a facility approved by the Department of Health Services or a probation department. Pursuant to A.R.S. §13-3601.01. A person who is ordered to complete a domestic violence offender treatment program must pay the cost of the program.

Although a judge may determine that court ordered domestic violence offender treatment (including educational classes to meet the requirements of the court order) is the financial responsibility of the offender under A.R.S. §13-3601.01, a member eligible for the Division cannot be considered a legally responsible third party with respect to themselves. As a result, it is the Division's expectation that the AdSS responsible for the provision of behavioral health services will provide domestic violence offender treatment when the service is deemed medically necessary. The member is not a source of first or third party liability as defined in A.A.C. R9-22-1001 when required prior authorization is obtained and/or the service is provided by an in-network provider. The AdSS must provide medically necessary services and ensure that the member's medical record includes documentation to justify the medical necessity for the services rendered.

Court Ordered Treatment For Persons Accused Of Other Crimes

Pursuant to A.R.S §36-2027, a court may order evaluation and treatment at an approved treatment facility of a person who is brought before the court and charged with a crime if:

A. It appears the person is an alcoholic, and

B. Such person chooses the evaluation and treatment procedures. The court cannot order the person to undergo treatment and evaluation for more than 30 days.

The cost of evaluation and treatment of an indigent patient treated pursuant to a court order under A.R.S. §36-2027 is the responsibility of the county, city, town or charter city whose court issued the order for evaluation.

When evaluation or treatment is ordered pursuant to this statute, the county, city, town or charter city whose court issued the order for evaluation is responsible for the cost of services to the extent ordered by the court. To the extent those services are

also Division covered services and the AdSS receives a claim for the services, the AdSS may direct the provider to bill the appropriate county, city, town or charter city.

Financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of court-ordered evaluation is outlined in this Policy Manual, Policy 437.

424 VERIFICATION OF RECEIPT OF PAID SERVICES

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 433.116, 42 CFR 455.20 and 232; AHCCCS Contractor Operations Manual, Policy 424-Attachment A; Section F3, Contractor Chart of Deliverables

DELIVERABLES: AHCCCS Required Survey Results; Verification of Receipt of Paid Services

Purpose

This policy applies to the Division's Administrative Services Subcontractors (AdSS). AdSS are responsible for verifying member receipt of paid services according to federal and contractual requirements, to identify potential service/claim fraud. The AdSS are expected to perform surveys as required in this policy through member contact and to report the results of these surveys to the Division in accordance with the timeframes specified in Section F3, Contractor Chart of Deliverables.

General Requirements

A. The AdSS must perform, at a minimum, quarterly surveys to determine member receipt of paid services.

B. A Quarterly Verification of Services Survey Report, is due as specified in Section F3, Chart of Deliverables. The AdSS will submit this information, using the format in AHCCCS Contractor Operations Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report.

Sampling

A. The sampling must be from claims with Dates of Services (DOS) from the reporting quarter and not more than 45 days from date of payment pursuant to 42 CFR 455.232 and 433.116(e). For example, the July 15th report would be for paid claims with DOS for January through March. Surveys can be performed at any point after claims have been paid.

B. Members who are surveyed must be eligible for the Division and enrolled with the AdSS during the period under review.

C. The sampling must consist of claims that resulted in payment.

D. The sampling must be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility).

E. The sample size must be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an AdSS with less than 2,000 members must be 50 claims (the minimum sample size refers to completed surveys).

Methodology

A. The audit can be performed by mail, telephonically, or in person. Concurrent review will be allowed; however, if used it must be recorded and tied back to a

successfully adjudicated claim.

B. Survey language should be in an easily understood language, including the description of services (e.g., x-ray, surgery, blood tests, counseling) when validating the receipt of paid services.

C. Individual survey results indicating that paid services may not have been received must be referred to the AdSSs fraud and abuse department for review and to the AHCCCS Office of the Inspector General (AHCCCS-OIG) department.

Reporting

A. The AdSS must submit a report that includes the total number of surveys sent out, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS-OIG for further review (AHCCCS Operations Policy Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report).

B. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the AdSS's corporate compliance program and, as a result, any referrals to AHCCCS-OIG and analysis and interventions where appropriate.

425 SOCIAL NETWORKING

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.10 and 438.104; 45 CFR 164.500 et seq; ACOM Policy 425 - Attachment A, Social Networking Attestation Statement; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Communications Administrator (Name and Contact Information); Social Networking Administrator (Name and Contact Information); Social Networking Applications Listing with URLs; Social Networking Attestation

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS may choose whether to engage in Social Networking activities; should they choose to participate this policy and its requirements apply. This policy establishes the requirements for the Division's AdSS regarding social networking activities.

Definitions

A. Broadcast - Video, Audio, or text transmitted through Social Networking Applications, via internet, cellular or wireless network for display on any device (e.g., comments, podcasts, blogs).

B. Friends/Followers - Persons who choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

C. Marketing - Any communication from a AdSS to a member of the Division who is not enrolled with that AdSS that can reasonably be interpreted as intended to influence enrollment in that particular AdSS, or to not enroll in, or to disenroll from, another AdSS.

D. Social Networking Activities - The use of Social Networking Applications, the development of AdSS-specific Social Networking Application sites/ pages, and Broadcast activities.

E. Social Networking Application - Web based services/platforms (excluding the AdSS'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 e-mail, comment posting, image sharing, invitation and instant messaging services – collectively also referred to as social media (e.g., Facebook).

F. Tags/Tagging - Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

G. Username - An identifying pseudonym associating the author to messages or content generated.

Social Networking Activities

A. AdSS must participate in Social Networking Activities to support learning and engagement.

B. All Social Networking material must comply with the requirements of this Policy, as well as the requirements for member information as outlined in AdSS Operations Manual, Policy 404. Any changes or amendments to previously approved member informational materials used in Social Networking Activities must be resubmitted to the Division in accordance with AdSS Operations Manual, Policy 404.

C. The AdSS is responsible for reviewing and continuous monitoring of its Social Networking Activities to ensure adherence to Division policy including, but not limited to, marketing restrictions, member information guidelines, and adherence to HIPAA Privacy Rules and provisions regarding safeguarding of Protected Health Information (PHI) [42 CFR 438.104, 42 CFR 438.10, 45 CFR Part 164, Subpart E].

D. The Division reserves the right to monitor the activities of the AdSS, including but not limited to, AdSS's oversight of its Social Networking Activities, to ensure ongoing compliance with this policy. The Division may perform audits as deemed necessary.

Social Networking Requirements

The AdSS must adhere to the following requirements when engaging in Social Networking Activities. The AdSS must:

A. Address programs and services of the Division program in support of the mission and delivery of services.

B. Safeguard member privacy information from unauthorized use or disclosure, which includes the security of Protected Health Information (PHI) and adherence to all HIPAA Privacy Rules, Division policies and contractual requirements.

C. Designate a Social Networking Administrator who is responsible for policy development, implementation and oversight of all social networking activities.

D. Use all available security features to prevent fraud and unauthorized access.

E. Ensure all connections must be initiated by the external user and not the AdSS.

F. Ensure all Social Networking Application sites and Broadcasts are clear, direct, professional, accurate, and presented in a well-organized manner. The AdSS should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.

G. Comply with copyright and intellectual property law and reference or cite sources appropriately.

H. Have a presence on Social Networking Application sites and must include an Avatar and/or a Username that clearly indicates what company is being represented.

I. Develop an internal company policy, based on the requirements of this policy, for the use of Social Networking and Broadcasts with regard to the Division's lines of

business. The policy must include a statement of purpose/general information explaining how the AdSS uses Social Networking and Broadcasting and how the AdSS continuously monitors Social Networking Activities. The AdSS must ensure applicable staff receives instruction and/or training on the Division and AdSS social networking policies before using social networking applications and broadcasts on behalf of the AdSS.

Social Networking Restrictions

The AdSS must adhere to the following restrictions regarding Social Networking Activities:

A. Social networking applications and broadcasts for the purposes of Marketing are prohibited.

B. The AdSS must not solicit feedback from members via social networking applications or broadcasts.

C. External user-generated content (comments/posts) is not permitted unless the AdSS has an intermediary review process in place in which the AdSS ensures all postings are appropriate and are in compliance with this policy.

D. The AdSS must not post information, photos, videos, links/URLs or other items online that reflect negatively on any individual(s), members of the Division enrolled with the AdSS, AHCCCS, the Division, or the state.

E. The AdSS is prohibited from tagging photographic or video content and must promptly remove all tags placed by others upon discovery unless written consent by those tagged has been obtained.

F. The AdSS must not identify members by name, or post, share, or publish information, including a member photo, that may lead to the identification of a member unless written consent has been obtained by the member.

G. The AdSS is prohibited from posting ads, whether targeted or general, on Social Networking Application platforms.

H. No affiliate/referral links or banners are permitted. This includes links to other non- Medicaid lines of business that the AdSS or a corporate affiliate is engaged in. When using any Social Networking Application which may automatically generate such linkage, recommendation, or endorsement on side bars or pop-ups (e.g., Facebook), the AdSS's Social Networking Application page must contain a disclaimer message prominently displayed in the area under the AdSS's control stating that such **items, resources, and companies are NOT endorsed by the AdSS, the Division, or AHCCCS.**

I. The use of the Department of Economic Security logo, AHCCCS logo, or State of Arizona seal is prohibited.

J. The use of materials that are inaccurate, misleading, or that otherwise make misrepresentations are prohibited.

AdSS Reporting Requirements

The AdSS must submit ACOM 425 Attachment A-Social Networking Attestation Statement, as specified in Section F3, Contractor Chart of Deliverables. Attachment A must include a listing of all Social Networking Applications used in the contract year with associated URLs.

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. R9-22-1303, A.A.C. R9-22-1305

DELIVERABLES: CRS Members With Completed Treatment

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). This Policy defines the processes used to accept and process applications for a Children's Rehabilitative Services (CRS) designation, and delineates the responsibility for coverage and payment of CRS conditions as well as other services that are the responsibility of the AdSS.

Definitions

A. Active Treatment - A current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22- 1301).

B. CRS Application - A submitted form with additional documentation required by the AHCCCS Division of Member Services (DMS) in order to make a determination whether an AHCCCS member is medically eligible for a CRS Designation.

C. CRS Condition - Pursuant to A.R.S. § 36-2912, those covered conditions that are medically disabling or potentially disabling and which qualify for CRS medical eligibility as specified in A.A.C. R9-22-1303.

D. Redetermination - A decision made by the AHCCCS DMS regarding whether a member continues to meet the requirements in A.A.C. R9-22-1305.

Policy

The AdSS must provide covered services to members under the age of 21 who have been confirmed to have a CRS condition requiring active treatment, as described in A.A.C. R9-22-1303. Members with a CRS qualifying condition will receive a CRS designation as determined by the Division of Member Services (DMS). AHCCCS may request, at any time, that the AdSS submit medical documentation to assist with review of a current CRS designation. DMS is responsible for processing and responding to requests for CRS designations and will accept and process an application in accordance with this Policy.

A. Application

1. Form Requirements – A CRS application must be submitted to DMS for a medical eligibility determination described in A.A.C. R9-22 Article 13. A copy of the required CRS application form and instructions are available on the AHCCCS website.

   a. The completed Application for AHCCCS CRS Designation may be faxed, mailed, or delivered in person to DMS as indicated on the AHCCCS website.

b. Upon submitting the completed CRS application to AHCCCS DMS, the AdSS must:

i. Notify in writing the member or his/her parent/guardian/ designated representative that an application for a CRS designation has been submitted on the member's behalf.

ii. Inform the member or his/her parent/guardian/designated representative that the member will be referred to a specialist for an evaluation of the CRS condition.

c. If a CRS application is submitted to AHCCCS by a provider acting on the member's behalf, the AdSS must work with the provider to ensure the AdSS is made aware of the application submission. Once the AdSS is made aware a provider has submitted an application, notification must be sent in accordance with b. above, and

d. The following documentation is required with submission of the application:

i. Documentation from a specialist who diagnosed the member, stating the member's diagnosis and the need for active treatment

ii. Diagnostic testing results that support the medical diagnosis.

2. Processing

a. DMS will verify Title XIX/XXI enrollment.

b. If further information is needed in order to make a determination of medical eligibility, DMS will contact the appropriate parties to request the information.

3. Determination and Notification

a. For members meeting medical eligibility criteria, DMS will identify the member with a CRS designation, effective on the same date as the determination, including those members who may be hospitalized at the time.

b. When a determination of CRS medical eligibility is made, DMS will notify the following parties:

i. Member/guardian/designated representative

ii. The entity who submitted the application (if authorized)

iii. The AdSS.

c. For members not meeting medical eligibility criteria, DMS will notify the member/guardian/designated representative and the AdSS of the decision.

The member's right to appeal the determination of medical eligibility, and the process for doing so, will be described in the DMS member notfication.

d. It is the responsibility of the AdSS to ensure that the information provided by DMS is made available to the appropriate areas and staff within its organization who may need the information.

B. Members Turning 21

At least 90 days prior to a member with a CRS designation turning 21 years of age, the AdSS must notify the member that his/her CRS designation ends upon his/her 21st birthday. The AdSS must ensure specialty services related to the member's CRS condition(s) are completed, as clinically appropriate, prior to the member's 21st birthday. The AdSS must continue to ensure appropriate service delivery and care coordination is provided, regardless of the member's CRS designation ending.

C. AdSS Responsibilities for CRS Services

The member may elect to use his/her private insurance network (providers) or Medicare providers to obtain health care services, including those for treatment of the CRS condition(s). AdSS responsibilities for payment of services for treatment of the CRS condition(s), when a member uses private insurance or Medicare, are further outlined in AdSS Operations Manual, Policies 201 and 434.

D. Termination of the CRS Designation

DMS may end a member's CRS designation for one of the following reasons:

1. The member loses Title XIX/XXI enrollment
2. The member no longer meets the medical eligibility criteria for CRS
3. The member has completed treatment for the CRS condition(s)
4. The Member turns 21 years of age. Refer to Section B of this Policy.

E. Request for Removal of the CRS Designation

In response to a member/guardian/designated representative's request for removing a CRS designation, DMS will send a CRS Designation Removal Form to the member/guardian/ designated representative for signature. Upon receipt of the signed form, DMS will end date the CRS designation.

F. Monitoring of the CRS Designation

Continued review of the CRS designation must be determined by verifying active treatment status of the CRS condition as described in A.A.C. R9-22-1305 and as follows:

1. AdSS Notification

   a. The AdSS is responsible for notifying AHCCCS of members under the age of 21 with a CRS designation who are no longer requiring active treatment for the CRS qualifying condition(s), including medical records indicating treatment has been completed,

   b. The AdSS must transmit to AHCCCS the members with Completed Treatment Report, for any member with a CRS designation who has completed treatment, and

   c. The above-referenced report must be sent as specified in Contract.

2. AHCCCS Notification

   a. If DMS determines that a CRS member is no longer medically eligible for CRS, DMS will end date the CRS designation in the member's record, and

   b. DMS will notify the member/guardian/designated representative that the member's CRS designation is inactive with AHCCCS.

431 COPAYMENT

EFFECTIVE DATE: October 1, 2019

Members eligible for 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: October 1, 2019
REFERENCES: 9 A.A.C. 22, Article 1

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). This policy establishes the Division of Developmental Disabilities (Division) expectations for the AdSS regarding the development, approval, and distribution of Member Identification Cards (Member ID Cards) and replacement Member ID Cards to members eligible for the Division (including newly enrolled members). Member ID Cards must meet the formatting, timeliness, and prior approval guidelines outlined in this policy.

The Member ID Card is used by the Division member when presenting for Medicaid services.

Program Requirements

The AdSS must ensure all members receive appropriate Member ID Cards in a timely manner.

A. Members requiring Member ID Cards must be identified as a result of the 834 Transaction File, a nightly transaction file, provided by the Arizona Health Care Cost Containment System (AHCCCS), that identifies newly enrolled members and changes to existing members. The AdSS must mail Member ID Cards as indicated below:

1. For new members, within 12 business days starting from the business day following AHCCCS making the 834 Transaction File available to the contractor

2. For other members, within five business days of the request.

Note: For AdSSs issuing Member ID Cards as a result of an 834 Transaction file, a business day is from 7:00 am to 7:00 am of the following morning. If the next day is a weekend or a holiday, the ending time is 7:00 am of the morning of the day following the weekend or holiday.

B. The AdSSs must monitor adherence to the timeliness standards in this policy for the Member ID Cards it issues directly.

C. If the AdSS replaces all Member ID Cards with a new version, members must receive their new Member ID Cards at least two calendar weeks prior to the card going into effect. When a new AdSS initiates services in the state, the Division will determine the timelines for issuing Member ID Cards.

D. An AdSS serving members dually enrolled in Medicare and the Division may issue a combined Medicare/ALTCS Member ID Card. The format for the combined Member ID Cards must meet the Centers for Medicare and Medicaid Services (CMS) requirements for Member ID Cards and be approved by the Division. For the requirement of an ID Number, the AdSS may adopt additional formatting

features included in this policy or prescribed by CMS if they do not conflict with this policy's minimum requirements.

Format of Member ID Cards

Member ID Cards must meet the format standards outlined in this policy. The following formatting standards may apply:

A. Front of Card

The front of the card must include:

1. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version. The approved logo is available from the Division. The AdSS must not edit or alter the approved logo, except as noted above.

2. AHCCCS Logo, in the approved color or black and white version. It can be 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 approved logo is available from AHCCCS. The AdSS must not edit or alter the approved logo, except as noted above.

3. In Arial font **no smaller than 11 points**:

   "Arizona Health Care Cost Containment System"

   The inclusion of "Arizona Health Care Cost Containment System" within the approved AHCCCS logo does not fulfill this requirement.

4. In Arial font **no smaller than 8 points**.

   - Member's name
   - AHCCCS ID number ()
   - AdSS name
   - AdSS telephone number
   - Phone number for members who are deaf or hard of hearing
   - Contact telephone number for accessing services from the Behavioral Health Entity.

B. Back of Card

In Arial font **no smaller than 7 points**:

1. The back of the Member ID Card or the card holder (a printed sheet, enclosing the Member ID Card, that is used during the mailing to the member) must include the following text:

"Carry this card with you at all times. Present it when you get service. 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 benefits visit <insert appropriate website address>."

2. The back of the Member ID Card, or the card holder, or an insert included in the card's mailing to the member if a card holder is not used, must contain the following text:

"To help protect your identity and prevent fraud, AHCCCS is adding pictures to its on-line 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 Member ID Card or card holder may include additional information (e.g., plan logos, contact information for contracted hospitals, or after-hours clinics) identified as appropriate, subject to the approval requirements of this policy.

Any new Member ID Card mailing must also include the most recent version of the AHCCCS Notice of Privacy Practices (NPPS).

Approval of Member ID Cards, and Other Compliance Requirements

A Member ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items must be submitted and obtain prior approval by the Division.

If the AdSS issues more than one version of a Member ID Card to its Division members, an example of each version must be submitted for approval.

Any third party subcontracted to produce or distribute Member ID Cards qualifies as an Administrative Services Subcontract. Direct Division contractors must obtain approval prior to implementation of the subcontract and identify the AdSS in the *Annual Subcontractor Assignment and Evaluation Report* as outlined in Policy 438 in the Division Operations Manual.

434 COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2923; A.A.C. R9-22-711, R9-22-1001 et seq, R9-22-1003; 42 U.S.C.1396a(a)(25)(A); 42 CFR 433.135 et seq, 42 CFR 433.136; Deficit Reduction Act of 2005 (Public Law 109-171), Section F3, Contractor Chart of Deliverables.

DELIVERABLES: Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)

This policy applies to the Division's Administrative Services Subcontractors (AdSS).

Purpose

Federal law 42 U.S.C.1396a(a)(25)(A) requires Medicaid to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid members. The purpose of this policy is to delineate the AdSS's requirements for Coordination of Benefit (COB) activities and Third Party Liability (TPL) recoveries.

Definitions

A. COB - The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

B. Copayment – A monetary amount that a member pays directly to a provider at the time a covered service is rendered (A.A.C. R9-22-711).

C. Cost Avoidance - To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C.R9-22 -1001 et seq.

D. Post-Payment Recovery - Subsequent to payment of a service by a contractor, efforts by that contractor, to retrieve payment from a liable third-party. Pay and Chase is one type of post-payment recovery.

E. Third Party - An individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan [42 CFR 433.136].

F. TPL - The legal obligation of third parties (e.g., certain individuals, entities. insurers or programs) to pay part or all of the expenditures or medical assistance furnished under a Medicaid state plan.

Policy

A. The AdSS is the payor of last resort unless specifically prohibited by applicable state or federal law. This means AdSS must be used as a source of payment for covered services only after all other sources of payment have been exhausted. The AdSS must take reasonable measures to identify potentially legally liable third-party sources. The AdSS is responsible for making third party payer information available through the AdSS's verification systems for use. Third party payor information may

also be obtained through DDD Systems. The AdSS is responsible for communicating TPL responsibilities to subcontractors per A.A.C. R9-22-1003.

B. The AdSS must coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et seq., so that costs for services otherwise payable by the AdSS are cost avoided or recovered from a liable third party.

C. AdSS is not the payor of last resort when the following entities are the third party:

1. Indian Health Services (IHS/638), contract health
2. Title IV-E
3. Arizona Early Intervention Program (AZEIP)
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 U.S.C. 300ff et seq.
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G

The two methods used for COB are Cost Avoidance and Post-Payment Recovery. The AdSS must use these methods as described in A.A.C. R9-22-1001 et seq., federal and state law, and DDD policy.

Cost Avoidance

The AdSS must cost avoid a claim if it has determined the probable existence of a liable party at the time the claim is filed. Determining liability takes place when the AdSS receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member.

Post-Payment Recovery

Pay and Chase – The AdSS must pay the full amount of the claim according to the AdSS service rate or specified contracted rate and then seek reimbursement from any third party if the claim is for any of the following:

A. Prenatal care for pregnant women, including services that are part of a global OB package

B. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program

C. Services covered by TPL that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Retroactive Recoveries Involving Commercial Insurance Payor Sources

Tagging – For a period of two years from the date of service, the AdSS must engage in retroactive recovery efforts for claims paid to verify if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the AdSS will seek recovery from the commercial insurance. The AdSS is prohibited from recouping payments from providers or requiring the involvement of providers in any way, unless the provider was paid in full from both the AdSS and the commercial insurance.

The AdSS has two years from the date of service to recover payments for a particular claim, or to identify (tag) claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when the AdSS has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment prior to the end of the AdSS' two-year recovery period. The AdSS must identify tagged claims in a monthly claims match-off file submitted to DDD as outlined in the AHCCCS Technical Interface Guidelines (TIG).

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

Encounter Adjustments Flagging – Although all encounters related to the AdSS' retroactive recovery efforts outlined above must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the AdSS is prohibited from requesting adjustments from, or adjusting related payments to, providers.

Instead, the AdSS must submit an external replacement file (via an AHCCCS approved vendor using a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project.

In order to submit an external replacement file, the AdSS must contact the Division Encounter Unit at the completion of the recovery project for a list of approved vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Encounters will not be adjusted when recoveries occur as a result of AHCCCS' efforts. AHCCCS will instead flag all encounters that are impacted by retroactive commercial insurance recoveries and will develop and maintain a database to store recovery payments.

Using the data from the replacement file submitted by the AdSS, and the database used to store AHCCCS' recoveries, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments when appropriate.

Other Third-Party Liability Recoveries

The AdSS must identify the existence of other potentially liable third parties through a variety of methods, including referrals and data mining related to the following:

A. Motor vehicle cases

B. Other casualty cases

C. Tortfeasors

D. Restitution recoveries

E. Workers' compensation cases

AdSS Discovery and Reporting of a Liable Third-Party

Reporting Requirements (Involving Commercial Insurance Payor Sources)

If the ADSS discovers the probable existence of a liable third party that is not known to AHCCCS/ Division, or identifies any change in coverage, the AdSS must report the information via the TPL Leads File or the TPL Referral Web Portal as specified in Section F3, Contractor Chart of Deliverables.

Reporting Requirements (Referrals and Data Mining)

Upon the identification of a potentially liable third party via referrals or data mining as described above, the AdSS must report the potentially liable third parties to AHCCCS' TPL contractor for determination of a mass tort case, total plan case, or joint case. AHCCCS' TPL contractor will refer total plan cases to the AdSS to be processed in accordance with AHCCCS, state, and federal laws and policies.

The AdSS must report total plan case settlement information to the Division, using Attachment A, the AHCCCS-approved casualty recovery Total Plan Case Settlement Notification Form, within 10 business days from the settlement date or in a monthly file approved by the Division.

Reporting Cost Avoidance and Recovery Activity

The AdSS must submit quarterly updates regarding cost avoidance/recovery activity as specified in Section F3, Contractor Chart of Deliverables.

435 TELEPHONE PERFORMANCE STANDARDS AND REPORTING

EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 435; Attachments A and B; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Telephone (Administrative) Performance Measures

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes AdSS standards and reporting requirements regarding the AdSS's performance when handling member and provider telephone calls. This policy does not include performance requirements for Crisis Services Response.

Definitions

A. Average Speed of Answer (ASOA) - The average online wait time in seconds that the member/provider waits from the moment the call is connected in the AdSS's phone switch until the call is picked up by a AdSS's representative or Interactive Voice Recognition System (IVR).

B. Daily First Contact Call Resolution Rate (DFCCR) - 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.

C. Monthy Average Abandoment Rate (MAAR) - 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.

D. Monthly Average Service Level (MASL) - 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).

E. Monthly First Contact Call Resolution Rate (MFCCR) - The sum of the DFCCRs divided by the number of business days in the reporting period.

Telephone Performance Standards

The AdSS is required to track all of the following Telephone Performance Standards for member and provider calls monthly:

A. The ASOA must be 45 seconds or less.

B. The MAAR must be 5% or less.

C. The MFCCR must be 70% or better.

D. The MASL must be 75% or better.

Telephone Performance Measure Reports

The AdSS must submit a quarterly Telephone Performance Measures Report showing the AdSS's performance based on the above standards. The report must include both of the following AHCCCS attachments adopted by the Division for use by the AdSS:

- ACOM Policy 435, Attachment A, Telephone Performance Measures Template to document the ASOA, MAAR, MFCCR, and MASL as described in this Policy
- ACOM Policy 435, Attachment B, Centralized Telephone Line Down Time Template, to report the down time for its centralized telephone lines, the dates of the occurrences, and the length of time they were out of service. The AdSS must complete separate templates for each month of the quarter.

The report must cover the AdSS's performance during the previous twelve months and must be submitted as specified in Section F3, Contractor Chart of Deliverables.

The AdSS must separately document performance for calls of the following types:

A. Member Calls

B. Provider Calls.

The AdSS must document the number of days in a month one or more of the standards were not met by type of call. If a current month's number of days where the standard was not met was more than two standard deviations greater than the average of the previous nine months, the AdSS must explain why the increase occurred, and summarize the steps it is taking to reduce the non-compliant calls.

If the AdSS is non-compliant with any standard on this deliverable, or the Division has concerns regarding the content reported during the reporting quarter, the Division may require the AdSS begin submitting this report monthly. The AdSS may submit a request to the Division's Compliance Coordinator to return to quarterly reporting after three consecutive months of compliance have been achieved.

436 NETWORK STANDARDS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 32-123 1 et seq, 32-1261 et seq, 32-1921 et seq, 32-1961 et seq, 36-401 et seq, 36-421 et seq, 36-436 et seq; A.A.C. R9-10, R9-10-101, R9-10-801 et seq, R9-22-101, R9-33-101 et seq; 42 CFR 438.206(b)(1); ACOM Policy 415-Attachment A, ACOM Policy 436-Attachment A, ACOM Policy 438 Attachment A; DES/DDD Contract, Section D

DELIVERABLES: Minimum Network Requirements Verification Template; Proposed Alternative Multispecialty Interdisciplinary Care Providers

This policy applies to the Division's Administrative Services Subcontractors (AdSSs). The AdSS must develop and maintain a provider network that is sufficient to provide all covered services to members eligible for the Division [42 CFR 438.206(b)(1)]. This policy establishes AdSS network standards for all AdSSs. Unless otherwise noted, the AdSS must assess its network against its entire membership for the purposes of complying with these standards. If established network standards cannot be met, it must be explained in the Network Development and Management Plan. See Policy 415 in the Division Operations Manual.

All references in this policy to exhibits and attachments in the AHCCCS Contractor's Operations Manual (ACOM) have been adopted by the Division for use by the AdSS.

Definitions

A. Behavioral Health Counselor, Adult - A behavioral health professional or behavioral health technician who provides interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral health problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. For the purposes of this Policy, a Behavioral Health Counselor, Adult is defined as a provider licensed to operate with the AHCCCS provider types: 11 "Psychologist," A4 "Licensed Independent Substance Abuse Counselor," 85 "Licensed Clinical Social Worker", 86 "Licensed Marriage & Family Therapist," 87 "Licensed Professional Counselor," or BC "Board Certified Behavioral Analyst."

The time and distance for these providers is measured using the AdSS's population of members aged 18 years or older.

B. Behavioral Health Counselor, Pediatric - A behavioral health professional or behavioral health technician who provides interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral health problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. For the purposes of this Policy, a Pediatric Behavioral Health Counselor is defined as a provider licensed to operate with the AHCCCS provider types 11 "Psychologist," A4 "Licensed Independent Substance Abuse Counselor," 85 "Licensed Clinical Social Worker," 86 "Licensed Marriage & Family Therapist," 87 "Licensed Professional Counselor," or BC "Board

Certified Behavioral Analyst."

The time and distance for these providers is measured using the AdSS's population of members under the age of 18 years old.

C. Behavioral Health Outpatient and Integrated Clinic - A class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients. For the purposes of this policy, a Behavioral Health Outpatient and Integrated Clinic is defined as facility licensed to operate using the AHCCCS provider types 77 "Mental Health Outpatient Clinic" and IC "Integrated Clinic."

D. Behavioral Health Residential Facility – A health care institution that provides treatment to an individual experiencing a behavioral health issue, as defined in A.A.C. R9-10-101 et seq. A behavioral health residential facility provides a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons with behavioral needs. For the purposes of this policy, a behavioral health residential facility is defined as a facility licensed to operate using the AHCCCS provider type B8 "Behavioral Health Residential Facility."

E. Cardiologist, Adult - A medical doctor who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system. For the purposes of this Policy, an adult Cardiovascular Specialist is defined as a provider licensed to operate with the AHCCCS provider types 08 "Physician," or 31 "Osteopath," and with the specialty code 62 "Cardiovascular Medicine."

The time and distance for these providers is measured using the AdSS's population of members aged 21 years or older.

F. Cardiologist, Pediatric - A medical doctor who specializes in the study or treatment of heart diseases and heart abnormalities. For the purposes of this Policy, an Pediatric Cardiologist is defined as a provider licensed to operate with the AHCCCS provider types 08 "Physician," or 31 "Osteopath," and with the specialty 151 "Pediatric Cardiologist."

The time and distance for these providers is measured using the AdSS's population of members under the age of 21 years old.

G. Crisis Stabilization Facility – An inpatient facility or outpatient treatment center licensed in accordance with A.A.C. R9-10, which provides crisis intervention services (stabilization). For the purposes of this policy, a Crisis Stabilization Facility is measured as a facility licensed to operate using the AHCCCS provider type 02 "Hospital" that has an organized psychiatric unit, 71 "Level I Psychiatric Hospital," IC "Integrated Clinic," 77 "Behavioral Health Outpatient Clinic" (24 hours per day, seven days per week access), B5 "Level I Subacute facility" (non-IMD), B6 "Level I Subacute facility" (IMD), and B7 "Crisis Service Provider."

H. Dentist, Adult - A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. § 32-1201 , Articles 2 and 3. For the purposes of this policy, Dentists are defined as a provider licensed to operate using

the AHCCCS provider type 07 "Dentist" without the specialty code "8-04-Dentist-Pediatric."

The time and distance for these providers is measured using the AdSS's population of members aged 21 years or older.

I. Dentist, Pediatric - A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. §32-1201. For the purposes of this policy, Dentists are defined as a provider licensed to operate using the AHCCCS provider type 07 "Dentist" with the specialty code "804- Dentist- Pediatric."

The time and distance for these providers is measured using the AdSS's population of members under the age of 21 years old.

J. Hospital - A class of health care 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. R9-10-801 et seq, and A.R.S. 36-401 et seq, A.R.S. 36-421 et seq, and A.R.S. 36-436 et seq. For the purposes of measuring network sufficiency, a hospital is a defined as a facility licensed to operate using the AHCCCS provider type 02 "Hospital" or C4 "Specialty Pier Diem Hospital."

K. Multi-Specialty Interdisciplinary Clinic (MSIC) - An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

L. Nursing Facility (NF) - A health care institution that provides inpatient beds or resident beds and nursing services to persons who need continuous nursing services but who do not require hospital care or direct daily care from a physician. For the purposes of this policy, a Nursing Facility is defined as a health care institution licensed to operate using the AHCCCS provider type 22 "Nursing Home."

M. Obstetrician/Gynecologist (OB/GYN) - 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. For the purposes of this Policy, an OB/GYN is defined as a provider licensed to operate using the following AHCCCS provider types:

Provider type 08 "Physician," 19 "Registered Nurse Practitioner" or 31 "Osteopath," and with at least one of the specialty codes:

1. 089 – Obstetrician/ Gynecologist
2. 090 – Gynecologist
3. 091 – Obstetrician
4. 095-Women's HC/OB-GYN NP

N. Pharmacy - A facility regulated by the State Board of Pharmacy and operating under A.R.S. 32-1901. For the purposes of this policy, a Pharmacy is defined as a provider

licensed to operate using the AHCCCS provider type 03 "Pharmacy."

O. Primary Care Physician (PCP), Adult - A healthcare practitioner responsible for the management of a member's health care. For the purposes of this Policy, an Adult PCP is defined 27 as a provider licensed to operate using the following AHCCCS provider types:

1. Provider type 08 "Physician" and 31 "Osteopath," with the specialty codes:

   a. 050-Family Practice

   b. 055-General Practice

   c. 060-Internal Medicine

   d. 089-Obsterician and Gynecologist, or

   e. 091-Obstetrician

2. Provider type 19 "Registered Nurse Practitioner" with the specialty codes:

   a. 095-Women's HC/OB-GYN NP, or

3. Provider type, 18 "Physician Assistant" with the specialty code:

   a. 798 – Physician's Assistant.

The time and distance for these providers is measured using the AdSS's population of members aged 21 years or older.

P. Primary Care Physician (PCP), Pediatric - A healthcare practitioner responsible for the management of a member's pediatric health care needs. For the purposes of this Policy, a Pediatric PCP is defined as a provider licensed to operate using the following AHCCCS provider types:

1. Provider type 08 "Physician" or 31 "Osteopath," and with at least one of the specialty codes:

   a. 050-Family Practice, or

   b. 150-Pediatrician, or

2. Provider type 19 "Registered Nurse Practitioner" with the at least one of the specialty codes:

   a. 084-RN Family Nurse Practitioner

   b. 87-RN Pediatric Nurse Practitioner

The time and distance for these providers is measured using the AdSS's population of members under the age of 21.

Q. Provider Affiliation Transmission (Pat) File - A data file which provides details of the providers within the AdSS's network and is used to measure compliance with this policy.

R. Psychiatrist, Adult - A medical doctor who specializes in mental health, including substance use disorders. For the purposes of this Policy, an adult Psychiatrist is defined as a provider licensed to operate with the AHCCCS provider types: 08 "Physician," or 31 "Osteopath," and with the specialty code 192 "Psychiatrist" or 195 "Psychiatrist and Neurologist."

The time and distance for these providers is measured using the AdSS's population of members aged 18 years or older.

S. Psychiatrist, Pediatric - A medical doctor who specializes in mental health, including substance use disorders. For the purposes of this Policy, a specialist Psychiatrist serving children is defined as a provider licensed to operate with the AHCCCS provider types 08 "Physician," or 31 "Osteopath," and with the specialty code 191 "Pediatric Psychiatrist," 192 "Psychiatrist," or 195 "Psychologist and Neurologist."

The time and distance for these providers is measured using the AdSS's population of members under the age of 18 years old.

Statewide Time and Distance Network Standards

For each county, the AdSS must have a network in place to meet time and distance standards outlined below:

A. Behavioral Health Counselor, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

B. Behavioral Health Counselor, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

C. Behavioral Health Outpatient and Integrated Clinic

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties - 90% of membership does not need to travel more than 60 miles from their residence

D. Behavioral Health Residential Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – See "Network Oversight Requirements" of this policy.

E. Cardiologist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence

F. Cardiologist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 60 minutes or 45 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 110 minutes or 100 miles from their residence

G. Crisis Stabilization Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 45 miles from their residence

H. Dentist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

I. Dentist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

J. Hospital

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 95 minutes or 85 miles from their residence

K. Nursing Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 95 minutes or 85 miles from their residence

L. Obstetrician/ Gynecologist

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 90 minutes or 75 miles from their residence

M. Pharmacy Services

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

N. PCP, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

O. PCP, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

P. Psychiatrist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence

Q. Psychiatrist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence

Other Statewide Network Standards

In addition to the time and distance standards outlined above, AdSSs must document a sufficient network to meet the service needs of its members based upon the minimum network requirements delineated in Attachment A.

A. Multi-Specialty Interdisciplinary Clinic (MSIC) Network Standards

The AdSS is expected to contract with all MSICs in the state, as well as any MSICs which have provided services to the AdSS's members. The AdSS must identify all contracted MSICs in Attachment A, including any multispecialty interdisciplinary care providers it has contracted with and the AHCCCS approval date. In the event the Contractor and an MSIC fail to negotiate a contract, the Contractor must continue to allow members to utilize the MSIC. In the absence of a contract, the Contractor shall reimburse the MSIC at the AHCCCS MSIC fee schedule.

Network Oversight Requirements

A. Minimum Network Standards Reporting Requirements

The AdSS must submit a completed ACOM 436 Attachment A reporting its compliance with time and distance standards, and the other statewide. The AdSS must report compliance with these requirements for each county in its assigned service area. A separate report must be submitted for each line of business.

The AdSS must analyze compliance with these network standards based upon the provider network reported through Provider Affiliation Transmission (PAT) and the Gap in Services Log. With the submission of Attachment A, the AdSS must include a summary identifying network gaps indicated by the analysis and the AdSS's strategies and efforts to address any network gaps identified.[70]

The Division must report its compliance with the standards identified as applying to its ALTCS provider network, and submit separate attachments for each of its subcontracted health plans providing services measured under these standards.

B. Network Planning Requirements

AdSSs will take steps to ensure these networks standards are maintained. If established network standards cannot be met, the AdSS must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; as required by Policy 415 in this Manual.

AdSSs are expected to review their networks for compliance with this policy.

AdSSs must report to the Division their AdSS gaps and short-term and long-term interventions to address the gaps, in their annual Network Development and Management Plans.

The AdSS must also conduct the following analysis of its behavioral health network~~s~~ and report results in the~~ir~~ Annual Network Development and Management Plan:

1. Behavioral Health Residential Facility Reporting

   For AdSS serving counties outside of Maricopa and Pima, for each county the AdSS must report the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted facility that provides Behavioral Health Residential Facility services.

2. Behavioral Health Outpatient and Integrated Clinic Reporting74

   For each county the AdSS must report performance with time and distance standards outlined above for Behavioral Health Outpatient and Integrated Clinics for each of the following populations:

   a. All members

   b. AHCCCS members enrolled with the Division

   c. Members determined to have a Serious Mental Illness

   d. Members over the age of 18 not determined to have a SMI, and

   e. Members under the age of 18.

3. Crisis Stabilization Facility Reporting

   For each county in their assigned service area, AdSS must report performance with time and distance standards outlined above for Crisis Stabilization Facilities for each of the following populations:

   a. All members

   b. AHCCCS members enrolled with the Division

   c. Members determined to have a Serious Mental Illness

   d. Members over the age of 18 not determined to have a SMI, and

   e. Members under the age of 18.

437 FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT-ORDERED EVALUATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-501.33, 36-520 et seq, 36-533 et seq, 36-545.04, 36-545.06, 36-545.07

This Policy applies to the Division's Administrative Services Subcontractors. The purpose of this Policy is to provide clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation (COE).

Definitions

A. Court-Ordered Evaluation - The proceedings and related services described in A.R.S. § 36-520 et seq (Title 36, Chapter 5, Article 4).

B. Court-Ordered Treatment - The proceedings and related services described in A.R.S. § 36-533 et seq (Title 36, Chapter 5, Article 5).

C. Medically Necessary Behavioral Health Services - Those behavioral health services necessary, in the judgment of a qualified medical practitioner, to treat an existing behavioral health condition or illness and/or to prevent the patient from potentially harming themselves or others.

D. Prepetition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services pursuant to A.R.S. §36-501.33.

Policy

AdSS subject to this Policy are responsible for providing medically necessary, covered behavioral health services to members including services provided pursuant to court order under A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5). As a matter of state law (A.R.S. §36-545.04), the cost of services provided as part of a legal proceeding under A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4) (Court-Ordered Evaluation) is the financial responsibility of the county in which the individual resided or was found (i.e., the county of origin).

Under A.R.S. §36-545.06, the cost of pre-petition screening and court-ordered evaluation is a county responsibility unless the county has an agreement with AHCCCS under A.R.S. § 36-545.07 to provide those services for the county.

Absent such an agreement between the state and the county, the AdSS is responsible for medically necessary, covered behavioral health services other than services associated

with the pre-petition screening and court-ordered evaluation. Services are NOT considered the county's responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis.
- A petition for court ordered treatment is filed with the court.
- The member is released following the evaluation.

The issue of voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. Furthermore, the refusal of a member eligible for Title XIX to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Services that are Medicaid covered for a Medicaid enrolled member that are separate from the COE services (such as case management) can continue to be paid with Title XIX funding during the COE time period.

The AdSS must accept and process timely claim submissions for medically necessary services for all members eligible for Title XIX receiving COE services in an inpatient setting for time periods that are not the county responsibility.

Fiscal responsibility for physical health services provided during the COE process remains with the AdSS with which the member is enrolled for the provision of physical health services, and is not the responsibility of the County of origin.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS EVALUATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901, ACOM 438 Attachments A and B, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, CMS document SMDL #09-001.
DELIVERABLES: Administrative Services Subcontracts; Administrative Services Subcontractor Evaluation Report; Administrative Services Subcontractor Non-Compliance Reporting; Corporate Cost Allocation Plans and Adjustment in Management Fees

This policy applies to the Division's Administrative Services Subcontractors (AdSS). It establishes guidelines and requirements for the AdSS entering into Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and Corrective Action Plans (CAPs).

Definitions

A. Administrative Services Subcontracts - An Administrative Services Subcontract is an agreement that delegates any of the requirements of the contract with the Division, including but not limited to:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
3. Management Service Agreements
4. Service Level Agreements with the Division or Subsidiary of a corporate parent owner.

Providers are not AdSS.

B. Change in Organizational Structure - A change in organizational structure is any of the following:

1. Merger
2. Acquisition
3. Reorganization
4. Change in Articles of Incorporation
5. Joint Venture
6. Change in Ownership
7. Change of Management Services Agreement (MSA) Subcontractor
8. Other applicable changes that may cause:

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

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

c. A change in legal entity name.

C. Management Service Agreement - A Management Service Agreement is a type of subcontract in which the owner of the AdSS delegates all or substantially all management and administrative services necessary for the provision of services as required in the contract with the Division.

D. Provider - A provider is any person or entity that contracts with the AdSS 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.

E. Approval of Subcontracts - The AdSS must submit all Administrative Services Subcontracts to the Division for prior approval, 60 days before the effective date of the subcontract. A copy of the proposed Administrative Service Subcontract must be submitted with AHCCCS Contractor Operations Policy Manual (ACOM) Policy 438 Attachment A, Administrative Services Subcontract Checklist.

1. The AdSS must retain the authority to direct and prioritize any delegated contract requirements.

2. The AdSS must require that subcontractors meet any performance standards applicable to the delegated services as mandated by the Division and AHCCCS.

3. The AdSS must ensure the agreement contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of the Division and AHCCCS.

4. A Change in Organizational Structure of an Administrative Services Subcontractor requires prior approval of the Division and AHCCCS.

a. The AdSS must follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this Policy.

b. If the Change in Organizational Structure is related to the AdSS Management Service Agreement (MSA), to the extent management of all or substantially all plan functions has been delegated to meet the Division's contractual requirements, the AdSS must submit the proposed change for prior approval as outlined in AdSS Operations Manual Policy 317.

Monitoring and Reporting

A. The AdSS must monitor its subcontractor's performance on an ongoing basis and complete a formal review of its subcontractors at least annually. The formal review must include a review of delegated duties, responsibilities, and financial position.

B. If at any time during the period of the Administrative Service Subcontract, the subcontractor is found to be in non-compliance, the AdSS must notify the Division.

C. The notification must include:

1. The subcontractor's name
2. Delegated duties and responsibilities
3. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern
4. The scope and estimated impact of the non-compliance upon members
5. The known or estimated length of time that the subcontractor has been in non-compliance
6. The subcontractor's CAP or strategies to bring the subcontractor into compliance
7. Sanction actions that may be taken because of the non-compliance

D. The Division reserves the right to request follow-up on any open CAP.

E. The results of a CAP must be communicated to the Division upon closure of the CAP.

Evaluation Report

The AdSS must submit a completed Administrative Services Subcontractor Evaluation Report annually, using ACOM Policy 438, Attachment B, Administrative Services Subcontractor Evaluation Report Template. The Administrative Services Subcontractor Evaluation Report must include 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 performance (operational and financial as appropriate) of the subcontractor, including the type of review performed

E. The next scheduled formal review date

F. All identified areas of deficiency, including, but not limited to those that:

1. Affect member services and/or

2. Cause a quality of care concern

G. CAP Information, including:

1. Any CAPs that occurred due to monitoring since the last Administrative Services Subcontractor Evaluation Report

2. Any subcontractor CAPs resulting from the annual formal review; and

3. Date reported to the Division.

4. Current status of CAPs.

Additional Requirements

A. All Administrative Services Subcontracts must reference and require compliance with the Minimum Subcontract Provisions available on the Division website.

B. In the event of a modification to Division Policy, guidelines and manuals, the AdSS must issue a notification of the change to its effected subcontractors of any effected subcontracts. Affected Administrative Services Subcontracts must be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.

C. In the event of a modification to Minimum Subcontract Provisions, the AdSS must issue a notification and amend Administrative Services Subcontracts.

D. All Administrative Services Subcontracts must 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 CMS document SMDL #09-001. AdSSs must disclose to the Division the identity of any excluded person.

E. All Administrative Services Subcontracts entered into by an AdSS are subject to review and approval by the Division.

F. All Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the Division Contract.

G. The AdSS must maintain a fully executed original or electronic copy of all Administrative Services Subcontracts, which is to be accessible to the Division within five business days of the request by the Division according to contract requirements.

H. The AdSS must ensure that all member communications furnished by the AdSS include the Division's name and comply with member notification requirements as outlined in AdSS Operations Manual, Policy 404.

I. Before entering into an Administrative Services Subcontract, the AdSS must evaluate the prospective subcontractor's ability to perform the delegated duties.

J. If the AdSS terminates a subcontract, the AdSS must ensure compliance with all aspects of the Division contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

ACOM 438 Attachment A, Administrative Services Subcontract Checklist

The Division has adopted the use of this checklist; see the AHCCCS website's ACOM webpage for Attachment A of this policy.

ACOM 438 Attachment B, Administrative Services Subcontractor Evaluation Report Template

The Division has adopted the use of this template; see the AHCCCS website's ACOM webpage for Attachment B of this policy.

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-22-101; 42 CFR 438.10(f)(4) and 207; Contract

DELIVERABLES: Material Change to Business Operations; Material Change to Provider Network

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes requirements for the AdSS regarding the identification and assessment of material changes to the AdSS's provider network and business operations and the approval process for such changes.

Definitions

A. Administrative Services Subcontracts - An agreement that delegates any of the requirements of the contract with Division, including:

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

Providers are not AdSSs.

B. Delegated Agreement - A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the AdSS pursuant to this contract.

C. Geographical Service Area (GSA) - An area designated by the Division within which an AdSS of record provides, directly or through subcontract, covered health care services to a member enrolled with that AdSS of record, as defined in A.A.C. R9-22-101.

D. Management Services Agreement (MSA) - A type of subcontract with an entity in which the owner of the AdSS delegates some or all of the comprehensive management and administrative services necessary for the operation of the AdSS.

E. Material Change to Business Operations - Any change in overall operations that affects, or can reasonably be foreseen to affect, the AdSS's ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific geographic region. Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Additional changes may include the addition of, or change in:

- Pharmacy Benefits Manager (PMB)
- Dental Benefit Manager
- Transportation vendor
- Claims processing system
- System changes and upgrades
- Member ID card vendor
- Call center system
- Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment
- MSA
- Any administrative services subcontract.

F. Material Change to the Provider Network - Any change in composition of, or payments to, an AdSS's provider network, that affects, or can reasonably be foreseen to affect, the AdSS's adequacy of capacity and services necessary to meet the performance and/or provider network standards as required in contract. Changes to provider network may include, but not limited to:

- Any change that would cause, or is likely to cause, more than 5% of the members in a geographic region to change the location where services are received or rendered
- Any change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.

G. Provider Group - Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

H. Unexpected Material Change to the Provider Network or Business Operations – A material change that was not anticipated by the AdSS.

Examples of unexpected changes to the provider network include providers giving less than 30 days' notice to the AdSS that they would no longer serve Medicaid members, or the AdSS's failure to reach an agreement with a provider on a contract renewal less than 30 days before the previous contract expires. An example of an unexpected Material Change to Business Operations includes the unexpected closure of a subcontractor.

The AdSS must have efficient and effective business operations and provider networks to ensure 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. The AdSS must develop a process to determine when changes to business operations or to the provider network constitute a material change.

Division or AHCCCS-initiated changes, such as changes in reimbursement methodologies (e.g. APR- DRG) or changes to reference tables impacting claims payment, and industry-initiated changes, such as CPT/Diagnosis code changes, are excluded from these policy requirements.

Identifying A Provider Network and/or Business Operations Material Change

A. The AdSS is responsible for evaluating all business operational and provider network changes, including unexpected changes, to determine if the change is a material change.

B. For changes impacting members and/or providers regarding the provider network and/or business operations, the AdSS must:

   1. Establish criteria and/or methodology for determining the impact of the change to members and providers.

   2. Evaluate the impact of the change to its membership and provider network, by geographic region as specified by the Division and as a whole, using the established criteria and/or methodology.

   3. Determine, based on the evaluation results, whether the change meets the definition of a material change as outlined in this policy, and determine whether it complies with contract and policy requirements.

   4. Maintain documentation of evaluation of all provider network and business operations changes.

C. The Division may request and review documentation of established methodology, criteria, and evaluation results, for all provider network and business operations changes, even for those changes that the AdSS determines do not constitute a material change.

D. For all changes that have a member impact, the AdSS must provide member notification as outlined in Policy 404 in the AdSS Operations Policy Manual.

E. Implementation must be planned to ensure continuity of care to members.

F. A Material Change to Business Operations may also constitute a Material Change to the Provider Network.

G. The Division reserves the right to identify an operations or network change as a material change.

Administrative Services Subcontractor Reporting Requirements

A. The AdSS must request, in writing, prior approval of a Material Change to the

Provider Network or business operations in accordance with this policy. A request for approval must include a detailed description of the proposed change and all requirements outlined above and summarized in AHCCCS Operations Manual Policy 439 Attachment A, the Provider Network/Business Operations Material Change Plan Checklist, as adopted by the Division.

B. For all material changes, the AdSS must include an accessibility analysis of the services impacted by the provider change:

1. For services the member must travel to receive, the AdSS must provide the average time and distance that members in the impacted areas must travel for the service before and after the change.

2. For services provided in the member's home, the AdSS must address the geographic coverage and sufficiency of providers in the impacted area before and after the change.

3. For transportation services, the AdSS must address the availability of vehicles dedicated to the AdSS line of business in the impacted area before and after the changes.

C. The AdSS must request prior approval, in writing, of a material change that involves major system changes and upgrades to the AdSS's information system that, at a minimum, affects claims processing, payment, or other major business component, or system changes that impact member or provider interactions with the AdSS. A request for approval must include a system change plan that includes a timeline and milestones, and outlines adequate testing to be completed before implementation.

D. A material change in the provider network and/or business operations requires a 30-day advance written notice from the AdSS to members and providers [42 CFR 438.10(g)(4).

E. If there is an unexpected Material Change to the Provider Network and/or to business operations, the AdSS must submit written notification to the Division no later than one business day of the AdSS becoming aware of the unexpected change. Notification must be submitted as specified in contract. The notification must include a detailed description of the change, address why it was unexpected, and include all of the requirements identified in AHCCCS Operations Manual Policy 439 Attachment A. If the AdSS is unable to provide some or all of the Attachment A requirements in its initial notification, the remaining requirements must be provided to the Division with one week of initial notification. The AdSS must also identify its plan for notifying members or providers of the unexpected change..

F. For any provider termination, when appropriate, the AdSS must make a good faith effort to give written notice to enrollees within 15 days after receipt or issuance of a provider termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

G. The Division will review and respond to AdSS requests for approval within 30 days of the submission. Incomplete submissions will not be approved and additional

information may be requested. The approval process will be expedited upon request for emergency situations.

H. The AdSS may be required to provide periodic updates on the status of the change or implementation.

I. The AdSS may be required to conduct meetings with providers and/or members to provide general information or technical assistance, or to address issues related to changes to business operations, changes in policy, reimbursement matters, prior authorizations, and other matters as identified or requested by the Division.

440 MANAGED CARE EXPIRATION OR TERMINATION OF CONTRACT

EFFECTIVE DATES: October 1, 2019

This Policy applies to Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to set forth requirements and responsibilities when the Contract between the Division and AdSS expires (contract expiration) or is terminated by either the Division or the AdSS (contract termination).

Definitions

A. Contract - A written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29.

B. Contract Expiration - The ending of the Contract pursuant to its terms without any action by a party to the agreement.

C. Contract Termination - The cancellation of the Contract, in whole or part (e.g. by GSA), as a result of an action taken by the Division or the AdSS.

D. Incurred but Not Reported (IBNR) - The liability for services rendered for which claims have not been received.

Policy

The AdSS is required to adhere to certain notification requirements and comply with specific responsibilities as outlined in Contract and this Policy in the event of Contract Expiration or Contract Termination. Upon determination of Contract Expiration/Termination, the Division will provide notice to the AdSS outlining the AdSS operational and reporting requirements for the Contract Expiration/Termination transition period as described below.

In either instance, Contract Expiration or Contract Termination, the AdSS is required to develop and submit a Plan to the Division for prior approval as described in the *General AdSS Responsibillities* section of this Policy. The Plan must clearly present the AdSS process for ensuring compliance with all contractual responsibilities through the transition period, regardless of whether a Contract expires or is terminated. AdSS are responsible to assist the Division in the transition of members.

AdSS Non-Renewal - General Notifications

A. If the AdSS elects not to renew the Contract, the AdSS provides the Division with at least a 180 day advance written notice prior to the Non-Renewal of the current Contract.

B. After receipt of the AdSS notification of intent not to renew, the Division will issue written notice to the AdSS specifying:

   1. The effective date of termination

   2. The AdSS operational and reporting requirements.

3. Timelines for submission of deliverables.

The Division Non-Renewal – General Notification

If the Division elects not to renew the Contract, the Division will provide written notice prior to the Non-renewal of the current Contract.

Contract Terminations by Contract Termination by the Division - General Notification

A. The Division may initiate termination actions for reasons, including but not limited to:

1. An AdSS notification of or refusal to sign a contract amendment.
2. Substantial failure to provide medically necessary services that the AdSS is required to provide under law or the terms of its contract to its enrolled members.
3. Failure to meet the Division Financial Viability Standards.
4. Material deficiencies in the AdSS provider network.
5. Failure to meet quality of care and quality management requirements.
6. Failure to comply with contract provisions or applicable state and federal laws or regulations.
7. For convenience, as stipulated in Contract.

B. In the event the Division initiates a Termination for Convenience action, pursuant to the Contract Terms and Conditions, the Division will provide written notice of the termination at least 90 days before the effective date of the termination. The notice will include the effective date of the termination and the AdSS operational and reporting requirements.

C. In the event the Division initiates a termination action of a Contract for failure to meet the requirements of Federal Law or the Contract the Division will provide the AdSS with notice of intent to terminate, the reason for termination and hearing rights [42 CFR 438.710].

1. In the event AdSS does not contest the intent to terminate the Contract, the Division will notify the AdSS in writing of:
   a. The effective date of termination
   b. The AdSS operational and reporting requirements
   c. Timelines for submission of deliverables.
2. In the event the AdSS files a request for a hearing to challenge the intent to terminate and the termination is upheld through the Administrative Hearing process, the Division will notify the AdSS in writing of:
   a. The effective date of termination

b. The AdSS operational and reporting requirements

c. Timelines for submission of deliverables.

D. The Division will provide AHCCCS with written notice no later than 30 days after the date of Contract termination, in accordance with 42 CFR 438.724.

General AdSS Responsibilities

For Contract expirations and terminations, the AdSS must adhere to the following:

A. Produce reports timely and perform all responsibilities through the dates specified in the Division notification.

B. Comply with all terms of the Contract including, but not limited to, the provision of all management and administrative services throughout the transition.

C. Maintain adequate staffing to perform all required functions as specified in Contract.

D. Designate an individual as Contract Transition Coordinator who must ensure the continuance of AdSS performance, operations, and member transitions through a time determined by AdSS, and provide this individual's contact information with submission of the Contract Expiration or Termination Plan.

E. Participate in any meetings, workgroups, trainings, or other activities scheduled by the Division related to the transition of members, to support a seamless transition.

F. Be responsible for payment of all outstanding obligations for medical care rendered to members.

G. Be responsible for the provision of a monthly claims aging report including Incurred But Not Reported (IBNR) amounts (as outlined in the Division Notification).

H. Be responsible for the provision of Quarterly and Audited Financial Statements up to the date specified by the Division.

I. Be responsible for the provision of encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed. Cooperate with reinsurance audit activities on prior Contract years.

J. Cooperate with the Division to complete and finalize any open and pending reconciliations.

K. Be responsible for the submission of Quality Management and Medical Management reports as required by contract, as appropriate, to provide information on services rendered up to the date of contract expiration or termination including Quality Of Care (QOC) concern reporting and investigations based on the date of service.

L. Be responsible for participation in and closing out Performance Measures and Performance Improvement Projects as required.

M. Provide a monthly accounting and disposition of Member Grievances and Provider Claim Disputes as outlined in the Division notification.

N. Be responsible for the retention, preservation, and availability of all records, including, but not limited to those records related to member grievance and appeal records, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement and those covered under HIPAA, as required by Contract, State and Federal law, including but not limited to, 45 CFR 164.530(j) (2) and 42 CFR 438.3(u).

O. Be responsible for the completion of existing third-party liability cases or making any necessary arrangements to transfer the cases to the Division authorized Third Party Liability (TPL) Contractor.

P. Be responsible for the following activities pertaining to member services and transitions:

1. Continue to serve enrolled members and provide all medically necessary covered services until the transition of all members is complete as specified by the Division.

2. Conduct all member transition activities in accordance with the Division requirements.

3. Cooperate with AdSS which are receiving members, to support seamless transition of all member services.

4. Transfer member data to AdSS which are receiving members using a file format and dates for transfer of member data specified by the Division.

5. The cost, if any, of reproducing and forwarding medical records.

Q. Return to the Division any funds advanced to the AdSS for coverage of members for periods subsequent to the date of termination within 30 days of the Contract termination.

R. Make available all data, information and reports collected or prepared by the AdSS in the course of performing its duties and obligations under the Contract to the Division within 30 days following expiration or termination of the Contract or such other period as specified by the Division.

For Contract terminations, the AdSS will, in addition to the above requirements:

1. Be liable for costs incurred by the Division in re-procuring materials or services under the Contract.

2. Be liable for costs associated with the transition of its members to a different AdSS.

Contract Expiration or Termination Plan

A. The AdSS must submit a Contract Expiration or Termination Plan to the Division, for approval. The Plan must be submitted to the designated Operations and Compliance Officer, within 30 days of the Division expiration/termination notice to the AdSS.

B. The Contract Expiration or Termination Plan must include, but is not limited to, the following:

1. A description of the AdSS process for ensuring compliance with all responsibilities delineated in the Contract including retention of sufficient staff to conduct business operations through the time period specified by the Division.

2. The designation of a Contract Transition Coordinator.

3. Timeline for submission of all required deliverables for the term specified by the Division.

4. Communications to all subcontractors and members related to the Contract expiration/termination, including a timeline for notification.

5. The method for transferring member data and disposition of any related medical records.

6. A Member Transition Plan to support a seamless transition of members including but not limited to members with:

   a. Significant medical or behavioral health conditions such as, a high-risk pregnancy or pregnancy within the last trimester, Serious Mental Illness (SMI), the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

   b. Ongoing services such as daily in home care, behavioral health services, dialysis, pharmacy, medical supplies, transportation, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition.

   c. Conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth.

   d. Prior authorized services including but not limited to scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, nursing home admission or Home and Community Based (HCBS) Placements, Continuing prescriptions, Durable Medical Equipment (DME), and medically necessary transportation orders.

   e. Significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, ventilator services.

   f. High needs/high costs.

7. In addition, the Member Transition Plan must also support a seamless transition for those members who present ongoing concerns to State and Federal entities and/or the media.

Release of AdSS Requirements after Contract Expiration or Termination

The AdSS remains responsible for all activities associated with the Contract expiration or termination until official written release from the Division has been granted.

A. The AdSS must submit to the Division, a written request for release.

B. The Division will provide an official written release upon satisfaction of activities associated with the Contract expiration or termination including, but not limited to, the following:

1. Audited Financial Statements inclusive of a balance sheet
2. Payment of all outstanding medical obligations for medical care rendered to members.
3. Encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed.
4. Reinsurance audit activities on prior contract years.
5. Finalization of any open or pending reconciliations
6. Performance Bond or Bond Substitute.

444 NOTICE AND APPEAL REQUIREMENTS (SERIOUS MENTAL ILLNESS APPEALS)

EFFECTIVE DATE: April 29, 2020

REFERENCES: ACOM Policy 444 - Notice and Appeal Requirements (Serious Mental Illness Appeals)

Attachment A - AHCCCS Notice of SMI Grievance and Appeal Procedure

Attachment B - Notice of Legal Rights for Persons with Serious Mental Illness

Attachment C - Notice of Decision and Right to Appeal (for Individuals with an SMI)

Attachment D - Notice of Discrimination Prohibited

This Policy applies to Administrative Services Subcontractors (AdSS). The purpose of this Policy is to ensure that persons seeking or receiving behavioral health services and persons seeking an SMI eligibility determination are provided notice and the opportunity to Appeal as required under Arizona Administrative Code (A.A.C.) R9-21-401.

DEFINITIONS

A. Action – The Denial or Limited Authorization of a requested behavioral health service. This includes:

1. Type or level of service;
2. Reduction, suspension or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide covered services in a timely manner;
5. Failure to act within established timeframes for resolving an Appeal or complaint and providing notice to affected parties; and
6. Denial of the Title XIX/XXI eligible person's request to obtain covered services outside the network.

B. Appeal – A request for review of a decision made by the Division, an AdSS, or an AdSS provider.

C. Denial - The decision to deny a request made by, or on behalf of, a behavioral health recipient for the authorization and/or payment of a covered service.

D. Limited Authorization - A service authorization that falls short of the original request, with respect to the duration, frequency, or type of service requested.

E. Prior Authorization - A process used to determine in advance of provision whether or not a prescribed procedure, service, or medication will be covered. The process is intended to act as a safety and cost savings measure.

F. Qualified Clinician - 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.

G. Reduction of Service - A decision to reduce the frequency or duration of an ongoing behavioral health service. A Reduction of Service does not include a planned change in service frequency or duration that is initially identified in the person's service plan and agreed to in writing by the person receiving services or his/her legal guardian.

H. Suspension of Service - A decision to temporarily stop providing a behavioral health service.

I. Termination of Service - A decision to stop providing a covered behavioral health service.

POLICY

A. APPLICABILITY

This policy applies to decisions made by the AdSS or the AdSS subcontracted providers regarding the need for, the timely provision of, or the continuation of services, and charges or co-payments for behavioral health services.

This Policy does not apply to:

1. Allegations of rights violations made by enrolled persons with a Serious Mental Illness (See ACOM Policy 446).
2. Actions or decisions that deny, suspend, reduce, or terminate a person's services or benefits as a result of changes in state or federal law which require an automatic change, or in order to avoid exceeding the state funding legislatively appropriated for those services or benefits.
3. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services.
4. TXIX Appeals of an Action affecting services subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services.

B. PROCEDURES

1. General Requirements for Notices and Appeals

a. Computation of Time

i. In computing any time prescribed or allowed by this policy, the period begins the day after the act, event or decision occurs. The time period shall be calculated using calendar days. Weekends and legal holidays are counted in the computation. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday.

b. Language and Format Requirements

i. Notice and written documents generated through the Appeals process shall be available in each prevalent, non-English language spoken within the geographic service area;

ii. The AdSS or AdSS subcontracted providers shall provide oral interpretation services at no charge to the behavioral health recipient to explain information contained in the notice or as part of the Appeal process for all non-English languages; and

iii. Notice and written documents generated through the Appeals process shall be available in alternative formats, such as Braille, large font, or enhanced audio, and take into consideration the special communication needs of the person applying for or receiving behavioral health services, and notice and written documents shall be written using an easily understood language and format.

c. Delivery of Notices

i. All notices and Appeal decisions identified herein shall 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 person at his or her home address, or the person has indicated that he or she does not want to receive mail at home, the alternate methods identified by the person for communicating notices shall be used.

d. Prohibition of Punitive Action

i. The Division, the AdSS, and the AdSS subcontracted providers are prohibited from taking punitive action against persons exercising their right to Appeal.

2. Notice Requirements

a. Notices pursuant to this section shall be delivered to:

i. The member/guardian/designated representative. For members identified as in need of Special Assistance, the person designated to meet the Special Assistance needs shall be notified.

b. Provision of notice shall be evidenced by retaining a copy of the notice in the comprehensive clinical record of the person receiving or requesting services.

3. Notices for persons being evaluated for or who have been determined to have SMI

a. The AdSS AdSS or AdSS subcontracted provider shall provide Attachment A (AHCCCS Notice of SMI Grievance and Appeal Procedure) to each person at the time of evaluation for an SMI eligibility determination.

b. The AdSS and AdSS' subcontracted providers shall provide a copy of Attachment B (Notice of Legal Rights for Persons with Serious Mental Illness) at the time of admission to the agency for evaluation or treatment. The person receiving this notice shall acknowledge in writing the receipt of the notice and this written acknowledgement shall be retained in the person's comprehensive clinical record. The AdSS and the AdSS' subcontracted providers shall post Attachment B (Notice of Legal Rights for Persons with Serious Mental Illness), in both English and Spanish, so that it is readily visible to persons visiting the agency.

c. The AdSS shall provide Attachment C (Notice of Decision and Right to Appeal (for Individuals with an SMI)) when:

i. Initial eligibility for SMI services is determined. The notice shall be sent within three days of the eligibility determination;

ii. A decision is made regarding fees or waivers thereof;

iii. An assessment report, Service Plan or Inpatient Treatment and Discharge Plan is developed, provided or reviewed;

iv. A decision is made to modify the service plan or to deny, reduce, suspend or terminate a service that is a non-Title XIX/XXI covered service. No notice is required when the requested service requires a physician's order, and the denial, reduction, suspension or termination is due to the physician's refusal to order the service. Decisions to modify the service plan to deny, reduce, suspend or terminate a service that is Title XIX/XXI covered requires notification. Notice shall be provided at least 30 days prior to the effective date of the change unless the person agrees to the change in writing, or a Qualified Clinician determines that the Action is necessary to avoid a serious or immediate threat to the health or safety of the person receiving services or others;

v. A decision is made that the person is no longer eligible for SMI services; or

vi. A PASRR determination, in the context of either a preadmission screening or an annual resident review, is made which adversely affects the person.

d. Every AdSS and AdSS subcontracted provider shall post Attachment D (Notice of Discrimination Prohibited), so that it is readily visible to persons visiting the agency and shall provide a copy of this form to the person at the time of discharge from the agency.

4. Notices for Non-SMI/Non-Title XIX/XXI populations

a. Notice is not required to persons who are not eligible for Title XIX/XXI or SMI services for service decisions under this policy.

5. Appeal Requirements

a. AdSS Responsibility in appeals

i. Upon request, the AdSS and AdSS Subcontracted providers shall provide assistance in explaining the Appeal process or in reducing the Appeal in writing to the appropriate Appeal form.

b. Who May File an Appeal (i.e., the Appellant)

i. An adult applying for or receiving services, his or her legal guardian, guardian ad litem, designated representative or attorney, and for persons identified as in need of Special Assistance, this includes the person designated to meet the Special Assistance needs,

ii. A legal guardian, parent with legal custody, court-appointed guardian ad litem, or court-appointed attorney of a person under the age of 18 years,

iii. A state or governmental agency that has executed an Intergovernmental Agreement/Interagency Service Agreement (IGA/ISA) with The Division for the provision of behavioral health services to persons served by the governmental agency, but which does not have legal custody or control of the person, to the extent specified in the ISA/IGA between the agency and the Division, or,

iv. A provider acting on the behavioral health recipient's behalf and with the written authorization of the recipient.

6. Appeal Process for Persons with a Serious Mental Illness

a. The Appeal process for persons designated as SMI applies to all persons who have been determined SMI eligible and to persons disputing an SMI eligibility determination,

b. Title XIX/XXI eligible persons with a SMI who are Appealing an Action (see definition) affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI Appeal process as outlined in Contract, or the Appeal process for persons with a SMI, and

c. An Appeal may be filed for one or more of the following. An Appeal may not be filed when the contested decision involves a request for a service that requires a physician's order, and the physician refuses to order the service:

i. The Appeal process for persons designated as SMI applies to all persons who have been determined SMI eligible and to persons disputing an SMI eligibility determination,

ii. Title XIX/XXI eligible persons with a SMI who are Appealing an Action (see definition) affecting Title XIX/XXI covered services may elect to use either the Title XIX/XXI Appeal process as outlined in Contract, or the Appeal process for persons with a SMI, and

iii. An Appeal may be filed for one or more of the following. An Appeal may not be filed when the contested decision involves a request for a service that requires a physician's order, and the physician refuses to order the service:

iv. Recommended services identified in the assessment report, SP or ITDP,

v. Actual services to be provided, as described in the ISP, plan for interim services or ITDP,

vi. Access to or prompt provision of services,

vii. Findings of the clinical team with regard to the person's competency, capacity to make decisions, need for guardianship or other protective services or need for Special Assistance,

viii. Denial of a request for a review of, the outcome of, a modification to or failure to modify, or termination of an SP, ITDP or portion of an ISP or ITDP,

ix. Application of the procedures and timeframes for developing the ISP or ITDP,

x. Implementation of the ISP or ITDP,

xi. Decision to provide service planning, including the provision of assessment or case management services to a person who is refusing such services, or a decision not to provide such services to the person,

xii. Decisions regarding a person's fee assessment or the Denial of a request for a waiver of fees,

xiii. Denial of payment of a claim,

xiv. Failure of the Contractor or AHCCCS to act within the timeframes regarding an Appeal, or

xv. A PASRR determination, in the context of either a preadmission screening or an annual resident review, which adversely affects the person.

7. Continuation of SMI services

a. If the Appeal relates to the modification or termination of a behavioral health service, the service under Appeal shall continue pending the resolution of the Appeal through the final agency decision, unless:

i. A Qualified Clinician 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,

ii. The person or guardian, if applicable, agrees in writing to the modification or termination.

8. Standard Appeal Process

a. Within five working days of receipt of an Appeal, the AdSS shall inform the appellant in writing that the Appeal has been received and of the procedures that will be followed during the Appeal,

b. If the AdSS refuses to accept a late Appeal or determines that the issue may not be appealed the AdSS shall inform the appellant in writing that he or she may, within 10 days of his/her receipt of the health plan decision, request an Administrative Review of the decision with the Division. This does not include those Actions or decisions described in Section A of this Policy to which this Policy does not apply, and,

c. If a timely request for Administrative Review is filed with the Dvision of the AdSS's decision as specified in this Policy, The Division shall issue a final decision of within 15 days of the request.

9. Informal Conference with the Contractor

a. Within seven days of receipt of an Appeal, the AdSS shall hold an informal conference with the appellant (including any guardian, guardian ad litem, designated representative, attorney, or case manager or other representative of the service provider, as applicable). If the appellant has been identified as needing Special Assistance, the AdSS shall contact the appellant's advocate, if no advocate has been assigned to the appellant, the AdSS shall contact AHCCCS Office of Human Rights and request that an advocate be present to assist the client during the informal conference and any other part of the Appeal process,

b. The Contractor shall schedule the conference at a convenient time and place and inform all participants in writing, two days prior to the conference, of the time, date and location, the ability to participate in the conference by telephone or teleconference, and the appellant's right to be represented by a designated representative of the appellant's choice,

c. The informal conference shall be chaired by a representative of the Contractor with authority to resolve the issues under Appeal, who shall seek to mediate and resolve the issues in dispute,

d. The AdSS representative shall 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,

e. If the issues in dispute are resolved to the satisfaction of the appellant, the AdSS shall issue a dated written notice to all parties, which shall 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,

f. If the issues in dispute are not resolved to the satisfaction of the appellant and the issues in dispute do not relate to the appellant's eligibility for behavioral health services, the appellant shall be informed that the matter will be forwarded for further Appeal to the Division for informal conference, and of the procedure for requesting a waiver of the the Division informal conference,

g. If the issues in dispute are not resolved to the satisfaction of the appellant and the issues in dispute relate to the appellant's eligibility for SMI services or the appellant has requested a waiver of the the Division informal conference in writing, the AdSS shall:

i. Provide written notice to the appellant of the process to request an administrative hearing,

ii. Determine at the informal conference whether the appellant is requesting the AdSS to request an administrative hearing on behalf of the appellant and, if so, file the request with the Division within three days of the informal conference,

iii. For a person who is in need of Special Assistance, send a copy of the Appeal, results of informal conference and notice of administrative hearing referenced in this Policy to the the Division Office of Human Rights, and

iv. If the appellant fails to attend the informal conference and fails to notify the AdSS of his or her inability to attend prior to the scheduled conference, the AdSS shall reschedule the conference in accordance with the requirements of this Policy. If the appellant fails to attend the rescheduled conference and fails to notify the AdSS of his or her inability to attend prior to the rescheduled conference, the AdSS shall close the Appeal docket and send written notice of the closure to the appellant.

1) If the appellant requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, the AdSS may re-open the Appeal and proceed with the informal conference.

2) For all Appeals unresolved after an informal conference with the Contractor, the Contractor shall forward the Appeal case record to the Division within three days from the conclusion of the informal conference.

10. Informal Conference

a. Unless the appellant waives an informal conference with the Division, or the issue on Appeal relates to eligibility for SMI services, the Division shall hold a second informal conference within 15 days of the notification from the AdSS that the Appeal was

unresolved.

i. At least five days prior to the date of the second informal conference, The Division shall notify the participants in writing of the date, time and location of the conference,

ii. The informal conference shall be chaired by a representative of the Division who shall seek to mediate and resolve the issues in dispute,

iii. The Division representative shall 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, and

iv. If the issues in dispute are resolved to the satisfaction of the appellant, the Division shall issue a dated written notice to all parties, which shall 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.

1) For a person in need of Special Assistance, the Division shall send a copy of the informal conference report to the Division Office of Human Rights.

v. If the issues in dispute are not resolved to the satisfaction of the appellant, the Division shall:

1) Provide written notice to the appellant of the process to request an administrative hearing,

2) Determine at the informal conference whether the appellant is requesting the Division to request an administrative hearing on behalf of the appellant and, if so, file the request within three days of the informal conference,

3) For a person who is in need of Special Assistance, send a copy of the notice as specified in this Policy to the Division Office of Human Rights,

4) In the event the appellant fails to attend the informal conference and fails to notify the Division of his or her inability to attend prior to the scheduled conference, the Division 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 appellant of his or her right to request an Administrative Hearing, and,

5) In the event the appellant requests the Appeal be re-opened due to not receiving the informal conference

notification and/or due to other good cause, the Division may re-open the Appeal and proceed with the informal conference.

11. Requests for Administrative Hearing

a. A written request for hearing filed with the Division shall contain the following information:

i. Name of the appellant and person receiving services (if different) and the case docket number),

ii. The decision being appealed,

iii. The date of the decision being appealed, and,

iv. The reason for the Appeal.

b. In the event a request for administrative hearing is filed with the AdSS, the AdSS shall ensure that the written request for hearing, Appeal case record and all supporting documentation is received by the Division within 3 days from such date, and

c. Administrative hearings shall be conducted and decided pursuant to A.R.S. §41- 1092 et seq.

12. Expedited Appeals

a. At the time an Appeal is initiated, the appellant may request an expedited Appeal in writing. The AdSS shall accept requests to expedite an Appeal for good cause, and for the following:

i. The Denial of admission to or the termination of a continuation of inpatient services, or

ii. A Denial or termination of crisis or emergency services.

b. Within one day of receipt of a request for an expedited Appeal, the AdSS shall:

i. Inform the appellant in writing that the Appeal has been received and of the time, date and location of the expedited informal conference, or,

ii. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal and that the appellant may, within three days of the AdSS's decision, request an Administrative Review of the AdSS's decision from The Division.

c. If the appellant requests an Administrative Review on a timely basis, the Division shall complete the review and issue a written decision within one day from the date of receipt. The decision of the Division shall be final.

13. AdSS Expedited Informal Conference

    a. Within two days of receipt of a written request for an expedited Appeal, the AdSS shall hold an informal conference to mediate and resolve the issues in dispute.

14. Division Expedited Informal Conference

    a. Within two days of notification from the Contractor, the Division shall hold an informal conference to mediate and resolve the issue in dispute, unless the appellant waives the conference, in which case the Appeal shall be forwarded within one day to the Division to schedule an administrative hearing, or

    b. If the Divisions informal conference is not waived, and it fails to resolve the Appeal, within one day of the informal conference, the Appeal shall be forwarded to the Division to schedule an administrative hearing.

445 SUBMISSION OF REQUEST FOR HEARING DOCUMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2901, A.R.S. § 41-1092 et seq, ACOM Policy 445, Attachment A

This Policy applies to the Division's Administrative Services Subcontractors (AdSS). This Policy describes the steps and processes the AdSS must take in submitting a request for a hearing to the AHCCCS Administration.

Definitions

A. AHCCCS - The AHCCCS Administration as defined in A.R.S. § 36-2901.

B. Appeal - A request for review of an action.

C. Claim Dispute – A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.

D. Day - Calendar day unless otherwise specified.

E. Director's Decision - The final administrative decision under A.R.S. § 41-1092(5).

F. State Fair Hearing - An administrative hearing under A.R.S. A.R.S. § 41-1092 et seq.

Policy Overview

The AdSS is responsible for the submission of requests for hearing to the Division's Office of Administrative Review. The Division will forward the hearing request file to the AHCCCS Office of Administrative Legal Services (OALS).

Documents must be submitted to the Division's Office of Administrative Review using Attachment A with all pertinent documentation.

Hearing Request File Submission Timeframes

A. Expedited member appeal hearing requests must be submitted no later than one (1) business day from receipt of the expedited hearing request.

B. Standard member appeal hearing requests must be submitted no later than three (3) business days from receipt of the hearing request.

C. Claim dispute hearing requests must be submitted no later than three (3) business days from receipt of the hearing request.

Hearing Request File Submission Method

Each AdSS must submit the hearing request files to the Division's Office of Administrative Review for member appeals and provider claim dispute hearing requests.

The AdSS must submit a standard Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) with the member appeal or provider claim dispute file.

Hearing File Content

Hearing files must be submitted with all of the following:

A. Submission of Request for Hearing Form (ACOM Policy 445, Attachment A)

B. Request for Hearing

C. Notice of Appeal Resolution or Notice of Decision

D. Appeal or Claim Dispute

E. Notice of Adverse Benefit Determination for member appeals, and

F. Signed Appointment of Representative for member appeals.

Submission of Request for Hearing Form, Attachment A

Each hearing file must include a Submission of Request for Hearing Form (ACOM Policy 445, Attachment A. The Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) must have all applicable fields completed. Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) must be the first page of the file submission.

Files submitted without an accurately completed Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) will not be accepted.

Notice of Hearing and Submission of Supporting Documents

The Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) submitted by the AdSS will be used to identify the hearing issue and applicable citations. Once a hearing file is submitted to AHCCCS any future changes to the issue or citations must be filed by the AdSS with the Office of Administrative Hearing as a Motion to Amend the Notice of Hearing.

The Division and the AHCCCS OALS reserves the right to make changes to the issue and any legal citations for accuracy.

In order to properly include additional information or supporting documentation into the record in support of their decision or action, the AdSS must file exhibits with the Office of Administrative Hearing and copy the Office of Administrative Review. If submitted to the Division or AHCCCS this information will not be added to the Administrative record on the AdSS's behalf.

446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. Title 32, Chapter 33; A.R.S. §§ 41-1092 et seq., A.R.S. § 36-550; A.A.C. R9-21-101(B), A.A.C. R9-21-403, A.A.C. R9-21-406, A.A.C. R9-21-410(B), ACOM Policy 444, AMPM Policy 960; ACOM Policy 446, Attachment A, AHCCCS Appeal or SMI Grievance Form (English and Spanish Versions)

This Policy applies to the Division's Administrative Services Subcontractors and outlines the process related to grievances and investigations concerning persons with a Serious Mental Illness (SMI).

This Policy does not apply to grievances or requests for investigation asserted by, or on behalf of, persons with an 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 due to limitations on legislative appropriation.

Definitions

A. Abuse - The infliction of, or allowance of, another person 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).

B. Administrative Appeal - An appeal to AHCCCS of a decision made by an AdSS as the result of a grievance.

C. Appeal - A request for review of an adverse decision by an AdSS.

D. Condition Requiring Investigation - An incident or condition that appears to be dangerous, illegal, or inhumane, including the death of a person with Serious Mental Illness.

E. Dangerous - A condition that poses or posed a danger or the potential of danger to the health or safety of a person with Serious Mental Illness.

F. Day – means calendar days, unless otherwise specified.

G. Grievance or Request for Investigation - A complaint that is filed by a person with Serious Mental Illness or other concerned person alleging a violation of an SMI member's rights or a condition requiring an investigation.

H. Illegal - An incident or occurrence that is or was likely to constitute a violation of a state or federal statute, regulation, court decision, or other law.

I. Inhumane - An incident, condition, or occurrence that is demeaning to a person with

Serious Mental Illness or that is inconsistent with the proper regard for the right of the person to humane treatment.

J. Mental Health Agency - Includes a regional authority, service provider, inpatient facility, or an agency that conducts screening and evaluation under A.A.C. Title 9, Chapter 21, Article 5, and A.A.C. R9-21-101(B)(47).

K. Preponderance of Evidence - A standard of proof that it is more likely than not that an alleged event occurred.

L. Serious Mental Illness - A condition as defined in A.R.S. § 36-550 diagnosed in persons 18 years and older.

M. Special Assistance - The support provided to a person determined to have a Serious Mental Illness who is unable to articulate treatment preferences and/or participate effectively in the development of the Planning Document, Inpatient Treatment and Discharge Plan (ITDP), or grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

Policy

For members who have been diagnosed with a Serious Mental Illness, the AdSS must conduct investigations into allegations of physical abuse, sexual abuse, and violations of rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a death of a member that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

General Requirements

A. The AdSS must respond to grievances and requests for investigations in accordance with this Policy and the requirements and timelines contained in A.A.C. Title 9, Chapter 21, Article 4.

B. In computing any period of time prescribed or allowed by this Policy, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

C. The AdSS must use a unique docket number for each grievance or request for investigation filed. The file and all correspondence generated must reference the docket number.

Resolving Grievances and Requests for Investigation

A. Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by an AdSS or one of its subcontracted providers and which does not involve a member death or an allegation of physical or sexual abuse, must be filed with and investigated by the AdSS.

B. Grievances or requests for investigation involving physical or sexual abuse or death must be filed with, and investigated by, AHCCCS.

C. The AdSS or its subcontractor must immediately take whatever action may be reasonable to protect the health, safety and security of any member, complainant or witness when a grievance or request for investigation is pending.

Grievance and Request for Investigation Process

A. Timeliness and Method for Filing Grievances and Requests for Investigation

1. A grievance or a request for investigation must be submitted to the AdSS or its subcontracted providers, orally or in writing, no later than 12 months from the date on which the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by AHCCCS or the AdSS, as applicable.

2. Within five days of receipt of a grievance or request for investigation, the AdSS must inform the person filing the grievance or request for investigation, in writing, that the grievance or request has been received.

3. Any employee or contracted staff of the AdSS or its subcontracted providers, must, upon request, assist a person receiving services, or his/her legal guardian, in making an oral or written grievance or request for investigation or direct the person to an available supervisory or managerial staff who will assist the person to file a grievance or request for investigation ((A.A.C. R9-21-403(F)).

4. If an AdSS or its subcontracted provider receives an oral grievance or request for investigation, it must accurately reduce it to writing on the AHCCCS Appeal or SMI Grievance Form (See ACOM Policy 446, Attachment A, Appeal or SMI Grievance Form, adopted by the Division for use by the AdSS).

B. Summary Disposition – AHCCCS or the AdSS may summarily dispose of a grievance or request for investigation without any notice or right for further review or hearing when:

1. The alleged violation occurred more than one year prior to the date the grievance or request is received, or

2. The grievance or request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in A.A.C. Title 9, Chapter

21, Articles 3 and 4.

C. Disposition Without Investigation - Within seven days of receiving a grievance or request for investigation, it may be resolved without conducting a full investigation if the matter:

1. Involves no material dispute as to the facts alleged in the grievance or request for investigation

2. Is frivolous, meaning that it:

   a. Involves conduct that is not within the scope of A.A.C. Title 9, Chapter 21

   b. Is impossible on its face

   c. Is substantially similar to conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated, or

3. Is resolved fairly and efficiently within seven days without a formal investigation.

   Within seven days of the receipt of the grievance or request for investigation, a written dated decision must be issued that explains the essential facts as to why the matter may be appropriately resolved without investigation and the resolution. The written decision must contain a notice of appeal rights and information to request assistance from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision must be sent to the person filing the grievance or request for investigation, to the AHCCCS OHR for persons who need Special Assistance, and to other parties as required by A.A.C. Title 9 Chapter 21, Article 4.

D. Conducting Investigations of Grievances

1. Investigations must be conducted pursuant to A.A.C. R9-21-406. The investigator must:

   a. Interview the person who filed the grievance and the person receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the person alleged to be the perpetrator of the rights violation, or physical or sexual abuse.

   b. If the person who is the subject of the investigation has been identified as needing Special Assistance, the investigator must contact the person's advocate; or if no advocate is assigned, the investigator must contact AHCCCS OHR, and request that an advocate be present to assist the person during the interview and any other part of the investigation process.

   c. Request assistance from the AHCCCS OHR if the person receiving

services needs assistance to participate in the interview and any other part of the investigation process.

d. Prepare a written report that contains at a minimum:

i. A summary for each individual interviewed of information provided by the individual during the interview conducted

ii. A summary of relevant information found in documents reviewed

iii. A summary of any other activities conducted as a part of the investigation

iv. A description of any issues identified during the course of the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation

v. A conclusion, describing those findings and/or factors that led to the conclusion, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence, and

vi. Recommended actions or a recommendation for required corrective action, if indicated.

2. Within five days of receipt of the investigator's report, AHCCCS's Deputy Director or the AdSS's CEO or designee will review the investigation case record and the report, and issue a written, dated decision that will:

a. Accept the report and state a summary of findings and conclusions, and any recommended actions or corrective action required, and send copies of the decision, subject to confidentiality requirements to the investigator, the AdSS, the person who filed the grievance, the person receiving services identified as the subject of the grievance (if different), the AHCCCS Office of Human Rights for a person in need of Special Assistance, and the applicable independent oversight committee. The decision will include a notice of the right to request an appeal of the decision within 30 days from the date of receipt of the decision. The decision will be sent to the grievant by certified mail or by hand-delivery, or

b. Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report within 10 days, absent extension.

3. Actions that may be taken or recommended, as indicated above, include:

a. Identifying training or supervision for, or disciplinary action against, an

individual found to be responsible for a rights violation or condition requiring investigation identified during the course of investigation

b. Developing or modifying a mental health agency's practices or protocols

c. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation

d. Imposing sanctions that may include monetary penalties, according to the terms of a contract, if applicable.

4. A grievant or the member who is the subject of the grievance, who disagrees with the final decision of the AdSS, may file a request for an administrative appeal with AHCCCS within 30 days from the date of the receipt of the decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the Division's decision.

5. If an administrative appeal is filed, the AdSS 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 AdSS to forward a full investigation case record that supports the AdSS's decision may result in a summary determination in favor of the person filing the administrative appeal. The AdSS must prepare and send, with the investigation case record, a memo that states:

a. Any objections the AdSS has to the timeliness of the administrative appeal

b. The AdSS's response to any information provided in the administrative appeal that was not addressed in the investigation report, and

c. The AdSS's understanding of the basis for the administrative appeal.

6. Within 15 days of receipt of a timely filed administrative appeal, AHCCCS will 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 prepare a written, dated decision that either:

a. Accepts the investigator's report with respect to the facts as found, and affirms, modifies, or rejects the decision of the AdSS with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within 30 days from the date of receipt of the decision, must be sent to the appealing party, with copies of the decision provided to the AdSS, AHCCCS OHR, and the applicable independent oversight committee; or

b. Rejects the investigator's report for insufficiency of facts and remands the matter with instructions to the AdSS for further investigation and

decision. The AdSS must conduct further investigation and complete a revised report and decision to AHCCCS within 10 days, after which AHCCCS will render a final decision. Or AHCCCS may reject the investigator's report for insufficiency of facts and remand the matter with instructions to the AdSS for further investigation and the issuance of a revised AdSS's decision, directly to grievant or client who is the subject of the grievance, along with notification of the right to request a second administrative appeal to AHCCCS of the AdSS's revised decision within 30 days from the date of receipt of the revised decision.

7. Extensions of Time - If an extension of any time frame related to the grievance process is needed, the extension must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:

   a. The AdSS investigator or any other AdSS official responsible for responding to grievances must address the extension request to the AdSS Director or designee,

   b. 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,

   c. An AdSS 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, and

   d. Requests for extension must be in writing, with copies to all parties.

Request for an Administrative Hearing

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.

A. Upon receipt of a request for a hearing, the hearing is scheduled and conducted according to the requirements in A.R.S. §§ 41-1092 et seq.

B. After the expiration of the timeframes for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals, the AdSS will take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report will be sent to the AHCCCS OHR for persons in need of Special Assistance.

Miscellaneous Matters Relating to the Grievance Process

A. In addition to a grievance or request for investigation that 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 Division Medical Policy Manual, Policy 960.

B. Grievance Investigation Records: The AdSS must maintain records in the following manner:

1. All documentation received related to the grievance and investigation process must be date-stamped on the day received.

2. A complete grievance investigation case record must be maintained for each case, and must include:

a. The original grievance/investigation request letter and the Appeal or SMI Grievance Form

b. Copies of all information generated or obtained during the investigation

c. The investigator's report, which will include:

- A description of the grievance issue
- Documentation of the investigative process
- Names of all persons interviewed
- Written documentation of the interviews
- Summary of all documents reviewed
- The investigator's findings, and
- Conclusions and recommendations.

d. A copy of:

- The acknowledgment letter
- Final decision letter
- Corrective action documentation, and
- Any information/documentation generated by an appeal of the grievance decision.

C. The AdSS must maintain all grievance and investigation files in a secure designated area and retain for at least five years.

D. The AdSS must maintain a public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

E. The AdSS must maintain confidentiality and privacy of grievance and investigations records.

F. Notice must be given to a public official, law enforcement officer, or other person, as

required by law, that an incident involving death, abuse, neglect, or threat to a person receiving services has occurred, or that a dangerous condition or event exists. Refer to AMPM Policy 960.

G. The AdSS must notify the Deputy Director of AHCCCS, or designee, when: (Refer to AMPM Policy 960)

1. A person receiving services files a complaint with law enforcement alleging criminal conduct against an employee.

2. An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a person receiving services.

3. An employee, contracted staff, or person receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a person receiving services.

448 HOUSING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-550; 24 CFR 582, 24 CFR 583, and the following:

- Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)
- ACOM Policy 448 Attachment A, AHCCCS Housing Application for Acquisition and/or Renovation or New Construction
- ACOM Policy 448 Attachment B, AHCCCS Housing Acquisition/Renovation Checklist,
- ACOM Policy 448 Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions
- ACOM Policy 448 Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement,
- ACOM Policy 444, Notice of Appeal Requirements (Serious Mental Illness Appeals)
- ADSS-Operations Policy 446,-Grievances and Investigations Concerning Persons with Serious Mental Illness.

Purpose

This Policy applies to Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (DDD, or the Division) to provide a guideline for the delivery of housing services, the development, implementation and management of housing programs and related funds for the eligible populations. [24 CFR Part 582 and 24 CFR Part 583]

Definitions

A. Arizona Department of Housing (ADOH) – A department established for state government in Arizona to assist in addressing needs for homes for working families. ADOH administers programs for Housing Partners who apply to the department for funding. The majority of the agency's programs are federally funded. The agency is also home to the Arizona Housing Finance Authority and the Arizona Home Foreclosure Prevention Funding Corporation.

B. Continuum of Care – A regional or local planning body that coordinates housing and services funding for homeless families and individuals as required by the U.S. Housing and Urban Development (HUD) Agency.

C. Department of Housing and Urban Development (HUD) – A U.S. government agency created in 1965 to support community development and home ownership. HUD does this by improving affordable home ownership opportunities, increasing safe and affordable rental options, reducing chronic homelessness, fighting housing discrimination by ensuring equal opportunity in the rental and purchase markets, and supporting vulnerable populations.

D. Homeless (HUD Definition) – A person is considered homeless only when he/she resides in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street)
- In an emergency shelter
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution
- Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and lacks resources and support networks needed to obtain housing
- Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing
    - For example, a person being discharged from prison after more than 30 days is eligible ONLY IF no subsequent residence has been identified and the person does not have money, family or friends to provide housing.
    - Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.

E. Homeless (Persons in these situations are not included in the HUD definition of or funding purposes) –

- Persons living in housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded
- Persons living with relatives or friends
- Persons staying in a motel, including a pay-by-the-week motel
- Persons living in a Board and Care, Adult Congregate Living Facility, or similar place
- Persons being discharged from an institution that is required to provide or arrange housing upon release, or
- Wards of the State, although youth in foster care may receive needed supportive services which supplements, but does not substitute for, the state's assistance.

F. Housing Acquisition and/or Renovation Programs – A housing program that provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). Eligible non-profit Housing providers work with the AdSS to locate properties, purchase and/or renovate them for the use of persons determined to have Serious Mental Illness following AHCCCS requirements, review and approval. The property is held for use of AHCCCS eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

G. Housing First – A Housing approach that works to quickly and successfully to connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

H. Housing Referral – A written authorization from the AdSS for the provision of covered services to an eligible member. The Housing Referral will constitute the agreement of the provider to provide services identified in the tenant's Individual Service Plan. Housing Referrals will be in such form and format determined by the AdSS.

I. HUD Housing Choice Voucher Program – The federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Individuals free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Housing choice vouchers are administered locally by Public Housing Agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

J. Independent Community Housing – A setting where a person can live either alone or with a roommate in a home or apartment without on-going daily supervision from behavioral health providers. Options include:

- HUD Section 8 programs through local Public Housing Authorities
- Low-income subsidized housing through local non-profit organizations
- Supportive Housing Programs funded with federal grants and administered by AdSS contracted housing providers
- State subsidized rental units, and
- Permanent Houses and apartments purchased with state funding.

K. Public Housing Authority (PHA) – HUD funded unit of local government that provides independent housing for low-income individuals and families. Program includes Section 8, Housing Choice Vouchers, and low rent units.

L. Rapid Housing – An intervention, informed by a Housing First approach that is a critical part of a community's effective homeless crisis response system. Rapid re-housing rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-

limited financial assistance and targeted supportive services. Rapid re-housing programs help families and individuals living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness, avoiding a near-term return to homelessness, and linking to community resources that enable them to achieve housing stability in the long-term. Rapid re-housing is an important component of a community's response to homelessness. A fundamental goal of rapid rehousing is to reduce the amount of time a person is homeless.

M. Section 8 – Section 8 is the more common name for the Housing Choice Voucher Program which is sponsored by HUD. Qualified applicants receive vouchers which are used to subsidize the cost of housing. These vouchers are awarded to individuals who meet certain income requirements. The goal of these programs is to provide affordable low-cost housing to low income occupants.

N. Serious Mental Illness (SMI) – A condition as defined in A.R.S. §36-550 diagnosed in persons 18 years and older.

O. Sponsor-Based Rental Assistance – Sponsor-based rental assistance provides a subsidy for rental assistance through contracts between the grantee and contracted sponsor organization. A sponsor may be a private nonprofit organization, or a community mental health agency established as a public nonprofit organization. Participants reside in housing owned or leased by the sponsor.

P. Supporting Housing Services – Services, as defined in the AHCCCS Behavioral Health Services Guide, that are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include:

- Utility subsidies
- Relocation services to a person or family for the purpose of securing and maintaining housing
- Employment services
- Budget and finance counseling, and
- Eviction prevention.

Q. Supportive Housing – Housing, as defined in 24 CFR Part 583, in conjunction with supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless persons with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless persons and families.

R. Tenant-Based Housing – A scattered-site program in which the tenant holds the lease and is directly responsible to the owner of the property. This program is comparable to the HUD Section 8 Housing Choice Voucher Program, but with modifications to meet the

needs of adults determined to have a Serious Mental Illness.

S. Traditional Housing – Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24 months.

Policy

A. General Housing Contracts Requirements

For the populations of persons determined to have a SMI or other eligible populations served by the AdSS (contingent upon available funding) and who are able to live independently, the AdSS must provide a number of programs to support independent living, such as rent subsidy programs, supportive housing programs and other transitional housing programs. Independent living must be supported with provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Housing programs must include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supportive housing services to maintain independent living.

The Contractor AdSS must maintain a sufficient number of dedicated staffs of housing professionals with knowledge, expertise, experience and skills and require housing subcontractors to employ a sufficient number of staffs with knowledge, expertise and experience to participate in and administer a variety of affordable housing programs for members. The AdSS must:

1. Require housing subcontractors to employ a sufficient number of staffs with financial management, screening and referral skills, knowledge of federal wait lists, grant writing knowledge for applying for new funds, and supportive services as required by HUD to maintain current HUD grants as they come up for renewal, and to fund future grants.

2. Submit plans describing the AdSS housing programs and submit periodic reports on housing programs, as outlined in Contract.

3. Develop and submit an Annual Housing Needs Assessment, that includes:

    a. A brief summary of the AdSS's Housing program history and/or current projects

    b. The specific eligibility group for any proposed new program and/or use of funds (e.g. SMI, GMH/SA, High Cost/High Needs Members) to include:

        i. A Program description

        ii. Barriers, trends and accomplishments in housing identified during the reporting period

        iii. Basis for need including supporting data and justification

        iv. Plan for identification of program candidates, and

        v. Collaborators.

4. Develop and submit for approval an Annual Housing Spending Plan for development, maintenance, use and acquisition of housing properties in a format specified by the Division and must at a minimum include:

   a. Project descriptions separated by population and funding source

   b. For each project the estimated number of new housing units and members housed and possible barriers

   c. Evidenced based best practices to be used improve housing capacity in responding to unmet housing needs and related issues; i.e. assessment scores

   d. All leveraged funds, their sources and collaborative efforts

   e. Project timeframes, and

   f. Monitoring and tracking process for each program.

5. Ensure that providers identify, and screen individuals determined to have SMI that satisfy Section 8 criteria and refer the prospective tenant to contracted Public Housing Authority.

6. Require providers to participate with the individual's treatment team in order to identify available housing units and to place the individual in an affordable appropriate living environment upon discharge from an institutional setting.

7. Comply with, requirements in ACOM Policy 444 for appeals related to supportive housing services.

8. Comply with AdSS Operations Policy Manual, Chapter 446 for Housing related grievances and requests for investigation for persons determined to have SMI.

B. Division Requirements for State Funding Supportive Housing Programs

The Division supports permanent supportive housing and has adopted the Substance Abuse and Mental Health Services Administration (SAMHSA) model for permanent supportive housing programs.

1. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program are:

   a. Tenants have a lease in their name, and, therefore, they have full rights of tenancy under landlord-tenant law, including control over living space and protection against eviction.

   b. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.

   c. Participation in services is voluntary and tenants cannot be evicted for rejecting services.

   d. House rules, if any, are similar to those found in housing for people who do not have psychiatric disabilities and do not restrict visitors or

otherwise interfere with a life in the community.

e. Housing is not time-limited, and the lease is renewable at tenants' and owners' option.

f. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.

g. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.

h. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.

i. Tenants have choices in the support services that they receive. Tenants are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.

j. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.

k. Support services promote recovery and are designed to help tenants choose, get, and keep housing, and

l. The provision of housing and the provision of support services are distinct.

2. The AdSS must comply with the following requirements to effectively manage limited housing funds in providing supportive housing services to eligible individuals. See the AHCCCS Covered Behavioral Health Services Guide for additional information on Supportive Housing. The AdSS must:

a. Accept all persons determined to have a SMI into a State Funded Housing Program subject to funding availability.

b. Utilize supportive housing allocations for eligible individuals and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for persons determined Title XIX/Non-Title XIX SMI persons, while another allocation may require it be used for those persons with GMH/SA eligibility.

c. Ensure safe and stable housing that is consistent with the member's recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.

d. Not actively refer or place individuals in a Homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other

similar facilities.

e. Provide the tenant with a 30-day notice at the time of the tenant's annual, recertification, if a rent payment is increased in state funded housing programs, The AdSS may charge up to, but not greater than, 30% of a tenant's income towards rent.

f. Not use supportive housing allocations for room and board charges in Residential Treatment settings. However, the AdSS may allow Residential Treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.

g. Not use supportive housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture. However, move-in assistance and eviction prevention services may be provided to those members in permanent housing. When move-in assistance is provided, assistance with deposits and payment for utilities must be prioritized over other methods of assistance, such as move-in kits or items consisting of pots and pans, dishes, sheets, etc. Subcontract with a non-profit organization that is eligible to serve as a grantee for HUD funded grant programs.

h. Ensure that their subcontracted providers doing business with agencies that have HUD grants, report data to the local Homeless Management Information System (HMIS) project manager on contract, to administer the HMIS data collection.

i. Ensure that contracted providers deliver a range of housing services and present available options for housing to persons determined to have SMI consistent with the individual's goals and needs in the Individual Service Plan.

j. Ensure that providers maintain all housing units currently in use, including units acquired through the State of Arizona housing funds specifically for members determined to have a SMI or other eligible populations served by the AdSS as funding permits.

k. Collaborate with State, County and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.

l. Develop new housing capacity, program initiatives and options when needed in collaboration with Division, ADOH and local HUD Continuum Of Care (COC).

m. Participate in the AHCCCS Quarterly Housing Meetings.

3. AdSSs awarded HUD funding are required to participate in the Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. The HMIS is used to coordinate care, manage program operations, and better serve clients.

4. The AdSS must develop and make available to providers the AdSS's contact information to receive additional guidance and requirements regarding these programs.

5. AdSS housing programs are required to include specialized housing units to meet the needs of persons who are difficult to place in the community partly due to crime free/drug free ordinances and specific behavioral health related service need including substance use disorders.

6. The AdSS must provide persons determined to have SMI who are discharged from the Arizona State Hospital, supervisory care homes or unlicensed board and care homes, with housing options that promote independent living.

7. The AdSS must require providers to participate with the member's treatment team in order to identify available housing units and to place the member in an affordable appropriate living environment upon discharge from an institutional setting.

8. The AdSS must advocate for persons determined to have SMI who are homeless and those released from Residential Treatment and Board and Care facilities to obtain housing units.

9. The AdSS must develop and make available to the providers policies and procedures regarding specific housing programs/funding and related requirements.

C. AdSS Monitoring Requirements of Subcontractors

The AdSS must monitor Housing subcontractors through the following activities:

1. Monitor providers for compliance with federal requirements of the SAMHSA Permanent Supportive Housing Fidelity Monitoring and HUD homeless grants.

2. Conduct regular inspections of housing units including tenant living situations to determine whether the individual has access to basic needs and whether the living environment is safe, secure and the least restrictive environment consistent with the treatment goals in the Individual Service Plan. Ensure contracted housing providers conduct these inspections also, and

3. Conduct a Housing Inventory of housing providers and tenants. This inventory must be submitted in the format and time required by the Division and must include:

   a. The number and types of housing programs.

   b. Number of units.

   c. Fund source for those units, and

   d. Populations served for each unit.

4. Develop and maintain an accounting system of all individuals in its housing program and of its housing and support service providers, and when requested or by Division Contract requirements, submit the data in a format approved by the Division.

5. Demonstrate that the AdSS's staff and provider housing program staff have received training and can demonstrate competency in the following:

   Clinical & Administrative Managers will demonstrate:

   Knowledge of the basic concepts found in the Federal Fair Housing Law and the Arizona Landlord Tenant Act as they apply to members and their contracted providers by passing a post-test conducted after an orientation session.

   Behavioral Health Professionals (BHP's), Behavioral Health Technicians (BHT's) & Behavioral Health Paraprofessionals (BHPP's) will demonstrate competency, by passing a post-test after training, in the following areas:

   a. Knowledge of basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords

   b. The general rights of members afforded by these laws, and

   c. The principles and availability of Housing support services.

   Case Managers will demonstrate that they capably:

   Understand the basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords.

   a. Explain lease requirements and rights of tenancy to Members in language they understand and can act upon,

   b. Visit members and schedule service appointments at their homes consistent with the law,

   c. Determine eviction risk and arrange for skill and or support service assistance to Members in coordination with Housing Providers,

   d. Document and involve the Member in investigating complaints originated by the Member or Landlord, and

   e. Pass a post test conducted after training and thereafter during routine clinical supervision.

   Housing Specialists and Case Managers will also demonstrate that they can capably conduct and use the current and emerging tools and best practices such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) by passing a post test conducted after Specialized Training program and thereafter during routine clinical supervision.

D. Requirements for Collaboration and Partnerships with Federal Housing Programs

1. The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. On May 20, 2009, a law was enacted to reauthorized HUD's McKinney-Vento Homeless Assistance Programs which in part outlined assistance programs for the homeless. The bill, known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, made numerous changes to HUD's homeless assistance programs to include the following:

   a. Significantly increased resources to prevent homelessness,

   b. Established incentives on the use of rapid re-housing programs, especially for homeless families,

   c. A revised definition of "Permanent Supportive Housing" for people experiencing chronic homelessness to establish an industry standard, and to add "families" to the definition of "chronically homeless", and

   d. The option for rural communities to apply under a different set of guidelines that may offer increased flexibility and assistance with capacity building.

2. The purpose of the COC Homeless Assistance Program is to reduce the incidence of homelessness in COC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act.

   The HUD HEARTH COC became effective August 31, 2012 and includes:

   a. Codifying the COC process

   b. Expanding the definition of homelessness,

   c. Focusing selection criteria more on performance,

   d. The HEARTH Act consolidates the programs formerly known as the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) Program, and the Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Program into one grant program: the COC program,

   e. The COC Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness,

   f. The AdSS is required to work in collaboration with the Arizona Department of Housing (ADOH), the Division and all Arizona HUD COCs to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD COC Homeless Assistance Programs awarded

throughout the State including but not limited to the HUD Housing Choice Voucher Program, and

g. AdSS's who administer the federal HUD Housing Choice Voucher Program must ensure the following:

i. Tenants pay 30% of their adjusted income towards rent.

ii. Vouchers are portable throughout the entire country after one year.

iii. Permanent housing is obtainable for individuals following program rules.

iv. The program is accessed through local Public Housing Authorities through a waiting list.

v. Initial screening is conducted by the Public Housing Authority; however, the final decision is the responsibility of the landlord, and

vi. A Crime Free - Drug Free Lease Addendum is required.

E. AHCCCS Requirements for State Housing Acquisition and/or Renovation Programs

The AHCCCS Housing Acquisition and/or Renovation program provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). The AdSS subcontracts with eligible non-profit Housing providers to locate properties, purchase and/or renovate them for the use of Division members in accordance with Division requirements, review and approval. The property is held for use of Division eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

1. The following conditions apply:

a. The AdSS must administer the AHCCCS Property Acquisition and Renovation Program through subcontracts with or partnerships with non-profit entities that have the capacity, experience, and knowledge of low-income housing programs, available funding streams and resources for supportive housing for adults determined to have SMI, and other eligible populations served by the AdSS (contingent upon available funding).

b. The AdSS must have prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division, and

c. For Acquisition and/or renovation of real property purchased by the AdSS's subcontractors with funds provided by the Division, excluding net profits earned under the Contract, the AdSS must complete the following:

i. Attachment A, the AHCCCS Housing Application for Acquisition and/or Renovation or New Construction

ii. All required documents to include the funding source used, prior to the purchase of any new property leveraged with funds provided through the Division, and when applicable, a Notice of Real Property Transaction, which must include the following:

- Copies of Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions (CC&Rs) recorded with the County Recorder's Office (the CC&Rs will cover a period of extended as indicated in the CC&R table based on use and costs)
- The funding source(s) used to purchase the property, specifically whether the purchase is to be made with funds provided through the Division and/or other matched funds
- The financing arrangements made prior to purchase the property
- Prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division
- A deed containing the use restrictions and covenants, conditions, or restrictions that ensures the property is used solely for the benefit of members and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions, and
- All documents as required in Attachment B, AHCCCS Housing Acquisition/Renovation Checklist.

d. The Division requires that the AdSS adopt Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement as minimum requirements for all agreements for Housing Acquisition and/or Remodel or New Construction made between the AdSS and Housing Contractors using State Funds.

449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

EFFECTIVE DATE: October 1, 2018

REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01; Section F3, Contractor Chart of Deliverables

DELIVERABLES: DCS & Adopted Children's Services Reporting: Access to Services; DCS & Adopted Children's Services Reporting: Calls and Reconciliation

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The purpose of this policy is to ensure the timely provision of medically necessary behavioral health services to children eligible for Title XIX services who are in out-of-home placement and in the legal custody of the Department of Child Safety (DCS) and to adopted children in accordance with A.R.S. § 8-512.01.

Definitions

A. Adoptive Parent - Any adult or adults who are residents of Arizona, whether married, unmarried or legally separated, who have 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.

B. Arizona Department of Child Safety (DCS) - 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.

C. Crisis - An acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

D. Crisis Services - Services provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

E. Out-of-Home Placement - For the purposes of this Policy out-of-home-placement means a foster home, kinship foster care, a shelter care provider, a receiving home or a group foster home.

The AdSS must ensure timely provision of all behavioral health services including, crisis services, 72-hour rapid response, urgent need response, assessment, and ongoing behavioral services, including screening and evaluation, for adopted children and children in out-of-home placement. The AdSS must provide coordinated care between the out-of-home placement or adoptive parent(s), all providers, and DCS, as appropriate.

General Requirements

In order to meet the needs of adopted children and children in out-of-home placement, the AdSS must:

A. Ensure services are provided in accordance with Policy 417 in this Policy Manual.

B. 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. Designated staff must be adequately trained on the provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There must be processes in place for staff to:

1. Address barriers to care.

2. Directly contact the crisis services vendor and/or provider.

3. Track and report calls as indicated in Section I of this Policy.

4. Report the above information to the Behavioral Health Coordinator.

Request for Behavioral Health Out-of-Home Treatment

The AdSS must ensure a determination is made, as expeditiously as the member's health condition warrants but no later than, 72 hours after a request is made by the out-of-home placement or adoptive parent for placement of the member in a behavioral health out-of-home treatment setting due to the child displaying dangerous or threatening behaviors. These settings include, but are not limited to, Behavioral Health Residential Facilities, and Behavioral Health Therapeutic Homes. If the AdSS determines there is insufficient information to make a determination, the AdSS must document all concerted efforts to obtain required information within the 72-hour timeframe.

A. If the member is hospitalized prior to a determination on the request for behavioral health out-of-home treatment setting, the AdSS must coordinate with the hospital to ensure an appropriate and safe discharge plan. The discharge plan must include recommended follow-up services, including recommendations made by the Child and Family Team. For additional requirements regarding discharge planning refer to Division Medical Policy Manual, Policy 1020.

B. The AdSS must collaborate with DCS and the Support Coordinator to ensure an appropriate alternative placement for the member to be discharged when:

1. It is unsafe for the member to return to the out-of-home placement or adoptive family, and/or

2. It is unsafe for the out-of-home placement or adoptive family for the member to return.

C. The AdSS must issue a Notice of Adverse Benefit Determination (NOA) in accordance with Policy 414 in this Policy Manual for any adverse action related to the request for placement of the member in a behavioral health out-of-home treatment setting.

D. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria was 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 placement or adoptive family. 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.

E. If the request for a behavioral health out-of-home treatment setting is denied, the AdSS must ensure medically necessary alternative services are provided.

Behavioral Health Appointment Standard

A. The AdSS must ensure services are provided in accordance with Policy 417 in this Policy Manual.

B. Upon notification from an out-of-home placement or adoptive parent that a recommended behavioral health service is not provided to a member per the Policy 417 in this Policy Manual, behavioral health appointment standards for children in DCS custody, the AdSS must:

1. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to Division's Customer Service Center at 602-542-0419 or email at DDDCustomerService Center@azdes.gov. 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.

2. Obtain the name and contact information of the identified non-contracted provider of service, if applicable to verify their AHCCCS registration.

3. Obtain information needed to determine medical necessity of requested services not received.

C. For services provided by a non-contracted provider, the AdSS must:

1. Not deny claims submitted based solely on the billing provider being out of the AdSS's network

2. Reimburse clean claims at the lesser of 130% of the AHCCCS FFS Rate or the provider's standard rate and in accordance with Policy 203 in this Policy Manual.

D. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

Continuity of Services

The AdSS is responsible for continuation and coordination of services the member is currently receiving. If a member moves into a different county because of the location of the out-of-home placement, 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 out-of-home placement's county of residence regardless of the AdSS's provider network.

Behavioral Health Coordinator

A. The AdSS must designate a key staff person whose primary role is to:

1. Serve as the member's single point of contact,

2. Accept and respond to:

a. Inquiries from the out-of-home placement, adoptive parent, or providers,

b. Issues and concerns related to the delivery of and access to behavioral health services for members in out-of-home placements or with adoptive parents.

3. Collaborate with the out-of-home placement and adoptive parents to address barriers to services, including nonresponsive crisis providers, and

4. Resolve concerns received in accordance with grievance system requirements.

B. The Behavioral Health Coordinator must:

1. Provide the number for crisis services and after hour's telephone line in their outgoing voicemail message and email,

2. Provide an expected timeframe for return calls in their outgoing voicemail message and email,

3. Respond to all inquiries as indicated by need or safety but no later than one business day, and

4. Follow up on all calls received by the after hour telephone line.

C. The AdSS must ensure the Behavioral Health Coordinator's contact information is:

1. Provided to DDD and DCS for distribution,

2. Prominently placed on the member page of the AdSS's website

D. The AdSS must ensure calls received by the Behavioral Health Coordinator that meet the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

Education

The AdSS is responsible for ongoing education to providers, members, families, and other parties involved with the member's care, including but not limited to the following:

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 outlined in this Policy

E. Covered services

F. Referral process

G. The role of the AdSS

H. The role of DDD and DCS

I. Additional trainings identified by the Member Advisory Council.

All AdSS member information must be in accordance with Division Administrative Services Subcontractor Policy 404.

The Division reserves the right to verify education programs when performing operational reviews of the AdSS.

Tracking and Reporting

A. Monitor on a monthly basis and submit quarterly, or upon request by the Division, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit ACOM, Chapter 449, Attachment A in the AHCCCS Operations Manual, Children in Out-of-Home Placement and in the Legal Custody of DCS and Adopted Children Services Reporting Access to Services, which includes the following:

1. Access to Services as specified in the reporting template

2. Provider terminations

List of providers that were formerly contracted with the AdSS but terminated their contract and provided services at the lesser of 130% of the AHCCCS FFS Rate or the Provider's standard service rate, and the amount spent on those services.

B. On a monthly basis, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit a report using ACOM, Chapter 449, Attachment B in the AHCCCS Operations Manual, Children in Out-of-Home Placement and in the Legal Custody of DCS and Adopted Children Services Reporting-Calls and Emails, on the 30th day after the reporting month as specified in the reporting template. The Division will provide a monthly listing to the AdSS's Behavioral Health Coordinator of children placed in DCS custody. The AdSS must report to the Division information on a monthly basis regarding members in DCS custody who have not received rapid response services. The AdSS must perform a reconciliation of members placed within DCS custody against 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 must ensure a rapid response service is delivered. The AdSS must submit a DCS Rapid Response Monthly Reconciliation Report as specified in the reporting template.

C. Member Advisory Council Plan

On an annual basis, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit on December 15th a Member Advisory Council Plan to the Division. The Plan must outline the schedule of Council meetings, membership, trainings, goals and objectives, including an evaluation of the previous year.

470 MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 12-2297; 45 CFR 164.530(j)(2)

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The AdSS will maintain all records for five years from the date of final payment under contract with the Division unless a longer period of time is required by law.

For retention of the member's medical records, the AdSS will 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 AdSS will 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 AdSS.

B. If the member is under 18 years of age, the AdSS will 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 AdSS, whichever date occurs later.

The AdSS will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j) (2).

If the AdSS contract with the Division is completely or partially terminated, the records relating to the work terminated must be preserved and made available for 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 AdSS contract with the Division, or costs and expenses of the AdSS contract with the Division to which exception has been taken by the Division, must be retained by the AdSS for five years after the date of final disposition or resolution thereof.