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101 MARKETING

REVISION DATE: 3/13/2024, 4/29/2020

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EFFECTIVE DATE: October 1, 2019

REFERENCES: Section F3, Contractor Chart of Deliverables; ACOM Policy 101 Attachment A Marketing Attestation Statement; ACOM Policy 101 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

PURPOSE

This policy establishes guidelines and restrictions for Administrative Services Subcontractors (AdSS) and their Subcontractors to remain in compliance when developing or using Marketing Materials or participating in Marketing activities related to AHCCCS and the Division.

DEFINITIONS

1. "Arizona Health Care Cost Containment System" or "AHCCCS" means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver

Demonstration Program and described in A.R.S. Title 36, Chapter 29.

2. “Administrative Services Subcontractor” or “AdSS” means an agreement that delegates any of the requirements of the Contract with AHCCCS to a person, individual or entity, who holds an Administrative Services Subcontract is an Administrative Services Subcontractor,

3. “Dual Eligible” means a Member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: a Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).

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

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

5. “Dual Marketing” means Marketing efforts specifically targeting a Division Member who is eligible for Medicare and Medicaid.
6. “Financial Sponsor” means any monies or in-kind contributions provided to an organization other than attendance fees or table fees, to help offset the cost of an event.
7. “Geographic Service Area” or “GSA” means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record.
8. “Marketing” means any communication from Contractors to a Member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the Member to enroll with the Contractor, or to not enroll or disenroll with another Contractor’s Medicaid product as specified in 42 CFR 438.104. Marketing does not include communication to any Member about a Qualified Health Plan, as specified in 45 CFR 155.20.

9. "Marketing-Health Message" means a slogan or statement on Marketing Materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.
10. "Marketing-Health Related" means an event that has a direct or indirect health care purpose, or it supports or contributes to any AHCCCS initiative or program goal. Giveaway items shall have a Health Message or a health care purpose to be considered health-related.
11. "Marketing Materials" means materials produced in any medium, by or on behalf of the Contractor that can reasonably be interpreted as intended for Marketing purposes. This includes general audience materials such as general circulation brochures, Contractor's website and other materials that are designed, intended, or used to increase Contractor Membership or establishing a brand.

12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
13. "Potential Member" means a Medicaid-eligible recipient who is not yet enrolled with a Contractor or a Member during Annual Enrollment Choice (AEC).
14. "Promotion" or "Promotional" means any activity in which Marketing Materials are given away or displayed with the intent to increase the Contractor's membership.
15. "Rural County" means a county that has been designated as non-urban by the United States Census.
16. "Social Networking Application" means web-based services or platforms, excluding the Contractor's State mandated website content, Member portal, and provider portal, for online collaboration that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation, and instant messaging services – collectively also referred to as social media.
17. "Subcontractor" means

a. A provider of health care who has contracted with an AdSS to furnish covered services to Members;

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

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

POLICY

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

1. Materials and Giveaways

   a. The AdSS shall only use Member Marketing Materials during Marketing activities that have been previously

approved as Member information under AdSS Operations Policy Manual, Policy 404 if they comply with the requirements of this policy.

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

c. The AdSS shall only distribute Marketing Materials and giveaways for up to two years from the date of approval.

d. The AdSS shall submit any changes or amendments to previously approved materials to the Division for approval prior to use.

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

f. The AdSS may distribute previously approved templates for a period of up to two years from the date of approval.

g. The AdSS shall only distribute health educational materials without prior Division approval if the materials:

   i. Include health-related and developed based on information from an approved recognized organization found in ACOM Policy 404, Attachment A.

   ii. Do not include AdSS specific information related to the Division Integrated Contract.

h. The AdSS shall ensure that:

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

   ii. Giveaway items are health related, or if not health-related, include a Health Message on the item;

   iii. All Marketing Materials identify the AdSS as a Division provider and are consistent with the

requirements for information to Members described in the AHCCCS Contract and in Division policies;

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

v. Marketing Materials distributed by the AdSS are distributed to its entire contracted GSA population;

i. The AdSS shall not:

i. Market directly to Members eligible for the Division; or

ii. Encourage or induce a Member to select a particular AdSS when completing the application; or

iii. 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.

2. Events
   a. The AdSS shall only participate in Health-Related Marketing events that are listed as pre-approved events in Section (A)(2)(e) of this policy, if the event is either:
      i. Health related; or incorporates a
      ii. Health education component.
   b. The AdSS shall submit a request for prior approval to AHCCCS if the event is not listed as a pre-approved event as specified in the AdSS contract containing the event name, date, location and address.
   c. The AdSS participation in events shall include AdSS staff in attendance and available to respond to participants.
   d. The AdSS shall only attend events after receiving approval from the Division when the following criteria apply:
      i. The AdSS pays sponsorship fees;
      ii. The AdSS donates benefits or items;
      iii. The AdSS distributes materials not previously approved by the Division within the last two years;

iv. The AdSS is not certain if an event would qualify as pre-approved.

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

i. Back to School Events;

ii. College or University Events;

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

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

v. Events where health education is a component;

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

vii. Community Center or Recreational Events;

viii. Community or/ Family Resource Events;

ix. Provider Events that the AdSS is contracted with;

x. Faith Based Events;

xi. Farmers Market Events;

xii. Health Educations Forum, community sponsored;

xiii. Safety Events;

xiv. Immunization Clinics;

xv. Senior Events;

xvi. Shopping Mall Events; and

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

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

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

ii. DES offices, except those listed on the approval list;

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

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

v. County or State Fairs;

vi. Bi-national Health Events;

vii. Political Events;

viii. Pharmacy Events not open to all AdSSs;

ix. Swap Meets;

x. AdSS's Event that is created and sponsored by the AdSS or through its affiliates for Division Members not enrolled with the AdSS, or for the general public; or

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

3. Sponsorships

a. The AdSS shall only participate as a Financial Sponsor of Health-Related Marketing events that have been pre-approved and listed in Section A.2.e. of this policy.

b. The AdSS shall submit a request to the Division prior to participation as a Financial Sponsor of Health-Related Marketing events that contains information as described in Section A.2 of this policy, in addition to the following criteria:

i. The dollar amount of the participation broken down and listed individually by each line of business; and

ii. Either a copy or description of any materials, including websites, on which the AdSS's name or logo will appear at the sponsored event, prior to production.

4. Press Releases

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

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

ii. All other press releases shall be submitted to the Division for prior approval.

5. AdSS Logos and Name Inclusion

a. The AdSS shall prevent misuse of their name and logo.

b. The AdSS may include the AdSS's logo without requesting prior approval on event flyers or websites that are

produced by hosting organizations, if the Division has approved the event.

c. The AdSS shall not allow use of the AdSS's name or logo for television advertising of the event.

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

B. RESTRICTIONS

The AdSS shall prohibit the following Marketing activities:

a. Solicitation of any individual, whether directly or indirectly;

b. References to a competing AdSS;

c. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;

i. For the purposes of this policy, Qualified Health Plans are not considered private insurance, and

ii. 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).

d. Television advertising;

e. Direct mail advertising;

f. Social Networking Applications as described in AdSS Policy Manual, Policy 425;

g. Marketing of non-mandated services;

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

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

j. Use of the Arizona Department of Economic Security, Division of Developmental Disabilities logo or AHCCCS logo;

k. Inaccurate, misleading, confusing or negative information about the Division or the AdSS; and any information that may defraud Members or the public;

l. 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;

m. AdSSs providing services in a GSA where its enrollment is capped to prohibit Members from selecting the AdSS may not engage in Marketing activities in that GSA, but may engage in outreach and retention activities with its current Members;

n. Marketing Materials containing any assertion or statement, whether written or oral, that the Member is required to ~~must~~ enroll with the AdSS to obtain benefits or to not lose benefits;

o. Marketing Materials containing any assertion or statement, whether written or oral, that the AdSS is endorsed by CMS, the Federal or state government, or a similar entity; and

p. Other restrictions as determined by the Division.

C. DUAL ELIGIBLE MARKETING

1. The AdSS shall submit to the Division all Dual Marketing Materials that:
   a. Have not been approved by CMS; or
   b. Includes reference to Division benefits; or
   c. Includes Division service information.
2. The AdSS shall adhere to the following restrictions regarding use of billboards that use the terms 'Medicaid' or 'AHCCCS':
   a. Limited to two in each urban county; Maricopa and Pima; and
   b. Limited to one in each Rural County.

D. AdSS RESPONSIBILITIES

1. The AdSS shall submit to the Division ACOM 101 Attachment B, Marketing Activities Report, containing Marketing costs, including:
   a. The previous six months of Marketing activities in which the AdSS was a participant as-separate line items in the quarterly financial statements; and

b. Any Marketing costs included in an allocation from a parent or other related corporation.

2. The AdSS shall review and revise all Marketing Materials on a regular basis in order to reflect current practices.

3. The AdSS shall submit any changes or amendments to previously approved Marketing Materials in advance to the Division for approval as indicated in this policy.

4. The AdSS CEO or their designee shall 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, addressing the compliance of its plan with the requirements of this policy.

E. SUBMISSION REQUIREMENTS

1. The AdSS shall submit all Marketing Materials including, giveaways, event requests, sponsorships, advertisements including the publications in which they will be placed, press releases, and Dual Eligible Marketing Materials as individual requests to the Division for approval at least 21 days prior to

dissemination as specified in the AdSS Contract with the Division.

2. The AdSS shall not submit Bulk submissions, containing more than one event, sponsorship, or press release, with the exception of giveaway items.
3. The AdSS shall submit giveaway items for approval separately from any event or sponsorship submission and may consist of more than one giveaway.
4. The AdSS shall submit advertisements, the publications in which the ad will be placed, to the Division for approval.
5. The AdSS shall ensure Marketing Material submissions are complete and include all corresponding documents.
6. The AdSS shall ensure the following criteria are completed when requesting an expedited review of Marketing Materials, when a 21-day notice is not possible:
   a. Follow the submission requirements as noted in this section;

b. Submit notification of the expedited request to the Division's Compliance Unit, ensuring expedited notification is clearly marked; and

c. Indicate the reason for the shortened time frame.

7. The AdSS shall resubmit any Marketing Materials to the Division for review and approval if any substantive changes or modifications of previously approved materials have been made, with the inclusion of:

   a. Date the material was previously approved;

   b. Reason for update; and

   c. All clearly identified content revisions.

8. The AdSS shall request a reconsideration of any Division decision by submitting a written request for reconsideration to the Division Compliance Unit and following the submission requirements for Marketing Materials as specified in the AdSS Contract with the Division.

9. The AdSS shall provide information to the Division in support of the AdSS' request for reconsideration.

103 FRAUD, WASTE, AND ABUSE

REVISION DATE: 4/10/2024

REVIEW DATE: 9/6/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901, A.R.S. § 36-2918, A.R.S. § 36-2957, A.R.S. §36-2903.01(K); A.A.C. R9-22-702; 42 CFR 455.101, 42 CFR 438.608, 42 CFR Part 438, Subpart H, 42 CFR 455, 42 CFR 455, Subpart A, 42 CFR 455, Subpart B, 42 CFR 455.2, 42 CFR 455.23, 42 CFR 455.101, 42 CFR 455.436; ACOM Policy 103; Division Operations Policy 103; State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act

PURPOSE

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

DEFINITIONS

1. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Division Program.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
   a. Claims processing, including pharmacy claims
   b. Pharmacy Benefit Manager (PBM)
   c. Dental Benefit Manager
   d. Credentialing, including those for only primary source verification through Credential Verification Organization (CVO)
   e. Medicaid Accountable Care Organization (ACO)

f. Service Level Agreements with any division or subsidiary of a corporate parent owner; providers are not AdSS.

g. CHP and the Division Subcontracted Health Plan

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

ii. Providers are not administrative services subcontractors.

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

4. “Contract” means the AdSS contract with the Division.

5. “Corporate Compliance Officer” means an individual located in Arizona and who implements and oversees the AdSS Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector

General. The Corporate Compliance Officer shall not hold any other position other than the Contract Compliance Officer position. The Corporate Compliance Officer shall be an onsite management official who reports directly to the ~~Contractor's~~ AdSS Chief Executive Officer (CEO) and Board of Directors, if applicable. The Corporate Compliance Officer shall be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract as specified in 42 CFR 438.608.

6. "Credible Allegation of Fraud" means the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. as specified in 42 CFR 455.2.

7. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, including any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2..

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

POLICY

A. The AdSS shall:

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

a. Prevent, detect, and report credible Fraud, Waste, and Abuse activities to the Division.

b. Implement a suspension, termination, or exclusion of a provider from the ADSS network of providers.

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

   a. Program integrity goals and objectives;

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

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

3. Submit the AdSS written Corporate Compliance Plan to the Division annually, as specified in the Contract.

4. Submit to the Division an external audit plan/schedule and audit report of all individual provider audits using ACOM 103

Attachment C as specified in Section (F)(3) of the AdSS contract with the Division, Contractor Chart of Deliverables.

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

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

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

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

b. AdSS shall submit a minimum of 20 audits semiannually.

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

5. Submit complete, accurate, and current disclosure information, as described in 42 CFR Part 455, Subpart B and as specified in Contract, upon execution of a Contract with the State and upon renewal of extension of the Contract utilizing Attachment A and Attachment A-1.
    a. The AdSS shall ensure review of its response by its legal counsel prior to submitting disclosure information.
    b. As specified in Contract, the AdSS shall submit all information electronically, without any exceptions.
    c. AHCCCS/Office of Administrative Legal Services (OALS) and AHCCCS-OIG reviews the AdSS submitted disclosure information for completeness and AHCCCS-OIG screens and confirms that persons listed in the submitted information are not excluded from participation in the Medicaid program.
6. Complete all information as specified in ACOM 103 Attachment A and Attachment A-1 to enable AHCCCS-OIG to confirm that

persons with an ownership or control interest in the AdSS are not excluded from participation in the Medicaid program.

a. The AdSS shall obtain and disclose the information regarding the ownership and control interest of its subcontractors.

b. The AdSS shall retain the results of the disclosure of ownership and control and the disclosure of information on persons convicted of crimes and reported to the Division.

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

d. Consistent with 42 CFR 457.990 and 42 CFR 438.606, the AdSS Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to

sign for the Chief Executive Officer or Chief Financial Officer shall sign the attestation.

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

7. Disclose, and require its subcontractors to disclose, to the Division the identity of any employee or person with ownership or control interest who is excluded from participation in any federal healthcare programs.

8. Comply with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 457.1285, and 42 CFR 438.608(a)(6)].

9. As a condition for receiving payments, establish written policies, and ensure adequate training and ongoing education for, all of its employees, including management, Members, and of any subcontractors or Agents of the AdSS regarding the following:

a. Detailed information about the Federal False Claims Act;

b. The administrative remedies for false claims and statements;

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

d. The whistleblower protections under such laws.

10. Ensure adequate training addressing Fraud, Waste, and Abuse prevention, recognition and reporting, and encourage employees, Members, and any subcontractors to report Fraud, Waste, and Abuse without fear of retaliation.

11. Ensure an internal reporting process relating to the reporting of Fraud, Waste, or Abuse that is well-defined is made known to all employees, Members, and any subcontractors.

12. Conduct research and proactively identify changes for program integrity that are relevant to the corporate compliance 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.

13. Regularly attend and participate in Division work group meetings.
14. Respond promptly and not later than 20 days to requests for information from the Division.
15. Cooperate with the Division regarding any allegation of Member billing in violation of A.R.S. § 36-2903.01(K) and A.A.C. R9-22-702.
16. Have a method of verifying with Division members that they received the services billed by Providers to identify potential service or claim fraud.
17. Perform periodic audits through Member contact and report the results of these audits to the Division as specified in ACOM Policy 424.
18. Maintain Compliance with all State and Federal laws and regulations related to Fraud, Waste, and Abuse, even if not directly specified in this policy.

B. 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 or is occurring, the AdSS shall immediately report the incident to AHCCCS-OIG as specified in Contract and by completing and submitting the "Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program" form available on the AHCCCS-OIG webpage, and attach all pertinent documentation that could assist AHCCCS in its investigation shall be attached to the form,;

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

c. When the AdSS has referred a case of alleged Fraud, Waste, or Abuse to AHCCCS-OIG, the AdSS shall take no

action to recoup, offset, or act in any manner inconsistent with AHCCCS-OIG’s authority to conduct a full investigation, obtain a comprehensive recovery of any suspected overpayments, or impose a civil monetary penalty;

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

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

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

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

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

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

j. As specified in the AHCCCS Minimum Subcontractor Provisions (MSPs), the requirements outlined in this section shall apply to any actions undertaken by the AdSS on behalf of a subcontractor.

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

    i. Recovery of an overpayment;

ii. Civil monetary penalties or assessments;

iii. Civil settlements or judgments;

iv. Criminal restitution;

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

vi. Other, as applicable.

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

i. That are the result of licensure issues;

ii. Quality of care concerns;

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

iv. Alleged Fraud, Waste, or Abuse.

C. THE ADSS' CORPORATE COMPLIANCE RESPONSIBILITIES RELATED TO FRAUD, WASTE, AND ABUSE

1. The AdSS shall:

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

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

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

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

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

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

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

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

i. Ensure the AdSS 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.

SUPPLEMENTAL INFORMATION

1. AHCCCS/Office of Inspector General (AHCCCS/OIG) is responsible for reviewing suspected incidents of fraud, waste, and/or abuse. This includes the preliminary investigation of credible allegations of fraud, the preliminary and full investigation of fraud, waste, and/or abuse, and any other matters necessary to comply with the authority or

obligations vested in AHCCCS/OIG under State or Federal law, rule, regulations, or policies.

2. AUTHORITY

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations, relating to fraud, waste, and abuse, involving the programs administered by AHCCCS. Pursuant to 42 CFR 455.12-23 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.

a. 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 AHCCCS-OIG.

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

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

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

e. Pursuant to state and federal law, AHCCCS is required in certain circumstances, and in other circumstances it may, act to

suspend, terminate, or exclude any person (individual or entity) from participation in the AHCCCS Program.

3. 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.

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

REVISION DATE: 2/24/2021, 06/15/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

Purpose

This policy applies to the Division of Developmental Disabilities (Division) 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 a mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010].

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

Policy

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

In accordance with 42 CFR 438.6(e), IMD Stays are covered for adult members age 21-64, as 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 the stay exceeds 15 cumulative days during a calendar month. The AdSS is responsible for the payment of these services.

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

C. The AdSS responsible for behavioral health services shall 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 shall continue to submit encounters for all medically necessary services including the IMD Stay, regardless of the length of the IMD Stay, and regardless if the Division recoups the capitation payment 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 the 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 ensure the member receives care in the setting most appropriate for the member's needs.

Capitation Recoupment

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

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

C. If two different AdSS are responsible for physical health services and behavioral health services for the member, the Division will recoup the entire monthly capitation payment from both AdSS after recoupment from the Division by AHCCCS.

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

E. This recoupment applies whether 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 the Division after receipt of same from AHCCCS.

G. After funds have been recouped between the Division and AHCCCS, 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 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 IMD Stay days 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 between AHCCCS and the Division, the Division will make a capitation payment to the AdSS equal to a pro-rated amount of the monthly capitation payment for each day the member is age 65 or older during the IMD Stay.

110 MENTAL HEALTH PARITY

REVISION DATES: 2/16/22, 3/24/21
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR Part 457, 42 CFR Part 438, ACOM 110 Attachment A, AMPM 1020 Attachment F

PURPOSE

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

DEFINITIONS

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

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

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

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

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

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

Mental Health Benefits - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

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

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

POLICY

A. MHPAEA Final Rule

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

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

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

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

B. Mental Health Parity Analysis Requirements

The AdSS are 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 AdSS are responsible for completing a parity analysis and submitting it to the Division. The Division is responsible for ensuring the AdSS are in compliance with this requirement.

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

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

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

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

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

C. Standard Parity Requirements

1. Benefit Packages

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

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

2. Defining MH/SUD and M/S Benefits

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

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

   AdSS shall utilize these definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, 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 shall apply the established benefit mapping when conducting the parity analysis. Refer to ACOM Chapter 100, Policy 110, Attachment A (AZ Parity Summary Benefit Package Mapping) for the benefit mapping.

Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

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

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

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

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

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

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

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

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

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

a. 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 (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 mental health parity analysis (Contract Year 2017) and presently (Fiscal Year 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 Division Operations Policy 431 (Copayment) 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.

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

Contract Year) currently applied to occupational therapy services in the outpatient classification are permissible under the parity requirements.

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

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

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

2) Prescription drug formulary;

3) Admission standards for provider network;

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

5) Provider reimbursement rates (including methodology);

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

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

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

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

1) Utilization management NQTLs,

2) Medical necessity NQTLs,

3) Documentation requirements NQTLS, and

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

iii. AdSSs shall 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 shall collect and analyze information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL, in writing

and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis and AdSS Specific Requirements

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

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

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

    c. Substantive changes to policies or procedures of the AdSS (or subcontractors performing administrative functions on the Division's behalf) that impact benefit coverage, access to care for provider contracting.

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

    a. Any actual Parity issues identified,

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

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

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

3. AdSSs that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package shall 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 the AdSS Contract with the Division.

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

5. In the event of a contract modification, amendment, novation, or other legal act changes which limits or impacts compliance with the mental health parity requirement, the AdSS shall conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the AdSS

shall 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 shall certify compliance with parity requirements prior to the effective date of the contract changes.

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

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

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

9. If there have been no changes that affect the AdSS benefit package, utilization, or Health Care Delivery Systems, the AdSS shall submit to the Division an annual attestation (ACOM Policy 110, Attachment B, Mental Health Parity Attestation Statement) certifying ongoing compliance with mental health parity requirements as specified in the AdSS Contract with the Division.

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

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

E. Division Oversight of AdSS Mental Health Parity

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

2. The AdSS shall participate in an annual Operational Review conducted by the Division to ensure AdSS compliance with Mental Health Parity analyses, methodology, processes, and other related functions including, but not limited to:

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

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

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

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

REVISION DATE: 11/8/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2903.01(G); 36-2904.G; 42 § C.F.R. 438.242(a); 45 §§ C.F.R. 160.101 et seq., 162.100 et seq. and 164.102 et seq.; AHCCCS Contract; Section F3 Contractor Chart of Deliverables

PURPOSE

This policy outlines the requirements for the adjudication and payment of claims for the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "Administrative Services Subcontract" means a contract that delegates any of the requirements of the Division's contract with AHCCCS.
2. "Clean Claim" means a claim that may be processed without obtaining additional information from the Provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
3. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and

Medicaid Services that are applied to claims to reduce improper coding and thus reduce improper payments of claims.

4. "Member" means the same as "client" as defined by A.R.S. § 36-551.
5. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS members.
6. "Receipt Date" means the day a claim is received at the AdSS's specified claim mailing address or received through direct electronic submission to the AdSS's electronic claims processing system or received by the AdSS's designated clearinghouse.
7. "Subcontractor" means one of the following:
    a. A Provider of health care who agrees to furnish covered services to Members; or
    b. A person, agency or organization with which the AdSS has contracted or delegated some of its management/administrative functions or responsibilities; or

c. A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Division agreement.

A. CLAIMS PROCESSING SYSTEMS REQUIREMENTS

1. The AdSS shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data.
2. These AdSS shall ensure that claims processes and systems generate information pertaining to the following areas:
   a. Service utilization;
   b. Claim disputes;
   c. Member grievances and appeals; and
   d. Disenrollment for reasons other than loss of Medicaid eligibility.

3. The AdSS shall inform Providers of the appropriate place to send claims at the time of notification or prior authorization using the following mechanisms:
   a. The AdSS subcontract;
   b. The AdSS Provider manual;
   c. The AdSS website; or
   d. Other Provider platforms.
4. The AdSS shall recognize the Receipt Date of the claim as the date stamped on the claim, or the date the claim is electronically received by the AdSS.

B. CLAIM TIMELY FILING, PAYMENT, AND REPORTING REQUIREMENTS

1. The AdSS shall adjudicate claims for each form type as follows, unless a subcontract specifies otherwise:
   a. 95% of all Clean Claims within 30 days of receipt of the Clean Claim; and
   b. 99% of all Clean Claims within 60 days of receipt of the Clean Claim.

2. The AdSS shall ensure 95% of Clean Claims reach paid status on a Provider's first billing submission.
3. The AdSS shall ensure less than 20% of a Provider's second submission of claims are denied.
4. The AdSS shall submit a report to the Division with the following Clean Claim payment or claim payment denial information monthly:
    a. Percentage of Clean Claims that reach paid status on a Provider's first billing submission.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the paid status percentage of Clean Claims falls below the contract performance minimum of 95%.
    b. Percentage of claims that are denied, calculated by dividing the total number of claims denied in the month by the total number of claims processed in the month.
        i. The AdSS shall highlight the appropriate field in the report and provide an explanation if the total

percentage of denied claims reported is above 20%; or

ii. The AdSS shall highlight the appropriate field in the report and provide an explanation if there is a 15% increase of denied claims from the previous reporting month.

5. The AdSS shall refer to Attachment B of the DDD Claims Dashboard Reporting Guide for additional reporting guidelines.

6. The AdSS shall not pay claims

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

7. Regardless of any subcontract with an Arizona Health Care Cost Containment System (AHCCCS) Managed Care Organization

(MCO), when one MCO recoups a claim because the claim is the payment responsibility of another AHCCCS MCO, the Provider may file a Clean Claim for payment with the responsible MCO.

8. If the Provider submits a Clean Claim to the responsible MCO, the Provider shall do so not later than the following timelines:
   a. 60 days from the date of the recoupment;
   b. 12 months from the date of service; or
   c. 12 months from the date that eligibility is posted;

   whichever date is later.

9. The AdSS shall not deny a claim on the basis of lack of timely filing if the Provider submits the claim within the timeframes listed in item 7 of this section.

10. The AdSS shall adhere to claim payment requirements that pertain to both contracted and non-contracted Providers.

C. DISCOUNTS

1. The AdSS shall apply a quick pay discount of 1% on acute hospital inpatient, outpatient, and freestanding emergency

department claims paid within 30 days of the date on which the Clean Claim was received.

2. The AdSS shall apply quick pay discounts to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a CMS 1450 (UB-04) claim form.

D. INTEREST PAYMENTS

1. The AdSS shall pay interest on late payments and report the interest as directed in the Division Encounter Manual and the DDD Claims Dashboard Reporting Guide.

2. The AdSS shall pay slow payment penalties or interest on payments made after 60 days of receipt of the hospital Clean Claim as follows:

   a. The AdSS shall pay interest at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.

   b. The AdSS shall apply slow pay penalties or interest to any acute hospital inpatient, outpatient, and freestanding

emergency department claims billed on a CMS 1450 (UB-04) claim form.

3. The AdSS shall pay interest on payments made after 30 days of receipt of a Clean Claim for authorized services submitted by a licensed skilled nursing facility as follows:
   a. At the rate of 1% per month; and
   b. Prorated on a daily basis from the date the Clean Claim is received until the date of payment.
4. The AdSS shall, for non-hospital Clean Claims, pay interest on payments made after 45 days of receipt of the Clean Claim as follows:
   a. At the rate of 10% per annum; and
   b. Prorated daily from the 46th day until the date of payment.
5. The AdSS shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original Clean Claim submission, not the claim dispute.

E. ELECTRONIC PROCESSING REQUIREMENTS

1. The AdSS shall accept and generate required HIPAA-compliant electronic transactions from or to any Provider or their assigned representative interested in and capable of electronic submission of:
   a. Eligibility verifications;
   b. Claims;
   c. Claims status verifications; and
   d. Prior authorization requests; or
   e. The receipt of electronic remittance.
2. The AdSS shall make claim payments via electronic funds transfer (EFT).
3. The AdSS shall accept electronic claim attachments.

F. REMITTANCE ADVICES

1. The AdSS shall generate an electronic remittance advice advice related to the payments or denials to Providers that includes at a minimum:
   a. The reasons for denials and adjustments;

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

c. The amount billed;

d. The amount paid;

e. Application of coordination of benefits (COB) and copays;

f. Providers rights for claim disputes;

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

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

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

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

G. GENERAL CLAIMS PROCESSING REQUIREMENTS

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

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

b. Multiple procedure or surgical reductions; and

c. Global day evaluation and management bundling standards.

2. The AdSS shall ensure that the claims payment system assess and apply data-related edits including:

a. Benefit package variations,

b. Timeliness standards,

c. Data accuracy,

d. Adherence to Division and AHCCCS policy,

e. Provider qualifications,

f. Member eligibility and enrollment, and

g. Overutilization standards.

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

a. In a manner consistent with the decision; and

b. Within 15 business days of the decision.

4. The AdSS claims payment system shall not require a recoupment of a previously paid amount when:
   a. The Provider's claim is adjusted for data correction, excluding payment to a wrong Provider; or
   b. An additional payment is made.
5. The AdSS shall submit encounters in accordance with Division and AHCCCS standards and thresholds.
6. The AdSS shall adhere to the following requirements when processing claims:
   a. COB and third party liability requirements per contract, and Policy 201 and 434 in the Division's Operations Manual;
   b. Claims processing requirements per contract and the DDD Claims Dashboard Reporting Guide;
   c. Claims recoupments and refunds requirements per contract, Division Operations Policy 412, and the DDD Claims Dashboard Reporting Guide; and

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

5. The AdSS, when cost avoiding a claim, shall apply the following payment provisions:

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

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

H. CLAIMS PROCESSING BY THE AdSS

1. The AdSS shall request prior approval from the Division for obtaining subcontracts for claims processing to be performed by or under the direction of a subcontractor.

2. The AdSS shall remain 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.
3. The AdSS shall forward all claims received to the subcontractor responsible for claims adjudication.
4. The AdSS shall require the subcontractor that processes claims to submit a monthly claims aging summary to the AdSS to monitor compliance with claims payment timeliness standards.
5. The AdSS shall monitor the payment processing subcontractor's performance on an ongoing basis and complete a formal review according to a periodic schedule.
6. The AdSS shall, upon completing the formal performance review of the payment processing subcontractor:
   a. Communicate any performance deficiencies resulting from the review to the subcontractor;
   b. Establish a corrective action plan that addresses the deficiencies; and

c. Provide the results of the performance review and the correction plan to the Division upon completion.

7. The AdSS shall 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.

<u>AdSS Responsibilities</u>

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. Administrative Services Subcontractors' Responsibilities

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

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

REVIEW DATE: 8/4/2023

EFFECTIVE DATE: October 1, 2019

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

PURPOSE

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

DEFINITIONS

1. "Dual Eligible Special Needs Plan" or "D-SNP" means a type of health benefits plan offered by a Centers for Medicare and

Medicaid Services (CMS) - contracted Medicare Advantage Organization (MAO) that limits its enrollment to those beneficiaries who are entitled to both Medicare (Title XVIII) program covered health benefits and full Medicaid (Title XIX) program covered health benefits.

2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS Members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as

specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. “File and Use” means a process whereby the AdSS submits qualifying Member Information Materials to the Division prior to use and can proceed with distributing the materials without any expressed approval from the Division.

4. “Human Immunodeficiency Virus” or “HIV” means a Sexually Transmitted Infection (STI) that damages white blood cells that are very important in helping the body fight infection and disease. HIV is also commonly transmitted through direct contact with certain bodily fluids (e.g., sharing syringes for intravenous substance use) such as blood, semen, rectal fluids and vaginal fluids, and breast milk.

5. “Incentive Item” means 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.
6. “Member” means the same as “Client” as defined in A.R.S. § 36-551.
7. “Member Information Materials” means 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.
8. “Prior Authorization” or “PA” means A process by which AHCCCS or the Contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness,

compliance with this Article and any applicable Contract provisions. Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.

9. "Retention Materials" means 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.
10. "Value-Added Services" means services, benefits, or positive incentives that promote healthy lifestyles and improve health outcomes among Members, including items previously defined as Member "Incentive Items."
11. "Vital Materials" means written materials that are critical to obtaining services which include, at a minimum, the following:
    a. Member Handbooks,
    b. Provider Directories,
    c. Consent Forms,
    d. Appeal and Grievance Notices,
    e. Denial and Termination Notices.

POLICY

A. MEMBER INFORMATION MATERIALS

1. The AdSS shall obtain approval from the Division for all Member informational materials (messages) including, but not limited to, print, e-mail, and voice-recorded information messages.
2. The AdSS shall comply with the requirements in this Policy for all Member Information Materials as well as the following related requirements:
   a. Cultural Competency, Language Access Plan and Family/Patient Centered Care (AdSS Operations 405);
   b. Member Handbook and Provider Directory (AdSS Operations 406);
   c. Social Networking activities (AdSS Operations 425);
   d. Member ID Cards (AdSS Operations 433);
   e. Change in Contractor Organizational Structure or change in Contractor name (ACOM 317);
   f. Material Changes (ACOM 439);

g. Notice of Adverse Benefit Determination and Notice of Extension notice (AdSS Operations 414);

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

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

3. The AdSS shall attest it is in compliance with Member Information requirements by signing and submitting ACOM 404 Attachment C.

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

5. The AdSS shall inform Members that Member Information Materials are available in paper form, without charge and upon

request, and shall provide these materials upon request within five business days.

6. The AdSS shall use state developed Member notices as indicated in Contract and Policy.

7. The AdSS shall make a good faith effort to give written notice to Members who received primary care from, or who are seen on a regular basis by, a provider who is terminated from the network. Written notice shall be provided to the Member:

   a. Within the later 30 calendar days prior to the effective date of the provider termination; or

   b. 15 calendar days after the receipt or issuance of the provider termination notice.

8. The AdSS shall submit draft Member notifications that are components of a material change even if previously submitted as a Member information material.

9. The AdSS shall ensure appropriate population health management for Member Information Materials when telephonic

and mail-based care management are not sufficient or suitable, including but not limited to the following settings:

a. Members who are homeless;

b. Members who are in shelters;

c. The Member's home; or

d. The Member's place of employment or school.

B. LANGUAGE, READABILITY, INTERPRETATION AND TRANSLATION REQUIREMENTS

1. The AdSS shall ensure all Member Information Materials include taglines in the prevalent non-English languages in Arizona and include large print, conspicuously visible font size, explaining the availability of written translation or oral interpretation services with the AdSS's toll free and TTY/TDY telephone numbers for customer service which shall be available during normal business hours.

2. The AdSS shall provide Members the AdSS' toll free and TTY/TDY nurse triage line telephone number, to be available 24hr/7days a week.

3. The AdSS shall make Vital materials available in the prevalent non-English language spoken for each Limited English Proficiency (LEP) population.
4. The AdSS shall not substitute Oral Interpretation services for written Translation of Vital Materials.
5. The AdSS shall ensure translation of Vital Materials is accurate and culturally appropriate.
6. The AdSS shall translate all written materials for Members into Spanish regardless of whether or not the materials are vital.
7. The AdSS shall ensure that all information prepared for distribution is written in an easily understood language and format for readability through the following measures:
    a. Maintain the information at a sixth grade reading level as measured on the Flesch-Kincaid scale.
    b. Use a font size no smaller than 12 point.
    c. Member Information Materials made available in alternative formats and in an appropriate manner that

takes into consideration special needs including but not limited to:

i. Visual limitation,

ii. Other disabilities, or

iii. Limited reading proficiency.

d. Large print materials made available using a conspicuously visible font size.

8. The AdSS shall make oral interpretation services, as well as written translation of documents from English into the Member's preferred language, available to Members at no cost. This applies to American Sign Language and all non-English languages, not just those identified as prevalent.

9. The AdSS shall ensure interpretative services including the use of auxiliary aids such as TTY/TDY are made available.

C. VALUE-ADDED SERVICES

1. The AdSS shall offer Value-Added Services to Members which promote healthy lifestyles and improve health outcomes.

2. The AdSS shall not offer Value-Added Services to Members to influence continued enrollment with the Division.
3. The AdSS shall not offer Value-Added Services such as Incentive Items that are exchangeable for items prohibited.
4. The AdSS shall offer Value-Added Services offered in a culturally sensitive, unbiased, and equitable manner.
5. The AdSS shall not receive compensation for Value-Added Services and shall not report the cost of Value-Added Services as allowable medical or administrative costs.

D. MATERIALS NOT REQUIRING SUBMISSION TO THE DIVISION

1. AdSS shall not submit the following materials for approval:
   a. Customized letters for individual Members.
   b. 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.
   c. Health related brochures developed by a nationally recognized organization included in ACOM Policy 404

Attachment A, do not require submission prior to distribution to Members, unless they reference any of the following, in which case the AdSS shall not distribute them at all, although the AdSS may utilize them to develop their own materials:

i. Services which are not medically necessary;

ii. Services which are not AHCCCS covered benefits; or

iii. Services which do not align with Division policy.

2. The AdSS shall submit a request to add names to ACOM 404 Attachment A of national organizations to be recognized by AHCCCS, upon identifying an organization missing from the list.

3. The AdSS shall refer to ACOM 404 for updates when considering using information from organizations listed in ACOM Policy 404 Attachment A.

4. The AdSS shall review the content of materials developed by the organizations listed in Attachment A to ensure that:

   a. The services are covered under the AHCCCS program.

b. The information is accurate.

c. The information is culturally sensitive.

5. The AdSS shall supplement or replace educational brochures customized for Medicaid Members developed by outside entities to educate Members.

E. MEMBER NEWSLETTER CONTENT AND REQUIREMENTS

1. The AdSS shall develop and distribute, at a minimum, two Member newsletters during each contract year.

2. The AdSS shall submit newsletters in the form of an initial mock-up version of what the Member will be receiving in addition to the individual articles referencing readability levels.

3. The AdSS shall not use the File and Use review process for the Member newsletter.

4. At a minimum, the Member newsletter shall 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. Information on Peer and Family supports;

k. AdSS contact information and 988 Crisis Hotline information in each newsletter;

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

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

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

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

p. Other information required by the Division or AHCCCS.

F. WEBSITE CONTENT

1. The AdSS's website shall contain all the information required in ACOM Policy 404- Attachment B.
2. The AdSS shall provide written notice to Members of the availability for the newsletter if newsletters are provided electronically.
3. The AdSS shall submit Attachment B as specified in Contract, annually.
4. The AdSS shall ensure:
    a. All of the information is located on the AdSS's website in a manner that Members can easily find and navigate.
    b. Information is in a format that can be retained and printed by the Member.

c. Websites are specific to the AdSS's Medicaid program and shall not include links or references to private insurance.

5. The AdSS website shall contain links and references to the AdSS's Medicare programs and services that exclusively promote coordination of care for Members enrolled in both Medicaid and Medicare.

6. The AdSS shall refer to ACOM 404 for requirements for the approval process for additional information added to the AdSS's website that is directly related to Members or potential Members.

G. SUBMISSION, REQUIREMENTS AND RESTRICTIONS FOR ALL OTHER MATERIALS

1. The AdSS shall inform all Members of any changes considered to be significant by the Division, 30 calendar days prior to the implementation date of the change including:

   a. Cost Sharing

   b. Prior Authorization

   c. Service Delivery

   d. Covered Services.

2. The AdSS shall 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.
3. The AdSS shall submit to the Division all other Member Information Materials intended for dissemination to Division Members at least 15 calendar days before they are to be released, for File and Use review, excluding surveys which are not subject to File and Use review.
4. The AdSS shall request an expedited review if a 15-day notice is not possible.
5. The AdSS shall ensure expedited requests are clearly marked as expedited.
6. The AdSS shall ensure expedited requests contain the reason for the shortened time frame.

7. The AdSS shall consider factors and materials which may require additional time to be reviewed include but are not limited to Member Information Materials which are:
   a. A component of new initiatives,
   b. Special projects,
   c. Consisted of bulk submission.
8. The AdSS shall submit the following information to the Division prior to releasing Member Information Materials:
   a. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its Members or Potential Members.
   b. Translations of the material into other languages as required by this policy are not required to be submitted.
   c. A cover letter containing a description of the purpose, the process the AdSS shall use to disseminate the material.
   d. The reading level of the material as measured on the Flesch-Kincaid scale.

9. 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.
    a. Member materials submitted outside of standard business hours shall be considered received the following Business Day.
    b. State Holidays that fall on business days are not counted as part of the 15-day review period.
10. The AdSS shall consider factors and materials which may require additional time to be reviewed include Member Information Materials which are:
    a. A component of new initiatives;
    b. Special projects;
    c. Consisted of bulk submission.
11. The AdSS shall submit Member Information Materials to the Division for approval, prior to using them for marketing purposes as specified in ACOM 101.
12. The AdSS shall ensure:

a. All materials shall be labeled with the AdSS's name or logo, this includes Member material that is:
   i. Located on the AdSS's website;
   ii. E-mail messages;
   iii. Voice or text-recorded phone messages delivered to the Member's phone; and
   iv. Other information as requested by AHCCCS.
b. Information contained within the material is:
   i. Accurate;
   ii. Updated regularly; and
   iii. Appropriately based on changes in benefits; Contract, policy, or other relevant updates.
c. Updated Member information is re-submitted for approval, including:
   i. The date the material was previously approved;
   ii. The reason for the update; and
   iii. Clearly identify all content revisions.

d. A log is kept for all Member material distributed each year; the log shall identify:
    i. The date the materials were originally submitted to the Division as described in this policy; and
    ii. Resubmission dates.

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

f. Member Information Materials:
    i. Do not directly or indirectly refer to the offering of private insurance;
    ii. Do not include inaccurate, misleading, confusing or negative information about AHCCCS, 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.

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

REVISION DATE: 04/26/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 457.1230(a), 42 CFR 457-1201(d), 42 CFR 438.3(d)(4), 45 CFR Part 92, 42 CFR 438.206(c)(2); Section F3, ACOM Policy 405, Attachment A

PURPOSE

This policy sets forth the Division of Developmental Disabilities' (Division) requirements for Administrative Services Subcontractors (AdSS) in offering accessible and high quality services in a culturally competent manner when providing family and member-centered care, as applicable.

DEFINITIONS

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

a. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups.

b. Culture defines the preferred ways for meeting needs and may be influenced by factors such as geographic location, lifestyle, and age.

c. 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.

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

3. “Interpretation” for the purpose of this policy means the act of verbally conveying the content and spirit of the original message, taking into consideration the cultural context.
4. “Language Assistance Service” means services including, but not limited to:
    a. Oral language assistance, including Interpretation in non-English languages provided in-person or remotely by a Qualified Interpreter for an individual with limited English proficiency, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with Limited English Proficiency,
    b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages other than English; and
    c. Taglines.
5. “Limited English Proficiency (LEP)” means individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be

limited English proficient, or "LEP." These individuals may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

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

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

8. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone, a video remote interpreting (VRI) service, or an on-site appearance:

   a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,

   b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized

vocabulary, terminology and phraseology, considering cultural appropriateness; and

c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.

9. "Qualified Translator" means for the purpose of this policy, a translator who:

a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

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

c. Is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any

necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

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

11. "Vital Materials" means information, provided to the member, which assists the member to receive covered services through the Arizona Long Term Care System (ALTCS) program. These materials include but are not limited to:
    a. Member handbooks,
    b. Notices of Adverse Benefit Determinations,
    c. Notices of Appeal Resolution,
    d. Consent forms,
    e. Member notices,
    f. Communications requiring a response from the member,

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

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

POLICY

A. Cultural Competency Plan

1. The AdSS shall have a comprehensive Cultural Competency program that includes Members with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity.

2. The AdSS shall develop a written Cultural Competency Plan (CCP) which includes measurable and sustainable goals.

3. The AdSS' CCP shall describe how care and services will be delivered in a culturally competent manner and shall include all information provided in ACOM Policy 405, Attachment A.

4. The AdSS shall identify a staff member responsible for implementation and oversight of all requirements for the Cultural Competency program and plan.
5. The AdSS shall require its workforce, as well as the workforce of their subcontractors, to adhere to all Cultural Competency requirements as specified in this policy.
6. The AdSS' CCP shall include:
    a. A description of methods used for evaluating the cultural diversity of its membership to assess needs and priorities to provide culturally competent care to its membership.
    b. An evaluation of the AdSS network, outreach services, and other programs to improve accessibility and quality of care for its membership.
    c. A description of the method(s) used for evaluating health equity and addressing health disparities within the AdSS' service delivery.
    d. A description of the provision and coordination needed for linguistic and disability-related services.

e. A description of Education and Training, which shall include:

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

ii. Customized training to fit workforce needs based on the nature of the contacts the AdSS workforce has with providers and or members.

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

iv. Methods used for providers and other subcontractors with direct member contact, which shall include an education program designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner and understanding of health literacy.

v. Additional efforts to train or assist providers and subcontractors with how to provide culturally competent services.

f. The AdSS shall track participation of its workforce in Cultural Competency trainings.

B. TRANSLATION AND INTERPRETATION SERVICES

1. The AdSS shall ensure access to oral Interpretation, Translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request, and at no cost to the member.
2. The AdSS shall provide Translation and Interpretation services that are accurate, timely, and protect the privacy and independence of the individual with Limited English Proficiency (LEP).
3. The AdSS shall ensure Translation services are provided by a Qualified Translator, and Interpretation services shall be provided by a Qualified Interpreter.

a. The AdSS shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to use an adult accompanying the member with LEP for Interpretation in the following situations:

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

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

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

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

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

c. The AdSS shall not permit reliance on a minor for Translation of any documents.

d. The AdSS shall only permit reliance upon minor children for Interpretation assistance when:

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

ii. There is no Qualified Interpreter immediately available.

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

4. The AdSS shall provide Translations and Interpretations in the following manner:

    a. Written member materials of all types shall be translated into Spanish regardless of whether or not the materials are vital.

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

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

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

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

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

5. The AdSS shall provide member information materials in compliance with Division AdSS 404.
6. The AdSS shall provide written notices informing members of their right to Interpretation and Translation services free of charge.
7. The AdSS and its subcontractors shall:
    a. Use licensed interpreters for the Deaf and the Hard of Hearing; and
    b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request, which include:
        i. Computer-aided transcriptions,
        ii. Written materials,
        iii. Assistive listening devices or systems,
        iv. Closed and open captioning; and
        v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

8. The AdSS may contact the Arizona Commission for the Deaf and the Hard of Hearing for 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.

C. CULTURAL COMPETENCY PLAN ASSESSMENT REPORTING

1. The AdSS shall assess its CCP for effectiveness to include modifications based on the assessment. The assessment shall consider:
   a. Linguistic need,
   b. Comparative member satisfaction surveys,
   c. Outcomes for certain cultural groups,
   d. Translation and Interpretation services and use,
   e. Member complaints and grievances,
   f. Provider feedback; and
   g. Employee surveys.
2. The AdSS shall track and trend identified issues, and identify actions taken to resolve the issue(s).

3. The AdSS shall address in the CCP how it communicates its progress in implementing and sustaining the CCP goals to all stakeholders, members and the general public.
4. The AdSS shall submit the CCP Assessment with ACOM 405 Attachment A.

D. LANGUAGE ACCESS PLAN

1. The AdSS shall submit a Language Access Plan with ACOM 405 Attachment A annually, that indicates how the needs of members with LEP are met.
2. The AdSS shall address each of the following elements in the Language Access Plan:
   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. Language Assistance Services

The AdSS shall provide the established point of contact for members who need Language Assistance Services. The AdSS shall 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.,

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 shall 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. Workforce Training

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

g. Assessment: Access and Quality

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

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

h. Stakeholder Consultation

Process for engaging stakeholder communities to:

i. Identify language assistance needs of members with LEP,

ii. Implement appropriate language access strategies to ensure members with LEP have meaningful access in accordance with assessments of member need; and

iii. 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 the Arizona Health Care Cost Containment System (AHCCCS), related to language access.

E. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

The AdSS shall provide Family-Centered care in all aspects of the service delivery system for members with special health care needs. The additional responsibilities of the AdSS for support of Family-Centered care include :

1. Recognizing the family as the primary source of support for the member's health care decision-making process and making service systems and personnel available to support the family's role as decision makers.
2. Facilitating collaboration among members, families, health care providers, and policymakers at all levels for the:
    a. Care of the member,
    b. Development, implementation, evaluation of programs; and
    c. Policy development.
3. Promoting a complete exchange of unbiased information between members, families, and health care professionals in a supportive manner at all times.

4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
5. Implementing practices and policies that support the needs of members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
6. Participating in Family-Centered Cultural Competency Trainings.
7. Facilitating family-to-family support and networking.
8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
9. Acknowledging that families are essential to the members' health and well-being and are crucial allies for quality within the service delivery system.
10. Appreciating and recognizing the unique nature of each member and their family.

406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

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

EFFECTIVE DATE: October 1, 2019

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

PURPOSE

This policy applies to the Division of Developmental Disabilities (Division) Administrative Services Subcontractors (AdSS). This policy establishes guidelines regarding Member handbooks and provider directories.

DEFINITIONS

1. "Business Day" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
2. "Long-Term Services and Supports" or "LTSS" means services and supports provided to Members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the

individual’s home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting as specified in 42 CFR 438.2.

3. “Member” means the same as “Client” as defined in A.R.S. § 36-551.
4. “Multi-Specialty Interdisciplinary Clinic (MSIC)” means a facility where specialists from more than one specialty meet with Members and their families in order to provide interdisciplinary services to treat Members.
5. “Responsible Person” means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.

A. GENERAL REQUIREMENTS,

1. The AdSS shall annually provide a Member Handbook to Members.

2. The AdSS shall annually provide a Provider Directory to Members,
3. The AdSS shall ensure the Member Handbook contains all information required, as identified in ACOM 406-Attachment A, including definitions as required by Centers for Medicare and Medicaid Services specified in ACOM 406-Attachment B.
4. The AdSS shall ensure required information is incorporated into the AdSS's Member Handbook in the order identified on the Checklist.
5. The AdSS shall submit the Member Handbook as described below in section B.
6. The AdSS shall publish information modifying or expanding the contents of the AdSS's Member Handbook, and distribute this information in the form of inserts and supply these inserts with subsequently distributed Member Handbooks when required by the Division.
7. The AdSS shall update paper provider directories at least quarterly.

8. The AdSS shall update electronic provider directories no later than 30 calendar days after receiving updated provider information.
9. The AdSS shall ensure the electronic versions of the Member Handbook and Provider Directory meet the following requirements:
   a. The format is readily accessible;
   b. The information is located in a place on the AdSS's website that is prominent and readily accessible and in a machine readable format which can be electronically retained and printed;
   c. The information is consistent with federal content and language requirements;
   d. 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 from the request; and
   e. The information adheres to the requirements identified in ACOM Policy 416.

10. The AdSS shall ensure language and format requirements are as outlined in Division Operations Policy 404.

B. MEMBER HANDBOOK REVIEW PROCESS

1. The AdSS shall submit to the Division its Member Handbook annually, along with a version reflecting changes from the previous contract year.
2. The AdSS shall also submit annually, a cover letter that includes the requirements as identified in ACOM 406-Attachment A, as specified in the contract or as directed by AHCCCS.
3. The AdSS shall submit a final copy of the Member Handbook to the Division after the Division has provided approval of a draft, as specified in the contract.

C. DISTRIBUTION REQUIREMENTS

1. Provider Directory
    a. The AdSS shall provide a Provider Directory to each Responsible Person within 12 Business Days of receipt of notification of the enrollment date.

b. The AdSS may provide the Provider Directory in hard copy format or written notification of how the Provider Directory information is available on the AdSS' website, via electronic mail, or via postal mailing.

   i. The AdSS may include this notification in the Member Handbook, or mail the notice separately.

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

   iii. The AdSS shall give the Member the option to obtain a hard copy version of the Provider Directory.

c. The AdSS shall acquire approval of the Member notification in accordance with Administrative Services Subcontractors Operations Manual, Policy 404.

2. Member Handbooks

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

b. The AdSS shall annually provide the Member Handbook, or notification of how to access the information in the Member Handbook, to each Member or their Responsible Person.

c. The AdSS shall provide written notification that the AdSS's Member Handbook is available on the subcontractor's website, upon request, via electronic mail or by postal mailing if required by the Division.

d. The AdSS shall make copies of the Member Handbook available to known consumer and family advocacy organizations and other human service organizations.

e. The AdSS shall update its Member Handbooks throughout the contract year when required by the Division to address program changes for inclusion, through inserts in the Member Handbook:

    i. These changes shall be incorporated in subsequently distributed handbooks through inserts until the handbooks are updated with the new information.

ii. The AdSS shall also post the content of the insert on the AdSS website.

D. PROVIDER DIRECTORY

1. The AdSS shall have a user-friendly, searchable, electronic Provider Directory, to include specialists for referrals, on the AdSS website.

2. The AdSS shall make available in an electronic and hard copy format a Provider Directory that meets the following requirements:

   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.

3. The AdSS shall adhere to the requirements identified in AdSS Operations Policy Manual, Policy 416.

4. The AdSS shall ensure the Provider Directory, hard copy and electronic, includes:

   a. Provider name as well as any group affiliation;

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

   c. Provider telephone number;

   d. Website Uniform Resource Locator (URL), as appropriate;

   e. Specialty, as appropriate;

   f. Non-English languages spoken;

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

   h. Information for the following provider types:

      i. Physicians, including specialists,

      ii. Hospitals,

iii. Pharmacies,

iv. Behavioral Health Providers,

v. Long-Term Services and Supports (LTSS) Providers, as applicable,

vi. Community-based, peer and family support providers throughout the State; and

vii. Multi-Specialty Interdisciplinary Clinic (MSIC)s.

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;

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 network offices that offer reasonable accommodations for Members such as:

i. Physical access,

ii. Accessible equipment; and

iii. Culturally competent communications and a description of how the Members can obtain details of the accommodations for specific providers.

l. Innovative service delivery mechanisms such as field clinics, virtual clinics, and an Integrated Medical Record to provide MultiSpecialty, Interdisciplinary Care (MSIC) when needed in other areas of the State;

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

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

407 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: AHCCCS Contractor Operations Manual (ACOM) Policy 407

INTENDED USERS: Division's Administrative Services Subcontractors (AdSS)

DELIVERABLES: Workforce Development Plan

PURPOSE

The purpose of this policy is to describe the AdSS requirements to establish and maintain a Workforce Development Operations (WFDO) to:

1. Monitor and collect information about the workforce;
2. Collaboratively plan workforce development initiatives; and
3. When necessary, provide direct assistance to providers to develop the workforce development plans.

DEFINITIONS

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

2. "Competency Development" means a systematic approach for ensuring workers are adequately prepared to perform the basic requirements of their jobs.
3. "Network Workforce Development Plan (WFD-P)" means the AdSS's blueprint for ensuring the ongoing growth and development of the network's workforce.
4. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
5. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
6. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and or connecting workers to information.
7. "Workforce Development Alliance (WFDA)" means a coalition of the WFD Administrators from each Managed Care Organization

(MCO) that jointly plan and conduct WFD activities for a particular line of business.

8. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources that the AdSS implements, including monitoring and assessing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to strengthen their WFD programs.

POLICY

A. GENERAL

1. The AdSS shall work with the Division, AHCCCS, and providers to ensure members receive services from a workforce that is qualified, capable, and sufficiently staffed.

2. The AdSS shall:

    a. Acquire, develop, and deploy a sufficiently staffed and qualified workforce that capably delivers services to members;

    b. Oversee the development of the provider workforce;

c. Establish workforce development policies including worker and workplace practices, that aligned with Division policies;

d. Analyze current and future healthcare trends, and forecast the workforce capacities and competencies needed to address these trends;

e. Ensure that workforce and development processes are aligned with the Division's workforce and workforce development policies;

f. Monitor the performance of its network, collect information about the workforce, develop plans to strengthen the workforce, and directly assist providers to develop and maintain a qualified, capable, and sufficiently capacitated workforce; and

g. Assist the Division with developing forecasting and plans concerning the WFD needs of Arizona's healthcare system.

3. The AdSS shall ensure that subcontracted provider organizations are:

a. Deploying a qualified, sufficiently staffed workforce;

b. Providing services to members eligible for the Division in an interpersonally, clinically, culturally, and technically effective manner; and

c. Offering training and resources to assist professionals and family caregivers with managing stress and burnout as required by the Report of the Abuse & Neglect Prevention Task Force.

B. ESTABLISH AND MAINTAIN A WORKFORCE DEVELOPMENT OPERATION

The AdSS shall:

1. Establish and maintain a WFDO that shall work together with Network Management, Quality Management, and Cultural Competency programs to ensure the workforce has the capacity needed to provide services and the diversity and capability required to competently deliver them.

2. Name a Workforce Development Administrator to lead the WFDO who shall:

a. Manage the AdSS's network specific process of continuous workforce quality development and improvement; and

b. Have a professional background, authorities, and ongoing training and development needed to lead the WFDO as specified in the AdSS contract.

3. Equip the WFDO with the organizational personnel and information processing support required to execute the following responsibilities of the WFDO:

   a. Monitor and assess current workforce capacity and capability;

   b. Forecast and plan future or needed workforce capacities and capabilities,

   c. Deliver technical assistance to its workforce to strengthen their WFD programs;

   d. Monitor, assess, forecast, plan, and provide technical assistance both independently and in coordination with WFDOs of the other MCOs to:

i. Independently act on the workforce needs of its network as identified by the AdSS's network and quality management departments; and

ii. Work closely with the Division and other MCOs to:

1) Achieve statewide system and industry specific WFD goals;

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

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

4. Ensure its workforce has access to, and is in compliance with, all workforce training and/or competency requirements specified in federal and state law, AHCCCS policies, Division policies, guidance documents, manuals, contracts, and other AdSS plans.

5. Ensure its workforce has access to all the resources necessary to engage designated audiences and satisfy the WFD requirements as specified in AHCCCS policies, Division policies, guidance documents, manuals, contracts, and other AdSS plans.

C. NETWORK WORKFORCE DEVELOPMENT PLAN

1. The AdSS shall produce a Network Workforce Development Plan (WFD-P) as specified in ACOM 407 and ACOM 407 Attachment A.
2. The AdSS shall ensure the WFD-P:
   a. Determines areas where, relative to network and quality requirements, specific increases in workforce capacity, worker competency and capability are needed;
   b. Determines if the WFD programs of a single provider, or the WFD programs of the provider network, for acquiring, developing, and maintaining a sufficiently staffed, diverse, and capable workforce should be enhanced to ensure compliance with the AdSS's network and quality requirements; and

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

3. The AdSS shall include as part of the Network WFD-P, but is not limited to, the following components:
   a. Description of the AdSS WFDO;
   b. Workforce Profile;
   c. Workforce Capacity Assessment, Development Goals, Work plan; and
   d. Workforce Capability/Competency Assessment, Development Goals, and Work plan.

4. The AdSS shall develop the WFD-P in collaboration with:
   a. Providers,
   b. AHCCCS members and their families; and
   c. Other stakeholders, including but not limited to:
      i. Other Contractors and industry;
      ii. Education; and

iii. Community groups.

5. The AdSS shall submit the Network WFD-P as specified in the AdSScontract.

D. MONITOR PROVIDER WORKFORCE DEVELOPMENT ACTIVITIES

As part of the routine audit and compliance monitoring process, the AdSS shall ensure:

1. The provider workforce has access to, and is in compliance with all workforce training and competency requirements specified by federal and state law, AHCCCS and Division policies, guidance documents, manuals, and other AdSS plans.
2. All AHCCCS required training content and competency descriptions are incorporated into the appropriate orientation, basic, specialized, or advanced levels of education or training program and evaluation processes and are made available to provider personnel.
3. Providers have processes for:
   a. Documenting training;

b. Verifying the qualifications, skills, and knowledge of personnel; and

c. Retaining required training and competency transcripts and records.

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

E. WORKFORCE DATA

1. The AdSS shall collect and analyze required and ad hoc workforce data that:

   a. Proactively identifies potential challenges and threats to the viability of the workforce,

   b. Conducts analysis of the potential impact of the challenges and threats to access to care for members,

   c. Develops and implements interventions to prevent or mitigate threats to workforce viability, and

   d. Develops indicators to measure and monitor workforce sustainability.

2. The AdSS shall use the collected data to directly assist the Division and AHCCCS WFD Administrator develop a comprehensive workforce assessment and forecast of WFD priorities.

F. PROVIDER TECHNICAL ASSISTANCE

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

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 NOTICE OF ADVERSE BENEFIT DETERMINATION

REVISION DATES: 06/28/2023, 7/28/2021

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

PURPOSE

This policy sets forth the Division's Administrative Services Subcontractors (AdSS) requirements for service authorization decisions and a Notice of Adverse Benefit Determination relating to Title XIX/XXI coverage of services. The AdSS shall follow all other requirements regarding a Notice of Adverse Benefit Determination set forth in Contract and referred to as a Notice of Adverse Benefit Determination throughout.

DEFINITIONS

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

weekends and holidays.

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

5. "Legal Holidays" means Legal Holidays, as defined by the State of Arizona are:
   a. New Year's Day – January 1
   b. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January
   c. Lincoln/Washington Presidents' Day – 3rd Monday in February
   d. Memorial Day – Last Monday in May
   e. Independence Day – July 4
   f. Labor Day – 1st Monday in September
   g. Columbus Day – 2nd Monday in October
   h. Veterans Day – November 11

i. Thanksgiving Day – 4th Thursday in November

j. Christmas Day – December 25

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

6. "Member" means the same as "Client" as defined in A.R.S. §36-551.
7. "Notice of Adverse Benefit Determination" means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the AdSS regarding the service authorization request and includes the information required by this Policy.
8. "Notice of Extension" or "NOE" means a written notice to a Member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.
9. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental

disability who is a member or an applicant for whom no guardian has been appointed.

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

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

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

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

POLICY

A. NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The AdSS shall provide a written Notice of Adverse Benefit Determination to the Responsible Persons described in 42 CFR 438.404, when the AdSS decides to deny or limit an authorization request or reduce, suspend, or terminate

previously authorized services.

2. The AdSS shall use the AHCCCS-developed Member Notice of Adverse Benefit Determination templates specified in 42 CFR 438.10(c)(4)(ii).
   a. The templates shall not be altered except for the areas designated in the template that permit alteration and the removal of the header.
   b. Refer to ACOM Policy 414 Attachment A for the Notice of Adverse Benefit Determination template.
3. The AdSS shall provide a Member Handbook that informs the Responsible Person:
   a. Of their right to make a complaint to the AdSS about an inadequate Notice of Adverse Benefit Determination.
   b. If the AdSS does not resolve the complaint about the Notice of Adverse Benefit Determination to the Responsible Person's satisfaction, the Responsible Person may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at: MedicalManagement@azahcccs.gov, and
   c. That the AdSS and its providers shall be prohibited from

taking punitive action against Responsible Persons exercising their right to Appeal.

d. That the AdSS shall inform the Responsible Person that oral interpretation services are available in any language, and alternative communication formats are available for Responsible Persons that are deaf or hard of hearing or blind or have low vision.

B. RIGHT TO BE REPRESENTED

1. The AdSS shall acknowledge the Responsible Person's right to be assisted by a third-party representative, including an attorney, during an Appeal of an Adverse Benefit Determination.
2. The AdSS shall have an Appeals process that registers the existence of the third party representative.
3. The AdSS shall ensure the required communications related to the Appeals process occur between the AdSS and the third party representative.
   a. The AdSS shall provide the Responsible Person's third party representative, upon request, timely access to documentation relating to the decision at Appeal.
   b. The AdSS shall be consistent with federal privacy laws, by

making reasonable efforts to verify the identity of the third party representative and the authority of the third party representative to act on behalf of the Responsible Person. The AdSS may require the third party representative to provide a written authorization signed by the Responsible Person.

c. The AdSS shall promptly communicate to the third party representative when the AdSS questions the authority of the third party representative or the sufficiency of a written authorization.

C. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

1. The Adss shall provide a Notice of Adverse Benefit Determination that meets the language requirements as outlined in AdSS Operations Policy 404.
2. The AdSS shall provide a Notice of Adverse Benefit Determination that clearly explains the Member specific reason for the AdSS' determination and the information needed so the Responsible Person can make an informed decision regarding Appealing the determination, and how to Appeal the decision.

3. The AdSS shall clearly inform the Responsible Person when the reason for the denial of a Service Authorization Request is due to the lack of necessary information and will give the Responsible Person the opportunity to provide the necessary information.
4. The AdSS shall provide a Notice of Adverse Benefit Determination that is consistent with 42 CFR 438.404 which includes an explanation of the specific facts that pertain to the decision:
    a. The requested service;
    b. The level of service which may include a request for an enhanced staffing ratio.
    c. The reason or purpose of the requested service;
    d. The reasons for the Adverse Benefit Determination the AdSS made or intends to make with respect to the requested service consistent with 42 CFR 438.404(b)(1);
    e. The effective date of a service denial, limited authorization, reduction, suspension, or termination;
    f. The right of the Responsible Person to be provided, upon request and 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);

g. The legal basis for the Adverse Benefit Determination including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable, reference to the general legal authorities alone is unacceptable;

h. Where the Responsible Person can find copies of the legal basis including.

    i. Reference to the benefit provision, guideline, protocol, or other criterion which the denial is based upon;

    ii. An accurate URL site, when a legal authority or an internal reference to the AdSS' policy manual is available online, to enable the Member to find the reference online;

i. A listing of legal aid resources;

j. The Responsible Person's right to request an Appeal and procedures for filing an Appeal of the AdSS Adverse Benefit Determination, including information on exhausting the AdSS' Appeals process described in 42 CFR 438.402(b) and the right to request a state fair hearing consistent with 42 CFR 438.402(c) including when the AdSS fails to make a decision in a timely manner regarding the Member's Appeal request;

k. The procedures for exercising the Responsible Person's rights as described in 42 CFR 438.404(b)(4);

l. The circumstances under which an Appeal process can be expedited and how to request it; and

m. Explanation of the Responsible Person's right to have benefits continue pending the resolution of the Appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the Responsible Person may be required to pay the costs of continued services if the Appeal is denied as specified in 42 CFR 438.420(d).

n. A statement that the provider who requested the Service

Authorization Request has the option to request a peer-to-peer discussion with the AdSS' Medical Director.

i. The AdSS shall allow the provider sufficient time for a peer-to-peer to occur before the AdSS issues its decision regarding the service authorization request.

ii. The AdSS shall allow at least 10 business days for the provider to request a peer-to-peer.

5. The AdSS shall not cite the lack of medical necessity as a reason for denial, unless the Notice of Adverse Benefit Determination also provides a complete explanation for the particular Member in this instance.
6. The AdSS shall include potential alternative options for consideration that may address the Member's condition when citing lack of medical necessity as a reason for the Adverse Benefit Determination.
7. The AdSS shall utilize a board-certified professional when citing lack of medical necessity and provide evidence of such upon AHCCCS request.
8. The AdSS shall provide a Notice of Adverse Benefit Determination that states the reasons supporting the denial,

reduction, limitation, suspension, or termination of a service.

9. The AdSS shall not provide a Notice of Adverse Benefit Determinations that does not give an explanation of why the service has been denied, reduced, limited, suspended, or terminated and merely refer the Responsible Person to a third party for more information.

10. The AdSS shall include a statement referring a Responsible Person to a third party for more help when the third party can explain treatment alternatives in more detail.

D. EPSDT

1. The AdSS shall cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX Member who is younger than 21 years of age when these provisions are applicable and shall specify the reason(s) why the service fails to correct or ameliorate defects or physical or behavioral health conditions or illnesses.

2. The AdSS shall explain the denial, reduction, limitation, suspension, or termination of the requested EPSDT service in accordance with AMPM 430 and this Policy.

3. The AdSS shall specify why the requested service does not meet the EPSDT criteria and is not covered.

4. The AdSS shall also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

E. RESPONSIBLE PERSON COMPLAINTS REGARDING THE ADEQUACY OR UNDERSTANDABILITY OF THE NOTICE OF ADVERSE BENEFIT DETERMINATION

1. The AdSS shall review the initial Notice of Adverse Benefit Determination against the content requirements of this Policy when a Responsible Person complains about the adequacy of a Notice of Adverse Benefit Determination.

2. The AdSS shall issue an amended Notice of Adverse Benefit Determination consistent with the requirements of this Policy when the AdSS determines that the original Notice of Adverse

Benefit Determination is inadequate or deficient.

3. The AdSS shall begin the timeframe for the Responsible Person to Appeal and continuation of services shall start from the date of the amended Notice of Adverse Benefit Determination when an amended Notice of Adverse Benefit Determination is required.

F. TIMEFRAMES FOR SERVICE AUTHORIZATION DECISIONS

All references to “days” in this Policy mean “Calendar Days” unless otherwise specified.

1. The AdSS shall ensure completion and issuance of the Service Authorization Request decision when a Service Authorization Request is submitted, within the following timeframes,standard requests, expedited requests, and whether the Service Authorization Requests relates to medications.
   a. The AdSS shall consider the date and time the AdSS or the Division receives the request to be considered the date and time of receipt, whichever is earlier, to be considered the date and time of receipt.
   b. The AdSS shall use the date and time to determine the due date for completion of the authorization decision,

depending on the timeframe applicable to the particular type of service request. The AdSS shall use electronic date stamps or manual stamping for logging the receipt.

2. The AdSS shall make sufficient attempts to obtain the information or clarification and document all attempts for Service Authorization Requests lacking sufficient clinical information necessary to render the decision or the required clarification.
3. The AdSS shall have a process for standard and Expedited Service Authorization Requests that do not involve medications. Service authorization decisions pertaining to requests for medication shall be completed within the timeframe specified below and do not follow the standard or expedited timeframes used for other Service Authorization Requests.
4. The AdSS shall prioritize the authorization decision and make the determination within the 72-hour Expedited Service Request timeframe as described in this section for Expedited Service Requests that meet these requirements.
5. 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 for standard Service Authorization Request.

6. The AdSS shall use the date and time the request is received to determine the completion time for the decision for an Expedited Service Authorization Request and medication requests.
7. Service Authorization Decision Timeframe for Medications:
   a. The AdSS shall issue service authorization decision for medication no later than 24 hours from receipt of the submitted request for prior authorization 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.
   b. The AdSS shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request when the prior authorization request lacks sufficient information for the AdSS to render a decision for the medication.
   c. The AdSS shall issue a final decision no later than seven

working days from the initial date of request. Refer to 42 CFR 438.3(s).

2. Standard authorization decision timeframe for Service Authorization Requests that do not pertain to medications:
   a. The AdSS shall issue service authorization decisions as expeditiously as the Member's condition requires but no later than 14 Calendar Days from receipt of the request for the service regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.
   b. The AdSS shall issue a Notice of Extension of up to 14 additional Calendar Days , utilizing ACOM 414 Attachment C, when the criteria for a service authorization extension are met as specified in section (H) of this Policy.
3. The AdSS shall treat the following Service Authorization Requests as an expedited request.
   a. Behavioral Health Residential Facility (BHRF)
   b. Determination for Member participation in a clinical trial shall be treated as an expedited request regardless the location or if the provider is in-network, and

c. Requests for services when a Member is awaiting disposition into an emergency department.

4. Expedited service authorization decision timeframe for Service Authorization Requests that do not pertain to medications:

   a. The AdSS shall issue an expedited service authorization decision as expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

   b. The AdSS shall issue a Notice of Extension (NOE) of up to 14 additional Calendar Days, utilizing ACOM 414 Attachment C, when the criteria for a service authorization extension are met as specified in this Policy.

5. Expedited Service Authorization Request treated as a Standard Authorization Request:

   a. The AdSS shall treat the Expedited Service Authorization Request as a Standard Authorization Request when the

Service Authorization Request fails to meet the requirements for an expedited consideration.

b. The AdSS shall have a process included in the AdSS' policy for prior authorization that describes how the Responsible Person shall be notified of the change to a Standard Authorization Request and be given an opportunity to provide additional information.

c. The AdSS shall permit the requesting provider to send additional documentation supporting the need for an Expedited Service Authorization.

6. Service authorization decisions not reached within the timeframes:

   a. The AdSS shall consider a Service Authorization Request decision that is not reached within the required timeframes for a standard, or expedited request, as a denial when the AdSS has not made a decision.

   b. The AdSS shall issue a Notice of Adverse Benefit Determination denying the request on the date that the timeframe expires.

7. Service authorization decisions not reached within the extended

timeframes:

a. The AdSS shall consider a service authorization decision that is not reached within the timeframe noted in the NOE as a denial.

b. The AdSS shall issue a Notice of Adverse Benefit Determination denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

G. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

1. The AdSS shall mail the Notice of Adverse Benefit Determination within the following timeframes:

a. For termination, suspension, or reduction of a previously authorized service, the Notice of Adverse Benefit Determination shall 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 shall provide a Notice of Adverse

Benefit Determination:

i. 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 a Notice of Adverse Benefit Determination shall be rendered no later than seven Working Days from the initial date of the request.

ii. 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 a NOE. For the NOE timeframes, refer to NOE requirements in this Policy [42 CFR

438.404(c)(3) and (4), 42 CFR 438.210(d)(1)].

iii. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless there is a NOE. Refer to NOE Requirements in section (H) of this Policy for NOE timeframes.

iv. As expeditiously as the Member's health condition requires, but no later than 72 hours from receipt of an Expedited Service Authorization Request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona unless there is a NOE. For extension timeframes, refer to NOE Requirements in this Policy.

H. NOTICE OF EXTENSION (NOE) REQUIREMENTS

1. Notice of Extension (NOE) timeframes:
    a. The AdSS shall extend the timeframe to make a service authorization decision for both standard and Expedited Service Authorization Requests when the Responsible Person or provider, with the written consent of the Responsible Person, requests an extension, or
    b. The AdSS shall document all attempts made to the requesting provider for the needed information.
    c. The AdSS shall notify the Responsible Person of the reason for the extension and attempt to obtain the Member's approval before the AdSS pursues an extension due to lack of sufficient clinical information.
2. The AdSS shall not pursue the NOE until the AdSS has made sufficient attempts to first obtain the necessary information from the Responsible Person within the standard or expedited timeframe, whichever is applicable. 42 CFR 438.404(c)(4) and 438.210(d).
3. The AdSS shall document all attempts made to the requesting provider for the needed information.

4. The AdSS shall notify the Member of the reason for the extension and attempt to obtain the Responsible Person's approval before the AdSS pursues an extension due to lack of sufficient clinical information.
5. The AdSS shall not send the NOE 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)];
    a. For Standard Service Authorization Requests, 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;
    b. For an Expedited Service Authorization Request, 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;

c. When the AdSS justifies the need for additional information is in the Member's best interest. The NOE shall 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)].

d. 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 Authorization Request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

e. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations (F)(6) in this Policy when the prior authorization requests lack sufficient information from the prescriber.

f. For an Expedited Service Authorization Request, requests

that do not involve medication, the 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.

6. When the AdSS extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210(d)(1) the AdSS shall:
    a. Provide the Responsible Person with written notice of the reason for the decision to extend the timeframe, including what information is needed in order to make a decision, and in easily understood language, refer to Division Operations Policy 404;
    b. Inform the Responsible Person of the right to file a grievance (complaint) when the Responsible Person disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and
    c. Issue and carry out the decision as expeditiously as the Member’s condition requires and no later than the date the

NOE expires consistent with 42 CFR438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii).

I. NOTICE OF ADVERSE BENEFIT SELF-MONITORING REQUIREMENT

1. The AdSS shall audit Notice of Adverse Benefit Determinations that have been issued as outlined below:
   a. Utilizing the AHCCCS provided Reporting Form;
   b. Reporting Notice of Adverse Benefit Determinations issued within the quarter prior;
   c. Report the Division's line of business when submitting the Scores and Summary described below;
   d. The auditor shall not be a staff member that writes or issues the Notice of Adverse Benefit Determination;
   e. The sample includes a Notice of Adverse Benefit Determinations from each of the following categories:
      i. Medical,
      ii. Dental,
      iii. Pharmacy, and
      iv. Behavioral Health
   f. The AdSS shall randomly select 30 Notice of Adverse

Benefit Determinations from each of the categories;

i. The AdSS shall randomly select eight From the 30 to be audited.

ii. The AdSS shall not audit the remaining 22 Notice of Adverse Benefit Determinations when the initial eight Notice of Adverse Benefit Determinations are all found to be in compliance, 95% or above;

iii. The AdSS shall audit the remaining 22 Notice of Adverse Benefit Determinations when any one of the eight Notice of Adverse Benefit Determinations issued are found to be out of compliance.

g. The AdSS shall submit a Notice of Adverse Benefit Determination Self-Audit Scores and Executive Summary to the Division as specified in the Contract.

2. The AdSS shall provide an Executive Summary that includes an analysis of the audit including:

a. A methodology for pulling the sample,

b. Deficiencies,

c. Plan of action to bring back into compliance,

d. Staff member involved in audit and credentials or role in

the organization, and

e. Score sheet

3. The AdSS shall submit a Notice of Adverse Benefit Determination Self-Audit Scores and Executive Summary to the Division as specified in the Contract.
4. The Division shall reserve the right to request specific Notice of Adverse Benefit Determinations and associated records for further review.

415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

REVISION DATE: 1/17/2024, 3/22/2023, 1/26/2022

REVIEW DATE: 10/10/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 415, 417, and 439; ACOM 415 Attachments A, B, D, F; 9 A.A.C. 22, Articles 1 and 2; A.R.S. §§ 36-2901, 36-3407; 42 CFR 457.1230, 42 CFR 438.207(b), Section F3, Contractor Chart of Deliverables

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes AdSS requirements for the submission of the Network Development and Management Plan and other periodic reporting requirements.

DEFINITIONS

1. "Attachment" means attachment to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) 415.
2. "Contract" means the Division's contract with AdSS.

POLICY

A. NETWORK DEVELOPMENT AND MANAGEMENT PLAN

1. The AdSS shall develop and maintain a Provider Network Development and Management Plan (NDMP), which assures the Division that the provision of covered services will occur as stated in the Contract [42 CFR 457.1230, 42 CFR 438.207(b)].
2. The AdSS shall evaluate and review activity and performance during the Contract year prior to the NDMP's submission date and address the AdSS's plan for network development and related activity during the Contract year in which it was submitted in the NDMP.
3. The AdSS shall specify in the NDMP the process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.
4. The AdSS shall include in the NDMP a comprehensive description of elements identified in Attachment B and shall submit as

specified in Contract. In the submission, the AdSS shall include the following:

a. Attachment A, Network Attestation Statement.

b. Attachment B, Network Development and Management Plan Checklist, in Microsoft Word format.

c. Attachment F, the Centers of Excellence Checklist (COE), in Microsoft Word format.

d. The Centers of Excellence (COE).

5. The AdSS shall 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 changes in services, geographic service areas, and payments.

B. PERIODIC NETWORK REPORTING

1. The AdSS shall submit Attachment D, as specified in Contract for Provider changes Due to rates report.

2. The AdSS shall submit changes resulting in a material change to the Division as specified in ACOM Policy 439.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

Durable Medical Equipment (DME) Wheelchair Service Delivery Reporting;

Provider Network Development and Management Plan;

Provider/Network Changes Due to Rates Report Attachment D and E;

Centers of Excellence Attachment to Provider Network Development and Management Plan

416 PROVIDER INFORMATION

REVISION DATE: 1/3/2024

REVIEW DATE: 7/20/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12, 42 CFR 438.100, 42 CFR 438.102

PURPOSE

This Policy applies to the Division's Administrative Services Subcontractors. This Policy establishes guidelines for AdSS regarding provider information requirements.

DEFINITIONS

1. "Americans With Disabilities Act" or "ADA" means the Americans with Disabilities Act of 1990, as amended, that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in 42 U.S.C. 126 and 47 U.S.C. 5.

2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources.
    a. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.
    b. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and

conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

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

3. "Material Change to the Provider Network" means any change that affects, or can reasonably be foreseen to affect, the AdSS's ability to meet the performance and provider network standards as required in contract including, any change that would cause or is likely to cause more than 5% of the Members in a Geographic Service Area (GSA) to change the location where services are received or rendered.

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

5. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care.

   a. A PCP may be:

i. A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17;

ii. A practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25;

iii. A certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15; or

iv. A naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

b. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

6. “Provider” means any person or entity that contracts with the Division, AHCCCS, or an AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.

6. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.
7. "Subcontractor" means:
   a. A provider of health care who agrees to furnish covered services to Members.
   b. A person, agency or organization with which the AdSS has contracted or delegated some of its management or administrative functions or responsibilities.
   c. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease of real property to obtain space, supplies equipment, or services provided under the Division agreement.
8. "Value-Based Purchasing" or "VBP" means a payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals and

measures in accordance with the VBP strategy selected for the contract.

a. VBP is a non-encounterable payment and does not reflect payment for a direct medical service to a member.

b. VBP payment typically occurs after the completion of the contract period but could include quarterly or semiannual payments if contract terms specify such payments in recognition of successful performance measurement.

POLICY

A. The AdSS shall develop, distribute, and maintain a provider manual. The AdSS shall 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 shall distribute a provider manual to any individual or group that submits claim and encounter data.

B. The AdSS shall ensure that all providers, whether contracted or not, meet the applicable Division and AHCCCS requirements with regard to covered services and billing.

C. The AdSS shall ensure that, at a minimum, the AdSS's provider manual contains information on the following:

1. The ability of the Member's Primary Care Physician (PCP) to treat behavioral health conditions within the scope of their practice.
2. Introduction to the AdSS that explains the AdSS's organization and administrative structure.
3. Provider responsibility and the AdSS's expectation of the provider.
4. Overview of the AdSS's Provider Services department and its function, including the expected response times for provider inquiries.
5. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services.
6. Appropriate and inappropriate use of the emergency department.
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

i. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations.

ii. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.

8. Description of dental services coverage and limitations.

9. Description of maternity and family planning services.

10. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.

11. Process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

12. Grievance and Appeal system process and procedures for providers and enrollees.

13. Billing and encounter submission information.

14. AdSS policies and procedures relevant to the providers that contain:
    a. Utilization management;
    b. Claims submission;
    c. Criteria for identifying provider locations that accommodate Members with physical or cognitive disabilities; and
    d. Primary Care Provider (PCP) assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.
15. Procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, that contains:
    a. Assigned Members' name,
    b. Assigned Members' date of birth,
    c. Assigned Members' AHCCCS ID,
    d. AHCCCS ID of the assigned PCP, and

e. Effective date of Member assignment to the PCP.

16. Policies relevant to providers including:

    a. Payment responsibilities as outlined in AdSS Operations Policy 432.

    b. Description of the Change of Contractor policies as outlined in AdSS Operations Policy 401.

    c. Nursing Facility and Alternative Home and Community Based Service (HCBS) Setting contract termination procedures as outlined in AdSS Operations Policy 421.

17. Reimbursement policies, including reimbursement for Members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

18. Cost sharing responsibility.

19. Explanation of remittance advice.

20. Criteria for the disclosure of Member health information.

21. Medical record standards.

22. Prior authorization and notification requirements, including a list of most frequently used services that require authorization, and

instructions on how to obtain a complete listing of services that require authorization.

23. Requirements for out-of-state placements for Members.
24. Claims medical review.
25. Concurrent review.
26. 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.
27. Credentialing and re-credentialing activities.
28. Fraud, waste, and abuse as specified in AdSS Operations Policy 103.
29. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including 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.

30. The AHCCCS Drug List and the AHCCCS Behavioral Health Drug List information available in a machine readable file and format, and information on:
    a. How to access the drug lists electronically or by hard copy upon request, and
    b. How and when updates to these lists are communicated.
31. Division and AHCCCS appointment standards.
32. Requirements pertaining to duty to warn and duty to report as outlined in Division Medical Manual, Policy 960.
33. Information for behavioral health providers on their responsibilities for submitting to the Division demographic information according to the AHCCCS DUGless Portal Guide34. Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964 requirements, as applicable.
35. Process providers shall use to notify the AdSS and the Division when a provider changes address, contact information, or other demographic information.

36. Information on services available through the AHCCCS Provider Enrollment Portal, how to access the portal, and how to update provider registration data including current population groups sets served.
37. Eligibility verification.
38. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964 and information on 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.
39. Peer review and the provider’s ability to dispute the process.
40. Medication management services as specified in the AdSS contract with the Division.
41. Member’s rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including the right to:
    a. Be treated with dignity and respect.

b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

c. Participate in treatment decisions regarding health care, including the right to refuse treatment.

d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

e. Request and receive a copy of the medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable state law.

f. Exercise rights and the exercise of those rights without adversely affecting service delivery to the Member.

42. That the AdSS has no policies that prevent the provider from advocating on behalf of the Member as specified in 42 CFR 438.102.

43. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

44. General and informed consent for treatment requirements.

45. Advance directives.
46. Transition of Members.
47. Encounter validation studies.
48. Incidents, accidents, and deaths reporting requirements as specified in AdSS Medical Manual 961.
49. Pre-petition screening, court ordered evaluations, and court ordered treatment.
50. Behavioral health assessment and service planning requirements:
    a. As specified in AMPM Policy 320-O;
    b. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650;
    c. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040;
    d. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P;

e. Partnership requirements with families and family-run organizations in the children and adult behavioral health system; and

f. Peer support and recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

51. Housing criteria for individuals determined to have SMI.
52. Seclusion, restraint, and emergency reporting requirements.
53. The SMI grievance and appeal process.
54. How providers assist Members in obtaining a Member Handbook and other new Member materials.
55. Outreach, engagement, re-engagement, and closure activities.
56. Requirements for grant funded services provided to Special Populations.
57. Behavioral health crisis intervention service requirements.
58. Partnership requirements with families and family-run organizations in the children and adult behavioral health system.

59. Training requirements.

60. The AdSS shall include guidance in the Provider Manual on which services are the responsibility of AdSS and which services are the responsibility of providers contracted with AdSS, and directions on how providers unsure of these responsibilities can obtain guidance.

D. REQUIRED NOTIFICATIONS

1. In addition to the updates required in this section, the AdSS shall require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, AdSS shall provide prior notification.

2. AdSS shall provide written or electronic communication to contracted providers in the following instances:

    a. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, AdSS shall provide written notice of the reason for declining any written request for inclusion in the network.

b. Material Changes - AdSS shall notify providers in advance of any Material Change to the Provider Network or business operations as specified in ACOM policy 439.

c. AdSS Policy and Procedure Changes – For any change in policy, process, or protocol, including prior authorization, retrospective review, or performance and network standards that affects or can reasonably be foreseen to affect the AdSS's ability to meet performance standards of AdSS contract with the Division, AdSS shall notify:

   i. The designated operations compliance officer to which AdSS is assigned, sixty calendar days before a proposed change, and

   ii. Affected provider, thirty calendar days before the proposed change.

d. AHCCCS Guidelines, Policy, and Manual Changes - AdSS shall notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals.

e. AdSS Provider Manual Changes - AdSS shall notify its providers when modifications are made to the provider manual.

f. Subcontract Updates

   i. If a modification to the AHCCCS Minimum Subcontract Provisions are modified, AdSS shall issue a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts.

   ii. AdSS shall amend the affected subcontracts on their regular renewal schedule or within six calendar months of the update, whichever comes first.

g. Termination of Contract – AdSS shall provide, or require its subcontractors to provide, written notice to hospitals and provider groups at least 90 calendar days prior to any contract termination, other than contracts between subcontractors and individual practitioners, without cause.

h. Disease and Chronic Care Management – AdSS shall disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

3. The Division shall distribute other communication to the AdSS upon request of AHCCCS. In these instances, AHCCCS shall provide prior notification.

417 APPOINTMENT AVAILABILITY, TRANSPORTATION TIMELINESS, MONITORING, AND REPORTING

REVISION DATE: 2/28/2024, 1/25/2023, 1/26/2022
REVIEW DATE: 10/10/2023
EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.206; 42 CFR 438.206(b)(4); 42 CFR 438.206(c)(1)((i)-(vi; ; 42 CFR 438.207(b); 42 CFR 457.1230 (a); A.R.S. § 8-512.01; ACOM 415; ACOM 417, ACOM Attachments A and B, ACOM 449

PURPOSE

This policy establishes Appointment accessibility and availability standards to ensure compliance with the Division's network sufficiency requirements. This policy establishes a common process for the AdSS to monitor and report Provider Appointment accessibility and availability to the Division. These policy requirements do not apply to emergency conditions. This policy applies to the Division's Administrative Services Subcontractors (AdSS).

DEFINITIONS

1. "1800 Report" means an Arizona Health Care Cost Containment System (AHCCCS) generated document provided quarterly, that

identifies Primary Care Physicians (PCPs) with a panel of more than 1800 AHCCCS members.

2. “Appointment” means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or service Provider in Provider and service categories identified below.

3. “Network Development and Management Plan” or “NDMP” means a plan the AdSS develops and maintains to ensure the provision of covered services will occur as stated in the Contract. The Network Development and Management Plan (NDMP) shall specify the AdSS’ process to develop, maintain, and monitor an adequate Provider network that is supported by written agreements and is sufficient to provide access to all services covered under the Contract and satisfies all service delivery requirements.

4. “Provider” means any individual or entity contracted with the AdSS that is engaged in the delivery of services, or ordering or

referring for those services, and is legally authorized to do so by the State.

5. “Urgent Care Appointment” means an Appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

A. APPOINTMENT STANDARDS

1. The AdSS shall require adherence to service accessibility standards and the contractual Appointment standards contained in 42 CFR 457.1230 (a) and 42 CFR 438.206.

2. The AdSS shall provide a comprehensive Provider network that provides access to all services covered under the Contract for all Members.

3. The AdSS shall cover contracted services through an out of network Provider until a network Provider is contracted if the

AdSS's network is unable to provide medically necessary services required under the Contract.

4. The AdSS shall use the results of Appointment standards, monitoring to validate it has an adequate network of Providers ensuring timely service coverage, and to reduce unnecessary emergency department utilization.

5. The AdSS shall have written policies and procedures about educating its Provider network regarding Appointment time requirements.

6. The AdSS shall:
   a. Develop a corrective action plan when Appointment standards are not met.
   b. Develop a corrective action plan in conjunction with the Provider when appropriate.

B. GENERAL APPOINTMENT STANDARDS

The AdSS shall require the following Appointment standards are met:

1. For primary care Provider Appointments:
   a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days of request, and
   b. Routine care Appointments scheduled within 21 calendar days of request.
2. For specialty physician Appointments, including dental specialists:
   a. Urgent Care Appointments scheduled as expeditiously as the Member's health condition requires but no later than two business days from the request, and
   b. Routine care Appointments scheduled within 45 calendar days of referral.
3. For dental Provider Appointments:
   a. Urgent Care Appointments scheduled as

expeditiously as the Member's health condition requires, but no later than three business days of request; and

b. Routine care Appointments scheduled within 45 calendar days of request.

4. For maternity care Provider Appointments:

Initial prenatal care Appointments for enrolled pregnant Members provided as follows:

a. First trimester, Appointments scheduled within 14 calendar days of request;

b. Second trimester, Appointments scheduled within seven calendar days of request;

c. Third trimester, Appointments scheduled within three business days of request; and

d. High-risk pregnancies, Appointments scheduled as expeditiously as the Member's health condition requires and no later than three

business days of identification of high risk by the AdSS or maternity care Provider, or immediately if an emergency exists.

C. PSYCHOTROPIC MEDICATION APPOINTMENT STANDARDS

The AdSS shall adhere to the following psychotropic medication Appointment standards:

1. Assess the urgency of the need immediately; and
2. Provide an Appointment, if clinically indicated, with a practitioner who can prescribe psychotropic medications within a time frame that ensures the Member:
   a. Does not run out of needed medications; or
   b. Does not decline in their behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

D. GENERAL BEHAVIORAL HEALTH APPOINTMENT STANDARDS

The AdSS shall ensure the following general behavioral health Appointment standards are met:

1. For behavioral health Provider Appointments:

   Urgent need Appointments occur as expeditiously as the Member's health condition requires but no later than 24 hours from identification of need.

2. Initial assessment:

   Occur within seven calendar days after the initial referral or request for behavioral health services.

3. Initial Appointment:
   a. Occur within time frames indicated by clinical need.
   b. Occur no later than 23 calendar days after the

initial assessment for Members age 18 and older; and

c. Occur no later than 21 days after the initial assessment for Members under the age of 18 years old.

4. Subsequent behavioral health services:

Occur as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

E. BEHAVIORAL HEALTH APPOINTMENT STANDARDS FOR PERSONS IN LEGAL CUSTODY OF THE ARIZONA DEPARTMENT OF CHILD SAFETY (DCS) AND ADOPTED CHILDREN

1. The AdSS shall ensure the following Appointment standards are met:

a. Rapid response:

When a child enters out-of-home placement within

the time frame indicated by the behavioral health condition, but no later than 72 hours after notification by the Arizona Department of Child Safety (DCS) that a child has been or will be removed from their home;

b. Initial assessment:

Within seven calendar days after the initial referral or request for behavioral health services;

c. Initial Appointment:

Within time frames indicated by clinical need, but no later than 21 calendar days after the initial assessment; and

d. Subsequent behavioral health services:

Within the time frames according to the needs of the person, but no longer than 21 calendar days from the identification of need.

2. The AdSS shall require Appointment standards for Members

in the legal custody of the DCS and adopted children are adhered to in order to monitor Appointment accessibility and availability.

F. PROVIDER APPOINTMENT AVAILABILITY REVIEW

1. The AdSS shall conduct regular reviews of Providers to assess the availability of routine and urgent Appointments for primary care, specialist, dental, behavioral health Providers, and behavioral health Appointments for Members in the legal custody of DCS and adopted children.

2. The AdSS shall review the availability of routine and urgent Appointments for maternity care Providers relating to the first, second, and third trimesters, as well as high risk pregnancies.

3. The AdSS shall consider an Appointment available to be delivered through telehealth an available Appointment where clinically appropriate.

4. The AdSS shall conduct Provider Appointment availability reviews

as a method to ensure sufficient Provider network capacity.

5. The AdSS shall conduct Provider Appointment availability reviews for all Providers or a statistically relevant sample of Providers throughout the Contract year.

6. The AdSS shall only use one of these methods at a time for conducting reviews:
   a. Appointment schedule review that independently validates Appointment availability,
   b. Secret shopper phone calls that anonymously validate Appointment availability, or
   c. Other methods approved by the Division.

7. The AdSS shall supplement the monitoring efforts prescribed in (F)(1) through (F)(6) by targeting specific Providers identified through the following performance monitoring systems:
   a. The 1800 Report,
   b. Quality of care concerns,

c. Complaints,

d. Grievances, or

e. The credentialing process.

8. The AdSS shall address any plans to change its existing methodologies for Appointment availability reviews in its annual NDMP as specified in ACOM Attachment 415-B.

9. The AdSS shall submit to the Division a request for approval for any additional methodologies that outline details, including scope, selection criteria, and any tools used to collect the information prior to implementing the proposed method, as specified in the Contract.

G. TRANSPORTATION TIMELINESS REVIEW

1. The AdSS shall ensure that medically necessary, non-emergent transportation is provided so a Member arrives on time for an Appointment, but no sooner than one hour before the Appointment; or wait no more than one hour after the

conclusion of the treatment for transportation home.

2. The AdSS shall ensure the following AHCCCS performance target is met: 95% of all combined completed pickup and drop off trips in a quarter are completed in the time frame specified in section (G)(1) above.

3. The AdSS shall evaluate compliance with these standards on a quarterly basis for all subcontracted transportation vendors or brokers and require corrective action if standards are not met.

4. The AdSS shall track all scheduled trips that were not completed.

H. TRACKING AND REPORTING

1. The AdSS shall track Provider compliance with Appointment availability and transportation timeliness as specified in the Contract, the F3 Chart of Deliverables, and outlined below in sections (H)(2) through (H)(4).

2. The AdSS shall submit to the Division a cover letter with ACOM

Attachment 417-A including all of the following:

a. A description of the methods used to collect the information;

b. An explanation of whether the AdSS is surveying all Providers in their network or a sample.

c. A sample of the Provider network needs to include the methodology for how the sample size meets a 95% statistically significant confidence level, including the calculations used to confirm the confidence level;

d. A summary of the findings and an explanation of trends in either a positive or negative direction;

e. An analysis of the potential causes for these findings and trends; and

f. A description of any interventions applied to areas of concern including any corrective actions taken.

3. The AdSS shall submit to the Division ACOM Attachment 417-B

for each line of business, with a cover letter for each submission including all of the following:

a. A summary of the findings including any identified positive or negative trends for timeliness, incomplete trips, and their reasons;

b. An analysis of the potential causes for these findings and trends; and

c. A description of any intervention applied to areas of concern including any corrective actions taken.

4. The AdSS shall provide additional corrective action steps for any reporting quarter where the average percentage of all completed trips for that quarter falls below the performance target of 95%.

5. The AdSS shall include a timeline with the corrective action steps in order to meet the performance target of 95% of trips being completed in the time frame specified in section (G)(1) above.

6. The AdSS shall, as a component of the NDMP, annually:

a. Conduct a review of its network sufficiency when there has been a significant decrease in Appointment availability performance over the previous year;

b. Compare its annual average performance to the previous Contract year's average performance for each standard, Provider type and Appointment type subcategory specified within this Policy under the sections for General Appointment Standards, General Behavioral Health Standards and Additional Behavioral Health Standards; and

c. Conduct a review of the sufficiency of its Provider network for any standard that decreased by more than five percentage points.

SUPPLEMENTAL INFORMATION

1. For additional information on behavioral health services and behavioral health standards for persons in the legal custody of

the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. § 8-512.01, refer to AdSS Policy 449.

2. Refer to AdSS Policy 415 for additional requirements regarding the submission of the NDMP.

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

REVISION DATE: 5/10/2023, 10/1/2021, 12/02/2020
EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 433;

PURPOSE

This policy establishes requirements regarding the development, approval, and distribution of Member Identification Cards (ID Cards) and replacement ID Cards. This policy applies to the Division of Developmental Disabilities' Administrative Services Subcontractors (AdSS) when members present for Medicaid services.

DEFINITIONS

1. "834 Enrollment Transaction File" means a nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly enrolled members and enrollment changes for existing members.

POLICY

A. PROGRAMMING REQUIREMENTS

1. The AdSS shall identify members requiring an ID Card as a result of the 834 Enrollment Transaction File. ID Cards shall be produced and distributed as follows:
    a. To new members within 12 business days from the business day following the Division providing the 834 Enrollment Transaction File to the AdSS, or
    b. Within five business days of the request for member replacement cards.
2. The AdSS may provide an option for the member to access the ID Card digitally in addition to providing the physical card.
3. The AdSSs shall monitor the timeliness standards in this policy for the ID Cards it issues directly.
4. The AdSS shall provide members with new ID Cards at least 14 calendar days prior to a new version going into effect.
5. The AdSS shall issue a combined Medicare Arizona Long Term Care System (ALTCS) ID Card when serving members dually enrolled in Medicare and the Division. The format for the combined ID Cards shall:

a. Meet the Centers for Medicare and Medicaid Services (CMS) requirements for ID Cards and be approved AHCCCS.

b. Meet the minimum formatting requirements identified in ACOM Policy 433 Attachment A as applying to ID Cards for members dually enrolled.

c. Adopt additional formatting features included in this policy or prescribed by CMS for the requirement of an ID Number, if the formatting does not conflict with this policy's minimum requirements.

B. FORMAT OF MEMBER IDENTIFICATION CARDS (ID CARDS)

1. The AdSS shall ensure ID Cards meet the format standards outlined in this policy or as specified in ACOM Policy 433 Attachment A. The following formatting standards apply:

   a. The front of the ID card shall include:

      i. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version.

ii. AHCCCS Logo in the approved color or black and white version no smaller than 1” long by .333” inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The AdSS must not edit or alter the approved logo, except as noted above.

iii. Arizona Health Care Cost Containment System in Arial font no smaller than 11 points.

iv. The following information in Arial font no smaller than 8 points:

1) Member’s name
2) AHCCCS ID number
3) AdSS name
4) AdSS telephone number
5) Division telephone number
6) TTY/TDY telephone number for members who are deaf or hard of hearing
7) Statewide crisis phone number

8) The nurse triage telephone number.

b. The back of the ID card shall include:

i. In Arial font no smaller than 7 points:

1) The following text: “Carry this card with you at all times. Present it when you get 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 health plan benefits, visit:

UnitedHealthcare Plan – www.uhc.com

Mercy Care Plan – www.mercycareaz.org

DDD Tribal Health Program (THP) –

DDD Customer Service 1-844-770-9500 ext. 7

2) The following text in the card’s mailing to the member if a card holder is not used:: “To help protect your identity and prevent fraud, AHCCCS is adding pictures to its online verification tool that providers use to verify

your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details."

2. The Division may include additional information on the ID card or card holder identified as appropriate, subject to the approval requirements of this policy.

3. The Division shall include the most recent version of the AHCCCS Notice of Privacy Practices (NPP) with any new ID Card mailing.

C. APPROVAL OF MEMBER IDENTIFICATION CARDS, AND OTHER COMPLIANCE REQUIREMENTS

1. The AdSS shall submit the ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items to the Division for prior approval..

2. The AdSS shall submit ID Cards requiring Division approval, as specified in Contract.
3. The AdSS shall obtain prior approval from the Division if more than one version of an ID Card is issued to members.
4. The AdSS shall ensure the card holder and any letters or information mailed to the member with the ID Card complies with requirements as specified in AdSS Operations Manual, Policy 404.
5. The AdSS shall obtain approval prior to implementation of a subcontract to print or distribute member identification cards and identify the subcontractor in the Annual Subcontractor Assignment and Evaluation Report as outlined in the Division Operations Manual, Policy 438.

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

REVISION DATE: 03/22/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 435; Attachment A (Worksheets A and B)

PURPOSE

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

1. "Average Speed of Answer (ASOA) means the average online wait time in seconds that the Member/provider waits from the moment the call is connected in the AdSS's phone switch until the call is picked up by a AdSS's representative or Interactive Voice Recognition System (IVR).
2. "Daily First Contact Call Resolution Rate (DFCCR)" means the number of calls received in a 24-hour period for which no

follow-up communication or internal phone transfer is needed, divided by the total number of calls received in the 24-hour period.

3. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

4. "Monthly Average Abandonment Rate (MAAR)" means this is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.

5. "Monthly Average Service Level (MASL)" means the total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).

6. "Monthly First Contact Call Resolution Rate (MFCCR)" means the sum of the DFCCRs divided by the number of business days in the reporting period.

POLICY

A. TELEPHONE PERFORMANCE STANDARDS

The AdSS shall adhere to the following Telephone Performance Standards for Member and provider calls monthly:

1. The ASOA shall be 45 seconds or less.
2. The MAAR shall be 5% or less.
3. The MFCCR shall be 70% or better.
4. The MASL shall be 75% or better.

B. TELEPHONE PERFORMANCE MEASURE REPORTS

1. The AdSS shall track performance based on standards noted above and report performance results monthly to the DDD OIFA Data Validation Specialist, including both AHCCCS worksheets within Attachment A:
   a. Worksheet A, Telephone Performance Measures Template to document the ASOA, MAAR, MFCCR, and MASL as described in this Policy.
   b. Worksheet B, Centralized Telephone Line Down Time Template to report:

i. Down time for AdSS centralized telephone lines,

ii. Dates of the occurrences; and

iii. Length of time they were out of service.

2. The AdSS in their report shall:

   a. Cover their performance during the previous twelve months;

   b. Submit as specified in Section F3, Contractor Chart of Deliverables; and

   c. Separately document performance for calls of the following types:

      i. Member Calls

      ii. Provider Calls.

3. The AdSS shall address non-compliance with any standard on this deliverable for any given month, by including in the report steps the AdSS plans to take to reduce the noncompliant performance.

436 NETWORK STANDARDS

REVISION DATES: 3/27/2024, 4/26/2023, 12/22/2021

REVIEW DATE: 9/12/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 32-1201 et seq 32-1901 et seq, 36-401 et seq, 36-421 et seq,; A.A.C. R9-10, R9-10-801 et seq, R9-22-101, R9-33-101 et seq; 42 § C.F.R. 438.206(b)(1); ACOM 415; ACOM 436; ACOM 438; AdSS Contract

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes Network Standards and the oversight and monitoring Network Standards for the AdSS.

DEFINITIONS

1. "Adult Developmental Home" or "ADH" means an Alternative Home and Community Based Service (HCBS) Setting for adults (18 or older) with Developmental Disabilities (DD) that is licensed by the Department of Economic Security (DES) to provide room, board, supervision and coordination of habilitation

and treatment for up to three residents as specified in A.R.S. § 36-551.

2. "Assisted Living Center" or "ALC" means an assisted living facility that provides resident rooms or residential units to eleven or more residents as specified in A.R.S. § 36-401.
3. "Assisted Living Facility" or "ALF" means a residential care institution that provides supervisory care services, personal care services, or directed care services on a continuing basis in compliance with Arizona Department of Health Services (ADHS) licensing criteria as specified in 9 A.A.C. 10, Article 8.
4. "Assisted Living Home" or "ALH" means an ALTCS approved alternative home and community based services (HCBS) setting that provides room and board, supervision, and coordination of necessary services to 10 or fewer residents.
5. "Attachment A" means, for the purpose of this policy, the ACOM Policy 436 Attachment A - Minimum Network Requirements Verifications Template document that specifies the Network

Standards in which the Division and the AdSS are required to meet.

6. “Behavioral Health Outpatient and Integrated Clinic, Adult” means a class of health care institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are age 18 and above.

7. “Behavioral Health Outpatient and Integrated Clinic, Pediatric” means a class of healthcare institution without inpatient beds that provides physical health services and behavioral health services for the diagnosis and treatment of patients who are under the age of 18.

8. “Behavioral Health Residential Facility” or “BHRF” means, as specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

   a. Limits the individual’s ability to be independent, or

b. Causes the individual to require treatment to maintain or enhance independence.

9. "Cardiologist, Adult" means a Medical Doctor (MD) who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system for patients aged 18 and above.

10. "Cardiologist, Pediatric" means a Medical Doctor (MD) who specializes in the study or treatment of heart diseases and heart abnormalities for patients under the age of 18.

11. "Crisis Stabilization Facility" means an inpatient facility or outpatient treatment center licensed as specified in 9 A.A.C. 10 that provides crisis intervention services (stabilization).

12. "Dentist, Pediatric" means a medical professional regulated by the State Board of Dental Examiners and operating as specified in A.R.S. § 32-1201 for patients under the age of 18.

13. "District or Service District" means a section of Maricopa or Pima County defined by zip code for purposes of establishing and measuring minimum Network Standards for Developmentally

Disabled (DD) Group Homes and Assisted Living Centers, and Assisted Living Homes..

14. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

15. "Geographic Service Area" or "GSA" means an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a Member enrolled with that Contractor of record, as specified in 9 A.A.C. 22, Article 1 and 9 A.A.C. 28, Article 1.

16. "Group Home" means a community residential setting for not more than six individuals with intellectual/developmental disabilities, that provides room and board and daily rehabilitation and other assessed medically necessary services and supports to meet the needs of each individual as specified in A.R.S. § 36-551.

17. “Home” means a residential dwelling that is owned, rented, leased, or occupied by a Member, at no cost to the Member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting, or an institution, or a portion of any of these that is licensed or certified by a regulatory agency of the state as a:
    a. Health care institution as specified in A.R.S. § 36-401;
    b. Residential care institution as specified in A.R.S. § 36-401;
    c. Community residential setting as specified in A.R.S. § 36-551; or
    d. Behavioral health facility as specified in 9 A.A.C. 20, Articles 1,4,5, and 6.
18. “Hospital” means a class of healthcare institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient as specified in A.A.C. Title 9, Chapter 10, Article 1 and A.R.S. Title 36, Chapter 4, Articles 1, 2, and 3.

19. "Member" means the same as "client" as defined in A.R.S. § 36-551.
20. "Multi-Specialty Interdisciplinary Clinic" or "MSIC" means an established facility where specialists from multiple specialties meet with Members and their families for the purpose of providing interdisciplinary services to treat Members.
21. "Network" means physicians, health care Providers, suppliers and hospitals that contract with an AdSS to give care to Members.
22. "Network Standards" means, as defined in ACOM 436, the requirements the Division and AdSS must meet and monitor to ensure that all covered services are available and accessible to Members.
23. "Nursing Facility" means, as defined in 42 § U.S.C. 1936r(a):
    a. An institution or a distinct part of an institution that:
        i. Is primarily engaged in providing to residents:
            a) Skilled nursing care and related services for residents who require medical or nursing care;

b) Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals; or

c) On a regular basis, health-related care, and services to individuals who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

ii. Is not primarily for the care and treatment of mental diseases;

iii. Has in effect a transfer agreement. meeting the requirements of 42 § U.S.C. 1861(l), with one or more hospitals having agreements in effect under 42 § U.S.C. 1866.

b. Any facility that is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of a Nursing Facility outlined in this section.

24. "Obstetrician/Gynecologist" or "OB/GYN" means a healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs, or who possesses special knowledge, skills, and professional capability in the medical and surgical care of the female reproductive system and associated disorders.
25. "Pharmacy" means a facility regulated by the State Board of Pharmacy and operating under A.R.S. § 32-1901.
26. "Primary Care Provider (PCP), Adult" means a person who is responsible for the management of the health care of Members who are over 21 years of age. A PCP may be a:
    a. Person licensed as an allopathic or osteopathic physician;
    b. Practitioner defined as a licensed physician assistant; or
    c. Certified nurse practitioner.
27. "Primary Care Provider (PCP), Pediatric" means a person who is responsible for the management of health care of Members who are under 21 years of age. A PCP may be a:
    a. Person licensed as an allopathic or osteopathic physician,

b. Practitioner defined as a licensed physician assistant, or

c. Certified nurse practitioner

28. "Provider" means a person, institution, or group engaged in the delivery of services, or ordering and referring those services, who has an agreement with AHCCCS to provide services to AHCCCS Members.

29. "Provider Affiliation Transmission" or "PAT" means a data file which provides details of the Providers within the AdSS's Network and is used to measure compliance with Network adequacy requirements.

POLICY

A. GENERAL NETWORK STANDARDS REQUIREMENTS

1. The AdSS shall develop and maintain a Provider Network that is sufficient to provide all covered services to Members eligible for the Division.

2. Unless otherwise noted, the AdSS shall assess its Network against its entire membership for the purposes of complying with Network Standards.

3. If established Network Standards cannot be met, the AdSS shall provide an explanation in the Network Development and Management Plan (NDMP).

B. STATEWIDE TIME AND DISTANCE NETWORK STANDARDS

1. For each county in the AdSS' assigned service area, the AdSS shall have a Network in place to meet the time and distance standards specified in this policy.
2. If the AdSS delegates Network activities, the AdSS shall ensure subcontractor compliance with applicable Network Standards.
3. For the purposes of this policy, the AdSS shall use its Network of the following Provider types and specialties in the table below to calculate compliance with this policy's time and distance standards.

PROVIDER CATEGORY	REQUIRED PROVIDER/SPECIALTY TYPE(S)
Behavioral Health Outpatient and Integrated Clinic, Adult and Pediatric	77 or IC
Behavioral Health Residential Facility (BHRF)	B8
Cardiologist, Adult	08 or 31 with a Specialty Code of

	062 or 927
Cardiologist, Pediatric	08 or 31 with a Specialty Code of 062, 151, or 927
Crisis Stabilization Facility	02, 71, B5, B6, B7, or 77 and ICs that are authorized to provide behavioral health observation/stabilization in accordance with A.A.C. 9-10-1012.
Dentist, Pediatric	07 with a Specialty Code of 800 or 804, C2 Federally Qualified Health Centers (FQHCs) identified by AHCCCS
Hospitals	02 or C4
Nursing Facilities	22
Obstetrician/Gynecologist (OB/GYN)	08, 19, 31, or CN with a Specialty Code of 089, 090, 091, 095, 181, or 219
Pharmacy	03 or 05
Primary Care Provider (PCP), Adult	08 or 31 with a Specialty Code of 050, 055, 060, 089, or 091 or
	19, CN with a Specialty Code of 084, 095, or 097 or
	18 with a Specialty Code of 798
Primary Care Provider (PCP), Pediatrics	08 or 31 with a Specialty Code of 050 , 150, or 176

	or
	19, CN with a Specialty Code of 084 , 087, or 097 or
	18 with a Specialty Code of 798

4. The AdSS shall use the methodology outlined in the table below to calculate its compliance with the following time and distance standards.

PROVIDER CATEGORY	APPLIES TO	MEMBER POPULATION	COUNTY	STANDARD (90% of membership does not need to travel more than)
Behavioral Health Outpatient and Integrated Clinic, Adult*	All Except CHP	18 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	60 miles from their residence
Behavioral Health Outpatient and Integrated	All*	under 18 years	Maricopa, Pima	15 minutes or 10 miles from their residence

Clinic, Pediatric*			All Others	60 miles from their residence
Behavioral Health Residential Facility (BHRF)	All	All	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	(Report in Network Plan, Refer to ACOM Policy 415-Attachment B)
Cardiologist, Adult*	All except CHP	21 years or older	Maricopa, Pima	30 minutes or 20 miles from their residence
			All Others	75 minutes or 60 miles from their residence
Cardiologist, Pediatric*	All	Under 21 years	Maricopa, Pima	60 minutes or 45 miles from their residence
			All Others	110 minutes or 100 miles from their residence
Crisis	ACC-RBHA	All	Maricopa,	15 minutes

Stabilization Facility	Only		Pima	or 10 miles from their residence
			All Others	45 miles from their residence
Dentist, Pediatric	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Hospitals	All	All	Maricopa, Pima	45 minutes or 40 miles from their residence
			All Others	95 minutes or 85 miles from their residence
Nursing Facilities	ALTCS E/PD Only	Living in "Own Home"	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	95 minutes or 85 miles from their residence

Obstetrician /Gynecologist (OB/GYN)	All	15 to 45 years old	Maricopa, Pima	45 minutes or 30 miles from their residence
			All Others	90 minutes or 75 miles from their residence
Pharmacy	All	All	Maricopa, Pima	12 minutes or 8 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Adult*	All Except CHP	21 years or older	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes or 30 miles from their residence
Primary Care Provider (PCP), Pediatrics*	All	Under 21 years	Maricopa, Pima	15 minutes or 10 miles from their residence
			All Others	40 minutes

				or 30 miles from their residence

5. The AdSS shall ensure Provider types marked with an asterisk are:
   a. Eligible for a telehealth standard modification; and
   b. Require 80 percent of a county's membership to meet time and distance standards in any county where telehealth services are available for the Provider category.
6. Multi-Specialty Interdisciplinary Clinic (MSIC) Network Standards
   a. The AdSS shall contract with all MSICs in the assigned Geographic Service Area (GSAs);
   b. Any MSICs which have provided services to the AdSS's Members; and
   c. The AdSS shall identify all contracted MSICs in Attachment A, including any MSIC Providers it has contracted with and the AHCCCS approval date.

C. NETWORK STANDARD REQUEST FOR EXCEPTION PROCESS

1. When the AdSS has exhausted its efforts to meet any Network Standard specified in this policy, the AdSS shall submit a request for an exception to the Network Standards to the Division.
2. The AdSS shall include the following required elements when submitting the request to the Division for an exception to the Network Standards as specified in the AdSS contract:
   a. The county or counties covered under the exception request;
   b. The Provider types covered under the exception request;
   c. A geospatial analysis showing the current Member access to the Provider types and counties covered under the exception request;
   d. An explanation describing why the AdSS cannot meet the established Network Standard requirements;
   e. An explanation of the efforts to contract with non-contracted providers that may bring the AdSS into compliance with the Network Standard, including a

discussion of the appropriateness of the rates offered to non-contracted Providers;

f. The AdSS's proposal for monitoring and ensuring Member access to services offered by Provider types under the exception request; and

g. The AdSS's plan for periodic review to identify when conditions in the exception area have changed, and the exception is no longer needed.

D. NETWORK OVERSIGHT REQUIREMENTS

1. Minimum Network Standards Reporting Requirements

a. The AdSS shall, in accordance with contract specifications, submit to the Division a completed Attachment A to report compliance with the applicable Network Standards in this policy.

b. The AdSS shall utilize the Attachment A tab that details the minimum Network requirements in each county to report the following minimum Network requirements:

i. Minimum contracts within a specific city or group of cities;

ii. Contracts within specified distances to specific cities;

iii. Minimum contracts within a county; and

iv. In certain instances, contracts in locations outside of a county's boundary, if applicable.

c. The AdSS shall submit a separate report for each line of business for each county in the assigned service area.

d. For purposes of calculating and reporting Network Standards data, the AdSS shall:

i. Use its enrollment and its Network as of the last day of the reporting period (March 31 and September 30);

ii. Report the percentages in Attachment A, 'Time and Distance' tab rounded to the nearest tenth of a percent; and

iii. Report 'N/R' (None Reported) for each time and distance standard, instead of a percentage, where

there are no Members meeting the population criteria in the county.

iv. Report in Attachment A, 'Time and Distance' tab, whether or not telehealth services are available in each county reported for each Provider type eligible for a telehealth standard modification by the AdSS,by adding a 'Y' or 'N' in the "Telehealth Available (Y/N)" row underneath the Provider type; and

v. Consider in its dental Network any contracted FQHC identified annually by AHCCCS as providing dental services.

e. The AdSS shall analyze compliance with the minimum Network Standards based upon the Provider Network reported through the Contractor Provider Affiliation Transmission (PAT) and EVV data as required in AdSS Medical Policy 542. With the submission of Attachment A,

the AdSS shall include a summary including, at a minimum, the following:

i. The AdSS strategies and efforts to address any areas of non-compliances;

ii. A summary of exceptions granted to the Network Standards specified in this policy; and

iii. The results of the AdSS's monitoring of Member access to the services governed under the exception.

c. As specified in the AdSS contract with the Division, the AdSS shall submit a completed Attachment A including a summary analysis of any areas of non-compliance with Network Standards specified in this policy, including strategies and efforts to address areas of non-compliance.

2. Network Plan Requirements

a. The AdSS shall take steps to ensure Network Standards are maintained.

i. If established Network Standards cannot be met, the AdSS shall identify gaps and address short and

long-term interventions in the Network Development and Management Plan (NDMP) as specified in AdSS Operations Policy 415.

ii. When an exception has been granted, the AdSS shall address the sufficiency of Member access to the area, and assess the continued need for the exception.

b. The AdSS shall report the Network gaps to the Division and short and long-term interventions to address the gaps, in its NDMP as specified in AdSS Operations Policy 415.

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

REVISION DATE: 3/27/2024, 7/26/2023, 2/16/2022

REVIEW DATE: 9/6/2023

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, and CMS document SMDL #09-001.

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy establishes guidelines and requirements for the AdSS entering into Administrative Services Subcontracts or Management Services Agreement (MSA) and monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and Corrective Action Plans (CAPs). Unless otherwise stated, requirements outlined in this policy for Administrative Services Subcontractors also apply to MSA.

DEFINITIONS

1. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the contract with the Division, including:
    a. Claims processing, including pharmacy claims;
    b. Pharmacy Benefit manager (PBM);
    c. Dental Benefit Manager;
    d. Credentialing, including those for only primary source verification;
    e. Medicaid Accountable Organization (ACO); and
    f. Service Level Agreements with the Division or Subsidiary of a corporate parent owner.
2. "Attachment A" means the Attachment A of the Administrative Services Subcontract Checklist. It is the AHCCCS deliverable template.
3. "Change in Organizational Structure" means any of the following:
    a. Merger
    b. Acquisition

c. Reorganization

d. Change in Articles of Incorporation

e. Joint Venture

f. Change in Ownership

g. Change of Management Services Agreement (MSA) Subcontractor

h. Other applicable changes that may cause:

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

   ii. Changes in critical Member information, including the website, Provider handbook and Member ID card

   iii. A change in legal entity name.

4. “Corrective Action Plan” or “CAP” means a written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions or tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are

generally used to improve performance of the Contractor or its Providers, to enhance Quality Management or Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

5. "Management Service Agreement" or "MSA" means a type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
6. "Medicaid Accountable Care Organization" or "ACO" means an entity that enters into a Value-Based Purchasing (VBP) arrangement with a Contractor which:
   a. Improves the health care delivery system by increasing the quality of care while reducing costs.
   b. Enters into VBP contracts with Provider groups or networks of groups.
   c. Coordinates Provider accountability for the health of their patient population, often through shared savings, shared risk, or capitated Alternative Payment Models (APM),

combined with quality incentives to ensure both quality outcomes and cost containment.

d. Supports Providers participating in APMs by providing services such as data analytics, technical assistance, Provider education, and Provider recruitment.

e. Operates as an intermediary between the Contractor and Providers, but not as a Provider of direct services to Members.

f. May or may not perform delegated administrative activities. Any delegated administrative activities to the Medicaid ACO are subject to prior approval by AHCCCS.

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

8. "Provider" means any person or entity that contracts with the AdSS for the provision of covered services to Members according to the provisions of A.R.S. § 36-2901 or any subcontractor of a Provider delivering services pursuant to

A.R.S. § 36-2901. Providers are not Administrative Services Subcontractors.

9. “Quality of Care” or “QOC” means an expectation that, and the degree to which the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

10. “Request for Proposal” or “RFP” means a document prepared by AHCCCS that describes the services required and that instructs a prospective Offeror how to prepare a response.

11. “Subcontractor” means:
    a. A provider of health care who agrees to furnish covered services to Members.
    b. An individual, agency, or organization with which the Contractor, or its Subcontractor, has contracted or delegated some of its management or administrative functions or responsibilities.

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

POLICY

A. APPROVAL OF SUBCONTRACTS

1. The AdSS shall submit all Management Services Agreements (MSA) and Administrative Services Subcontracts to the Division for prior approval as noted below and as specified in the AdSS contract with the Division, 60 days before the effective date of the subcontract.

   a. The AdSS shall submit an unredacted copy of the proposed Subcontract to the Division with AHCCCS Contractor Operations Policy Manual (ACOM) Policy 438 Attachment A, Administrative Services Subcontract Checklist.

b. The local Chief Executive Officer (CEO) shall retain the authority to direct and prioritize all work performed through a delegated contract.

c. The AdSS shall require that subcontractors meet any performance standards applicable to the delegated services as mandated by the Division and AHCCCS.

    i. The AdSS shall notify a change in Organizational Structure of Administrative Services Subcontractor to the Division.

    ii. If a complete Attachment A submission is required, the AdSS shall follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this policy.

d. The AdSS shall notify and obtain prior approval from the Division of a Change in Organizational Structure of an Administrative Services Subcontractor.

    i. If the Change in Organizational Structure is related to the AdSS MSA, the AdSS shall submit the

proposed change for prior approval as outlined in AdSS Operations Policy Manual, Policy 317.

B. MONITORING AND REPORTING

1. The AdSS shall adhere to all requirements for any contractual relationship and delegation as listed in 42 CFR 438.230.
2. The AdSS shall monitor its subcontractor's performance on an ongoing basis and complete a formal review of the subcontractors at least annually.
3. In the formal review, the AdSS shall conduct a review of delegated duties, responsibilities, and financial position of the subcontractors.
4. If at any time during the period of the Administrative Service Subcontract, the subcontractor is found to be in non-compliance, the AdSS shall notify the Division within 30 days of discovery with the following information:
    a. The subcontractor's name
    b. Delegated duties and responsibilities

c. Identified areas of non-compliance and whether the non-compliance affects Member services or causes a quality of care concern

d. The scope and estimated impact of the non-compliance upon Members

e. The known or estimated length of time that the subcontractor has been in non-compliance

f. The subcontractor's CAP or strategies to bring the subcontractor into compliance

g. Sanction actions that may be taken because of the non-compliance

5. The AdSS shall review and respond to any follow-up questions for more information related to an open CAP requested by the Division.

6. The AdSS shall communicate the results of a CAP with the Division upon closure of the CAP.

C. EVALUATION REPORT

1. The AdSS shall submit a completed Administrative Services Subcontractor Evaluation Report annually, using ACOM Policy 438, Attachment B, Administrative Services Subcontractor Evaluation Report Template.
2. The AdSS shall ensure that the Administrative Services Subcontractor Evaluation Report includes the following:
    a. The name of the subcontractor;
    b. The delegated duties and responsibilities;
    c. The date of the most recent formal review of the duties, responsibilities, and financial position, as appropriate, of the subcontractor;
    d. A comprehensive summary of the evaluation of the operational and financial, as appropriate, performance of the subcontractor, including the type of review performed;
    e. The next scheduled formal review date;
    f. All identified areas of deficiency that:
        i. Affect Member services; or

ii. Cause a quality of care concern; and

g. CAP Information, including:

i. Date reported to the Division;

ii. A detailed description of the reason(s) the Subcontractor was placed on a CAP;

iii. A description of the steps taken by the Subcontractor to address the CAP; and

iv. The current status and expected completion time of the CAP.

D. ADDITIONAL REQUIREMENTS

1. Before entering into an Administrative Services Subcontract, the AdSS shall evaluate the prospective subcontractor’s ability to perform the delegated duties.
2. The AdSS shall ensure that all Administrative Services Subcontracts reference and comply with the Minimum Subcontract Provisions available on the AHCCCS website.

3. In the event of a modification to Division Policy, guidelines, and manuals, the AdSS shall issue a notification of the change to its affected subcontractors of any affected subcontracts.
4. The AdSS shall amend the affected Administrative Services Subcontracts on the regular renewal schedule or within six calendar months of the update, whichever comes first.
5. In the event of a modification to Minimum Subcontract Provisions, the AdSS shall issue a notification and amend Administrative Services Subcontracts.
6. The AdSS shall ensure that all Administrative Services Subcontracts reference and comply with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436, and State Director Letter (SMDL) 09-001.
7. AdSS shall disclose to the Division the identity of any excluded person.

8. The AdSS shall ensure that all Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the Division Contract.
9. The AdSS shall maintain a fully executed original or electronic copy of all Administrative Services Subcontracts and make them accessible to the Division within five business days of the request by the Division according to contract requirements.
10. The AdSS shall 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.
11. If the AdSS terminates a subcontract, the AdSS shall ensure compliance with all aspects of the Division contract notwithstanding the subcontractor termination, including availability of and access to all covered services and provision of covered services to Members within the required timeliness standards.

SUPPLEMENTAL INFORMATION

DELIVERABLES:

1. Administrative Services Subcontracts
2. Administrative Services Subcontractor Evaluation Report
3. Administrative Services Subcontractor Non-Compliance Reporting
4. Corporate Cost Allocation Plans and Adjustment in Management Fees

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 HEARING REQUESTS

REVISION DATE: 10/11/2023

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2901, A.R.S. § 41-1092 et seq, ACOM Policy 445, Attachment A

PURPOSE

This Policy sets forth guidance for Administrative Services Subcontractors (AdSS) contracted with the Division of Developmental Disabilities (Division)when submitting a request for a hearing to the Arizona Health Care Cost Containment System Administration.

DEFINITIONS

1. "Arizona Health Care Cost Containment System (AHCCCS)" - means Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services (CMS) as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
2. "Appeal" means the review of an adverse benefit determination.
3. "Business Day" means the same as Day – Business/Working.

4. "Day – Business/Working" means Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
5. "Director's Decision" - The final administrative decision under A.R.S. § 41-1092(5).
6. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
7. "State Fair Hearing" - An administrative hearing under A.R.S. A.R.S. § 41-1092 et seq.
8. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. HEARING REQUEST FILE SUBMISSION TIMEFRAMES

The AdSS shall submit hearing requests within the following timeline:

1. Expedited Member Appeal hearing requests must be submitted no later than one Business Day from receipt of the expedited hearing request.

2. Standard Member Appeal hearing requests must be submitted no later than three Business Days from receipt of the hearing request.
3. Claim dispute hearing requests must be submitted no later than three Business Days from receipt of the hearing request.

B. HEARING REQUEST FILE SUBMISSION METHOD

1. The AdSS shall submit the hearing request files to the Division's Office of Administrative Review for Member Appeals and provider claim dispute hearing requests
2. 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.

C. HEARING FILE CONTENT

Hearing files must be submitted with all of the following:

1. Submission of Request for Hearing Form, ACOM Policy 445, Attachment A,
2. Request for Hearing,
3. Notice of Appeal Resolution or Notice of Decision,

4. Appeal or Claim Dispute,
5. Notice of Adverse Benefit Determination for Member Appeals; and
6. Signed Appointment of Representative for Member Appeals.

D. SUBMISSION OF REQUEST FOR HEARING FORM ATTACHMENT A

1. The AdSS shall include an accurately completed Submission of Request for Hearing Form ACOM Policy 445, Attachment A that:
   a. Is the first page of the file submission, and
   b. Have all applicable fields completed.
2. The AdSS shall not submit a request without an accurately completed Submission of Request for Hearing Form ACOM Policy 445, Attachment A.
3. The Division shall forward the hearing request file to the AHCCCS Office of General Counsel (OGC).

E. SUBMISSION OF ADDITIONAL SUPPORTING DOCUMENTS

Any changes or additional information to be included to the issue or citations after a hearing file is submitted to AHCCCS, shall be:

1. Filed by the AdSS with the Office of Administrative Hearing as a Motion to Amend the Notice of Hearing, and
2. Copied to the Office of Administrative Review.

SUPPLEMENTAL INFORMATION

1. The Submission of Request for Hearing Form ACOM Policy 445, Attachment A submitted by the AdSS is used to identify the hearing issue and applicable citations.
2. Additional information or changes submitted to the Division or AHCCCS is not added to the Administrative record on the AdSS's behalf.
3. The Division and AHCCCS OGC reserves the right to make changes to the issue and any legal citations for accuracy.

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. <u>Homeless (HUD Definition)</u> – 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. <u>Homeless (Persons in these situations are not included in the HUD definition of or funding purposes)</u> –

- 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. <u>Housing Acquisition and/or Renovation Programs</u> – 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. <u>Housing First</u> – 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. <u>Housing Referral</u> – 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. <u>HUD Housing Choice Voucher Program</u> – 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. <u>Independent Community Housing</u> – 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. <u>Public Housing Authority (PHA)</u> – 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. <u>Rapid Housing</u> – 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

REVISION DATES: 4/13/22, 9/15/21
EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01; A.A.C. R9-10-101

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS) whose contract includes this requirement. The purpose of this policy is to ensure the timely provision of behavioral health services to children eligible for Title XIX services who are residing with an out-of-home caregiver or children in out-of-home dependency with Department of Child Safety (DCS), as specified throughout this policy, and to adopted children in accordance with A.R.S. § 8-512.01.

DEFINITIONS

Adoptive Parent means any adult who is a resident of Arizona, whether married, unmarried, divorced or legally separated, who has adopted a child. For purposes of this policy, the adoptive parent is that of a child who is eligible under Title XIX of the Social Security Act.

Arizona Department of Child Safety (DCS) is the department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.
2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention, and treatment services pursuant to this chapter.

Behavioral Health Out-of-Home Treatment means highly individualized treatment services and support interventions to meet the needs of each child and their family. When community-based services are not effective in maintaining the child in their home setting, or safety concerns become critical, the use of out-of-home treatment services can provide essential behavioral health interventions to stabilize the situation. The primary goal of out-of-home treatment intervention is to prepare the child and family, as quickly as possible, for the child's safe return to his/her home and community settings.

Crisis means an acute, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior.

Crisis Services means services that are community based, recovery-oriented, and member focused that work to stabilize members as quickly as possible to assist them in returning to

their baseline of functioning.

Member for purposes of this policy includes children residing with out-of-home caregivers, children in out-of-home dependency with DCS, and adopted children.

Out-of-Home Caregiver for purposes of this policy is where a child in DCS custody resides (i.e., kinship care, foster care, a shelter care provider, a receiving home, independent living program or group foster home).

Rapid Response is a process that occurs when a child enters into DCS custody. When this occurs, a behavioral health service provider is referred and then dispatched within 72 hours to assess a child's immediate behavioral health needs and to refer the child for additional assessments through the behavioral health system. (Refer to AdSS Medical Policy 541.)

POLICY

The Administrative Services Subcontractor (AdSS) shall ensure timely provision of all behavioral health services for members enrolled with the DDD Health Plan. The AdSS shall provide coordinated care between the out-of-home caregiver or adoptive parent(s), all providers, and DCS, as appropriate.

A. GENERAL REQUIREMENTS

1. To meet the needs of members residing with out-of-home caregiver, children in out-of-home dependency with DCS, and adopted children, the AdSS shall:

    a. Ensure services delivered are provided as specified in AdSS Operations Policy 417, and

    b. Ensure the availability of a telephone line, with designated staff, adequately trained on the provisions of this policy and the procedures in place to address calls.

B. REQUEST FOR BEHAVIORAL HEALTH OUT-OF-HOME TREATMENT

1. After a request is made to place a member in behavioral health out-of-home treatment, the AdSS shall issue a determination as to that request no later than 72 hours or as expeditiously as the member's health condition warrants due to the member displaying dangerous or threatening behaviors directed towards themselves or others. These settings include, but are not limited to, Behavioral Health Facilities as specified in A.A.C R9-10-101. If the AdSS determines there is insufficient information to make a determination, the AdSS shall document all substantive efforts to obtain required information within the 72-hour timeframe. If the request for behavioral health out-of-home treatment is denied, the AdSS shall ensure medically necessary alternative services are provided. BHRF denials by the AdSS shall be sent to the Division Utilization Management Unit for secondary review by the Behavioral Health Medical Director.

2. If the member is hospitalized due to threatening behaviors prior to a determination on the request for behavioral health out-of-home treatment,

the AdSS shall coordinate with the hospital to ensure an appropriate and safe discharge plan. The discharge plan shall include recommended follow-up services, including recommendations made by the Child and Family Team (CFT). For additional requirements regarding discharge planning refer to the AdSS Medical Policies 580 and 1020.

3. The AdSS shall collaborate with DCS and the Support Coordinator to ensure an appropriate alternative for the member to be discharged when:

   a. It is unsafe for the member to return to the out-of-home caregiver or adoptive parent(s), and/or

   b. It is unsafe for the out-of-home caregiver or adoptive parent(s) for the member to return.

4. The AdSS shall issue a Notice of Adverse Benefit Determination (NOA), as specified in AdSS Operations Policy 414, for any adverse action related to the request for any adverse action related to the request for behavioral health out-of-home treatment.

5. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria 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 caregiver or adoptive parents. In these cases, the AdSS is responsible for payment regardless of principal diagnosis on the claim and may negotiate with the hospital for an appropriate rate.

C. BEHAVIORAL HEALTH APPOINTMENT STANDARD

1. Upon notification from an out-of-home caregiver or adoptive parent that a recommended behavioral health service is not provided to a member (as specified in AdSS Operations Policy 417), the AdSS shall:

   a. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to the Health Plan Customer Service (Mercy Care 800-624-3879 and United Healthcare 800-348-4058), as applicable;

   b. Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the AdSS;

   c. Obtain the name and contact information of the identified non-contracted provider of service, if applicable, to verify their AHCCCS registration; and

   d. Obtain information needed to determine medical necessity of requested services not received.

2. For services provided by a non-contracted provider, the AdSS shall:

a. Not deny claims submitted based solely on the billing provider being out of network, and

b. Reimburse clean claims at the lesser of 130% of the AHCCCS Fee-For-Service Rate or the provider's standard rate and as specified in AdSS Operations Policy 203.

c. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

D. EDUCATION

1. The AdSS is responsible for providing education to providers, members, families, and other parties involved with the member's care, on an ongoing basis. This includes but is not limited to the following areas:

   a. Rights and responsibilities as delineated in A.R.S. §8-512.01,

   b. Trauma-informed care,

   c. Navigating the behavioral health system,

   d. Coordination of care as specified in this policy,

   e. Covered services,

   f. Referral process including Arizona Families First (Family in Recovery Succeeding Together; AFF),

   g. The role of the AdSS,

   h. The role of DCS as applicable, and

   i. Additional trainings identified by the Member Advisory Council or obtained via stakeholder input.

2. The AdSS shall provide training and education to primary care providers regarding the behavioral health referral process.

3. All AdSS member information shall meet the requirements of AdSS Operations Policy 404.

4. The Division reserves the right to verify education programs when performing oversight of the AdSS.

E. REQUIREMENTS FOR CHILDREN IN THE CUSTODY OF DCS

In addition to the requirements above, the AdSS shall also adhere to the requirements included in this section:

1. Telephone Line

   a. Ensure the availability of a telephone line, with designated staff, that is

responsible for handling incoming calls after business hours related to delivery of services, including failure of an assessment team to respond within two hours, and

b. Designated staff shall be adequately trained on the provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There shall be processes in place for staff to:

   i. Address barriers to care,

   ii. Directly contact the crisis services vendor and/or provider,

   iii. Track and report calls as specified throughout Policy, and

   iv. Report the above information to the Children Services Liaison.

2. Continuity of Services

   a. The AdSS are responsible for continuation and coordination of services the member is currently receiving.

   b. If the member moves into a different county because of the location of the out-of-home caregiver, the AdSS must allow the member to continue any current treatment in the previous county and/or seek any new or additional treatment in the current county of residence regardless of the AdSS provider network.

3. Children Services Liaison

   a. The AdSS shall designate an individual whose role is to serve as the member's single point of contact for accepting and responding to:

      i. Inquiries from the out-of-home caregiver, adoptive parent, or providers,

      ii. Issues and concerns related to the delivery of and access to behavioral health services for members,

      iii. Collaborate with the out-of-home caregiver and adoptive parents to address barriers to services, including nonresponsive crisis providers, and

      iv. Resolve concerns received in accordance with grievance system requirements.

   b. The Children Services Liaison shall:

      i. Provide the number for crisis services and afterhours telephone line in their outgoing voicemail message and email,

      ii. Provide an expected timeframe for return calls in their outgoing voicemail message and email,

iii. Respond to all inquiries as indicated by need or safety but no later than one business day, and

iv. Follow up on all calls received by the afterhours telephone line.

c. The AdSS shall ensure the Children Services Liaison contact information is:

i. Provided to DDD and DCS for distribution,

ii. Prominently placed on the member page of the AdSS' website, and

iii. Included in the Member Handbook.

d. The AdSS shall ensure calls received by the Children Services Liaison that meet the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

F. TRACKING AND REPORTING

1. The AdSS shall:

a. Monitor, as specified in Contract, an Access to Services Report using Attachment A to ACOM 449:

b. Monitor on a monthly basis, and submit as specified in Contract, the number of calls and emails received by the Children Service Liaison and the afterhours line related to children residing with out-of-home caregiver or children in out-of-home dependency with DCS specific to this Policy (Attachment B to ACOM 449), and

c. Monitor on a monthly basis, and submit as specified in Contract, a Rapid Response Reconciliation reporting all Rapid Response information for children in DCS custody (Attachment B). The AdSS shall perform a reconciliation of members placed in DCS custody in contrast to those who have received a Rapid Response service. For any identified members in DCS custody who have not been engaged in behavioral health services, the AdSS shall ensure a Rapid Response service is delivered. For any identified members in DCS custody who are already receiving or otherwise are engaged in behavioral health services, the AdSS shall ensure an assigned service provider contacts the member and caregiver to conduct an assessment of the current status.

G. DIVISION OVERSIGHT OF AdSS

The AdSS shall comply with the Division oversight activities including but not limited to the following methods to ensure compliance with this policy and policies referenced within this policy:

1. Annual Operational Review of related standards including but not limited to:
    a. AdSS has policies and procedures in place and demonstrates compliance to ensure members in foster care receive behavioral health services in alignment with this policy and AdSS 417.
    b. AdSS demonstrates compliance with the initiation and coordination of a referral when a behavioral health need has been identified and follows up to determine if the member received behavioral health services.
    c. AdSS provides evidence of training and education provided to primary care providers regarding the behavioral health referral process.
    d. AdSS monitors for evidence in the medical record and the member's individual service plan that medically necessary services were determined by a qualified behavioral health professional.
2. Receive and review deliverable reports to ensure compliance and address service gaps or non-compliance. Submit collated data received from the AdSS and submit reports as required by contract to AHCCCS.
    a. AHCCCS Deliverable Attachment A to ACOM 449
    b. AHCCCS Deliverable Attachment B to ACOM 449
    c. AHCCCS Deliverable Attachment A to ACOM 417
3. Conduct a cadence of oversight meetings with each AdSS for the purpose of reviewing compliance and addressing concerns with access to care or other quality of care.
4. Ongoing monitoring and evidence of compliance through Behavioral Health Chart Audits.

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.

1022 JUSTICE REACH-IN

EFFECTIVE DATE: January 18, 2023

REFERENCES: 42 CFR § 438.62(b); A.R.S.§ 36-551; AMPM 1022; AMPM 541

PURPOSE

This policy applies to the Division's Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop a process for justice system reach-in care coordination activities, to support facilitating transition of members who have chronic and/or complex care needs out of jails and prisons, into communities.

DEFINITIONS

1. "Administrative Services Subcontract/Subcontractor" means a person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor. Providers are not Administrative Services Subcontractors.
2. "Care Management" means a group of activities performed to identify and manage clinical interventions or alternative treatments for identified members to

reduce risk, cost, and help achieve better health outcomes. Distinct from Case Management, Care Management does not include the day-to-day duties of service delivery.

3. "Justice System Liaison" for the purpose of this policy means a Division staff person who is located in Arizona and is the single point of contact for justice system stakeholders, such as jails/prisons/detention facilities, courts, law enforcement, and community supervision agencies. This position is responsible for ensuring care coordination of justice-involved members and for oversight and reporting of Justice System reach-in Care Coordination activities. This position also serves as the single point of contact for justice system stakeholders engaged programmatically in arrest diversion or incarceration alternative initiatives intended to reduce the number of individuals from entering the justice system. This includes, but is not limited to, sequential intercept modeling, crisis system utilization, and

specialty court programs.

POLICY

A. JUSTICE REACH-IN

1. Administrative Services Subcontractors shall notify the Division's Justice System Liaison, upon becoming aware that a Division member has become an inmate of a public institution.

2. The AdSS shall assist the Justice System Liaison in reach-in care coordination efforts, for members who have been incarcerated for 20 days or longer and have an anticipated release date.

3. The AdSS shall establish care management protocols for members involved in reach-in care coordination, which include but are not limited to members who have substance abuse disorder and/or meet medical necessity criteria to receive Medication Assisted Treatment (MAT), as consistent with AMPM 1022.

4. The AdSS shall notify the Division upon becoming aware that the incarcerated member's enrollment has not been suspended

to allow the Division to adjust eligibility dates, based upon AHCCCS' notification of incarceration in AHCCCS' 834 files sent to the Division.

5. The AdSS shall also utilize the renewal date information to identify incarcerated members who may have missed their eligibility redetermination dates while incarcerated causing a discontinuance of benefits, and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

6. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections, Rehabilitation, and Reentry (ADCRR) to provide care management to members

7. The AdSS shall begin reach-In care activities upon knowledge of a member's anticipated release date and shall include education regarding care, services, resources, appointment information, subcontracted provider and care management contact information.

8. The AdSS shall monitor progress and submit a monitoring

progress report throughout the year as specified in the current Contract.

5000 REINSURANCE POLICY

REVISION DATE: 11/8/2023
EFFECTIVE DATE: December 15, 2021
REFERENCES: Section F3, Contractor Chart of Deliverables; 42 U.S.C. § 1396b (i); 42 USC § 1396d(r)(5); 42 CFR § 441.35; 42 CFR § 433.135 et seq.; A.R.S. § 36-2903; A.R.S. § 8-512; Title XIX/XXI; A.A.C. R9-22-1001; A.A.C. R9-22-720; AHCCCS Reinsurance Manual; AHCCCS Contract; DDD Health Plans Contract; ACOM 408; ACOM 414; AMPM 1620-I; AMPM 310-DD; AMPM 300-2A; DDD Medical Policy Manual, Policy 310-DD; AdSS Operations Manual, Policy 414; AdSS Medical Manual, Policy 1001

PURPOSE

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

DEFINITIONS

1. "Adjudicated Claim" means a claim that has been received and processed by the AdSS which resulted in payment or denial of payment.
2. "Administrative Services Subcontract" means an agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following: 1. Claims processing, including pharmacy claims, 2. Pharmacy Benefit Manager (PMB), 3. Dental Benefit Manager, 4. Credentialing, including those for only

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

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

7. “Biologic Drugs” means products produced by biotechnology. These drugs are referred to as biologicals, biological drugs, or biopharmaceuticals.
8. “Case” means a record for a Member that is composed of one or more Adjudicated Encounters.
9. “Case Type” means a description of the type of Reinsurance being paid to the AdSS based on the Member’s medical condition and eligibility. Case Types include, but are not limited to DES, Hemophilia, von Willebrand Disease, Gaucher’s Disease, Biologic or high cost specialty drugs, transplants, and High Cost Behavioral Health Services.
10. “Catastrophic Reinsurance” means reimbursement, full or partial, depending on the Case Type, from the Division to the AdSS for the cost of care associated with certain medical conditions and specific drugs described in the Contract, AMPM, and DDD policy.
11. “Clean Claim Status” or ”Clean Encounter” means a claim or Encounter that may be processed in the AHCCCS Prepaid Medical Management Information System (PMMIS) without obtaining additional information from the Contractor of service or from a third party and has passed all of the Encounter and Reinsurance edits within the 15 month timely

filing deadline. This does not include claims being appealed or claims that are the subject of a grievance, under investigation for fraud or abuse, or claims under review for medical necessity.

12. "Coinsurance" means the percentage rate established each Contract Year by AHCCCS, at which the Division will reimburse the AdSS for covered services above the Deductible.
13. "Contract" means, for the purposes of this policy, the legal written agreement that the Division has with AHCCCS for providing health care coverage to Members who are eligible for ALTCS. This coverage includes physical health services and Behavioral Health Services.
14. "Contractor" or "Division", for the purposes of this policy, means an organization or entity that has a prepaid capitated contract with AHCCCS to provide goods and services to Members, either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS statutes and rules, and Federal law and regulations.
15. "Contract Year" means the twelve-month period beginning on October 1st through and including September 30th for Reinsurance. The

Contract Year may not correspond with the term of a Contract as specified in Section A of an entity's Contract with AHCCCS.

16. "Deductible" means the annual amount established each Contract Year by AHCCCS, of Reinsurance covered services that must be paid and encountered by the AdSS for each individual Member before the AdSS receives Reinsurance payments from the Division.

17. "DES Case Type" means certain covered inpatient facility services as described in the Contract, AMPM, and this policy that may qualify for Reinsurance reimbursement.

18. "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" means covered services for Members under 21 to correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of "Medical Assistance" as defined in the Medicaid Act (Federal Law Subsection 42 USC 1396d (a)). Services are covered under EPSDT even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

19. “Encounter” means a record of health care related service that is a mirror image of a claim and is rendered by a provider or providers registered with AHCCCS to a Member who is enrolled with the Division on the date of service.
20. “Gaucher’s Disease” means an inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
21. “Hemophilia” means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of hemophilia - A, B, and C. The severity of hemophilia is related to the amount of clotting factor in the blood.
22. “Hemophilia” means a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of Hemophilia - A, B, and C. The severity of Hemophilia is related to the amount of clotting factor in the blood.
23. “High Cost Behavioral Health” or “BEH” means specialized mental health services for ALTCS Members that were discontinued under

Catastrophic Reinsurance, unless the Member was approved prior to October 1, 2007 and was active on September 30, 2007.

24. “Member” means the same as “client” as defined in A.R.S. § 36-551.
25. “Notice of Adverse Benefit Determination” means a written notice provided to the Member that explains the reasons for the Adverse Benefit Determination made by the AdSS regarding the service authorization request and includes the information required by this Policy.
26. “Prepaid Medical Management Information System” or “PMMIS” means the AHCCCS mainframe pricing system of record that the Division uses for accessing the Reinsurance System.
27. “Prior Period Coverage” or “PPC” means the period of time prior to the Member’s enrollment, during which a Member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a Member is enrolled with the Division.
28. “Prospective Coverage” means the period of time from when the AdSS receives notification the Member has been assigned to their plan and is expected to be capitated for the Member.

29. “Regular Reinsurance” means a partial reimbursement from AHCCCS to the Division for covered inpatient facility services (DES Case Type) as described in the Contract, AMPM, and DDD policy.
30. “Reinsurance” or “RI” means a stop-loss program provided by AHCCCS to the Division for the partial reimbursement of covered medical services incurred for a Member beyond an annual Deductible level.
31. “Reinsurance Payment Cycle” means the monthly updating of Reinsurance files in PMMIS for payment processing starting the first Wednesday of the month from 5:00 p.m. until the following Wednesday morning.
32. “Reinsurance System” means the PMMIS application for accessing Reinsurance Case data.
33. “Second Level Review” means a review performed by a Division Medical Director who has the appropriate clinical expertise in managing a Member’s condition or disease. Second Level Review is used to screen for medical necessity and compare the findings to clinical data in the Member’s medical record to ensure Division Members are receiving medically appropriate and high quality care.

34. "Skilled Nursing Facility" or "SNF" means a nursing facility for those Members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.

35. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a Member eligible for AHCCCS benefits."Von Willebrand Disease" means an inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

POLICY

A. GENERAL REINSURANCE REIMBURSEMENT REQUIREMENTS FOR ALL CASE TYPES

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

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

4. The AdSS shall ensure Encounters meet the following criteria to qualify for Reinsurance reimbursement:
   a. The Encounter is approved and adjudicated within required time frames per the AHCCCS Contract and this policy;
   b. The Encounter associates to a Reinsurance Case;
   c. The Encounter is medically necessary;
   d. The service is non-experimental;
   e. The service is cost effective; and
   f. The service does not exceed an established cost threshold.
5. The AdSS shall not submit final Reinsurance claims which cross over Contract Years.
6. The AdSS shall base reimbursement of all covered Reinsurance Encounters on the following, unless costs are paid under a sub-capitated arrangement as outlined in subsection (8):
   a. Costs paid by the AdSS;
   b. Net of interest;
   c. Penalties;

d. Discounts;

e. AHCCCS Coinsurance rates;

f. Medicare payment; and

h. Third Party Liability (TPL) payment.

7. The AdSS shall base reimbursement of Reinsurance Encounters for costs paid under a sub-capitated arrangement on the following:

    a. The lower of the AHCCCS allowed amount;

    b. Reported AdSS paid amount;

    c. Net of interest;

    d. Penalties;

    e. Discounts;

    f. AHCCCS Coinsurance rates;

    g. Medicare payment; and

    h. TPL payment.

8. The AdSS shall refer to the Reinsurance page on the AHCCCS website for current:

    a. Deductible levels;

    b. Coinsurance rates;

c. Eligibility requirements;

d. Documentation requirements;

e. Covered high cost or Biologic Drugs;

f. Required time frames for submitting documentation and requests;

g. Reinsurance forms;

h. AHCCCS Reinsurance policy;

i. Transplant rates and Contracts; and

j. Reinsurance processing training manual and instructions.

9. The AdSS shall coordinate benefits with first party, Medicare, and TPL payers as required by Division Operations Policy Chapter 4001 and by the AHCCCS Contract.

11. The AdSS shall submit requests for Reinsurance reimbursement to the Division by 5:00 p.m. if the due date lands on a business day; or by 5:00 p.m. the next business day, if the due date lands on a weekend or State-recognized holiday.

12. The AdSS shall comply with medical audits on Reinsurance Cases upon request from the Division.

B. REGULAR REINSURANCE (DES CASE TYPE) REQUIREMENTS

1. The AdSS shall submit reimbursement requests for the following Regular Reinsurance covered inpatient hospital services provided to Members:
    a. Acute care hospitals (provider type 02);
    b. Specialty per diem hospitals (provider type C4);
    c. Accredited psychiatric hospitals (provider type 71);
    d. Per diem rates for Skilled Nursing Facility (SNF) services provided within 30 days following an acute inpatient hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any Contract Year when:
        i. The SNF stay is the first continuous SNF stay post inpatient discharge; or
        ii. The second SNF admission follows an additional inpatient stay.
    e. Services specified in the AHCCCS Reinsurance System RI325 screen entitled “RI Covered Services”.

2. The AdSS shall not request Regular Reinsurance from the Division for the following inpatient provider service types that are not covered by AHCCCS:
   a. Same day admit-and-discharge services;
   b. Mental health residential treatment centers;
   c. Subacute facilities; and
   d. Services that are not specified in the AHCCCS Reinsurance System RI325 screen entitled "RI Covered Services".
3. The AdSS may request Regular Reinsurance reimbursement for the Member's Prospective Coverage and Prior Period Coverage (PPC) enrollment periods.
4. The AdSS shall not submit requests for Regular Reinsurance on the following types of claims:
   a. Final claims that cross over Contract Years; and
   b. Interim claims.
5. The AdSS shall request Regular Reinsurance consideration from the Division for the final claim associated with the full length of a Member's hospital stay as long as the days of the hospital stay do not cross Contract Years.

C. GENERAL CATASTROPHIC REINSURANCE REQUIREMENTS

1. The AdSS shall request from the Division partial reimbursement of Catastrophic Reinsurance for medically necessary covered services provided to Members for the following Case Types:
   a. Hemophilia;
   b. Von Willebrand Disease:
   c. Gaucher's Disease;
   d. Biologic or high-cost specialty drugs;
   e. High Cost Behavioral Health; and
   f. Case Types other than transplants exceeding $1 million.
2. The AdSS shall not pay Deductibles for Catastrophic Reinsurance Cases.
3. The AdSS shall request a new Catastrophic Reinsurance Case by submitting the following documents to the Division for initial review and submittal to AHCCCS within 30 days of the identification of the Member's initial diagnosis or enrollment with the AdSS:
   a. The Request for Catastrophic Reinsurance form; and
   b. Supporting clinical documentation.

4. The AdSS shall ensure the Member's medical condition meets the criteria in Sections D, E, and F prior to submitting a new request for a new Catastrophic Reinsurance Case to the Division.
5. The AdSS shall submit the following documentation to the Division within 30 days of the start of the Contract Year for continuation of previously approved Catastrophic Reinsurance Cases:
   a. The Request for Catastrophic Reinsurance form; and
   b. The Non-Transplant Catastrophic Reinsurance Member List form.
6. The AdSS shall provide the Division with supporting clinical documentation for previously approved Catastrophic Reinsurance Cases upon request.
7. The Division shall submit approval or denial letters received from AHCCCS in response to Request for Catastrophic Reinsurance forms to the AdSS that submitted the request.
8. The AdSS shall utilize the AHCCCS Contract for Hemophilia factor and blood disorders as the authorizing payor.

9. The Division shall reimburse the AdSS for all medically necessary services provided during the Contract Year:
   a. The current Coinsurance Rate for Catastrophic Cases; or
   b. The AdSS's paid amount, whichever is lower, depending on the subcap/CN1 code on the Encounter.
10. The Division shall reimburse the AdSS Catastrophic Reinsurance retroactively for a maximum of 30 days from the date the request is received by the AHCCCS.
11. The AdSS shall be responsible for prior authorization and care coordination for all components covered under the Contract for their Members.
12. The AdSS shall submit Reinsurance requests to the Division for catastrophic claims that contain any PPC and Prospective Coverage.

D. CATASTROPHIC REINSURANCE REQUIREMENTS FOR BLOOD DISORDERS

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

2. The AdSS shall request Catastrophic Reinsurance for Members diagnosed with the following von Willebrand Disease types only:
    a. Type 1 and Type 2A that do not respond to desmopressin (DDAVP);
    b. Type 2B, Type 2M, and Type 2N based on diagnosis only; and
    c. Type 3 based on diagnosis only.
3. The AdSS shall review clinical records to confirm the Member's type of von Willebrand's Disease and whether or not the Member has responded to a DDAVP medication prior to requesting Catastrophic Reinsurance.
4. The AdSS shall request Catastrophic Reinsurance for all Members diagnosed with Gaucher's Disease Type I.
5. The AdSS shall not request Catastrophic Reinsurance for Gaucher's Disease Type 2 and Type 3.

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

1. The AdSS shall request Catastrophic Reinsurance to cover the cost of medically necessary Bologic and high cost specialty drugs for Members. .
2. The AdSS shall request Catastrophic Reinsurance for the covered Biologic and high cost specialty drugs listed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website.
3. The AdSS shall be reimbursed the following by the Division when a biosimilar or generic equivalent of a Biologic Drug is available and AHCCCS has determined that the biosimilar is more cost effective than the brand-name product:
    a. The current Catastrophic Coinsurance rate of the lesser of the Biologic or high cost or its biosimilar equivalent for Reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific Member.
    b. The current Catastrophic Coinsurance rate of the paid amount of the branded Biologic Drug if the AHCCCS Pharmacy and Therapeutics Committee mandates the

utilization of only the brand name Biologic or high-cost specialty drug rather than the biosimilar.

4. The AdSS shall be reimbursed the Catastrophic Coinsurance rate the lesser of the following by the Division in the instances in which AHCCCS has specialty Contracts, or when legislation and policy limits the allowable reimbursement,:
   a. The AHCCCS contracted or mandated amount;or
   b. The AdSS's paid amount.
5. The AdSS may submit requests for new biological drugs or high-cost specialty drugs to the Division for consideration for Reinsurance purposes.
6. The AdSS shall encounter all Biologic or high-cost specialty drugs on a Form C pharmacy claim to be eligible for Reinsurance.

F. CATASTROPHIC REINSURANCE REQUIREMENTS FOR HIGH COST BEHAVIORAL HEALTH

1. The AdSS shall request Catastrophic Reinsurance reimbursement from the Division for medically necessary covered services provided during the Contract Year for Members enrolled in the

High Cost Behavioral Health (BEH) Program prior to October 1, 2007.

2. The AdSS shall submit the following to the Division no later than 10 business days prior to the expiration of the current approval to request continuation of BEH Reinsurance reimbursement:
   a. The High Cost Behavioral Health Reinsurance form, located in the AHCCCS website reauthorization request; and
   b. Supporting medical documentation as required in AMPM 1620-I.
3. The AdSS shall comply with the 10 business day timeframe and documentation requirements as required in item 2 of this section or the Division will deny additional Reinsurance reimbursement.
4. The AdSS shall ensure Encounters for covered services provided to enrolled BEH Members are adjudicated to be eligible for Reinsurance reimbursement.
5. The AdSS shall ensure medical documentation substantiating the Member's treatment is provided in the least restrictive treatment setting to be eligible for Reinsurance.

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

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

1. The AdSS shall request Reinsurance reimbursement for all medically necessary Reinsurance covered expenses provided in a Contract Year, after the Reinsurance Case total value meets or exceeds $1 million, which is comprised of:
   a. The total AdSS paid amount; and
   b. The Deductible.
2. The AdSS shall notify the Division once a Reinsurance Case total value reaches $1 million.
3. The AdSS shall submit the following to the Division once a Reinsurance Case total value reaches $1 million:
   a. Request to create Case Types:
      i. Catastrophic Regular Acute (DDC);
      ii. Catastrophic Hemophilia (CHM);

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

iv. Catastrophic ALTCS (CLT).

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

4. The Division shall disqualify the AdSS from receiving reimbursement for Catastrophic Cases and related Encounters exceeding $1 million when the AdSS fails to do the following within 15 months of the end date of service:

a. Notify the Division of a Reinsurance Case reaching $1 million; or

b. Notify the AHCCCS Reinsurance Unit of Encounters that should be transferred; or

c. Adjudicate related Encounters.

H. TRANSPLANT REINSURANCE OVERVIEW

1. The AdSS shall request the AHCCCS contracted Coinsurance rate for transplant services from the Division for the cost of care for enrolled Members:

a. Age 21 years and older who meet transplant Reinsurance coverage criteria for the specific transplant types listed in AMPM 310-DD and the AHCCCS State Plan.

b. Under age 21, who under the EPSDT Program, are covered for all non-experimental transplants necessary to correct or ameliorate defects, illnesses, and physical conditions whether or not the particular non-experimental transplant is covered by the AHCCCS State Plan or listed in AMPM 310-DD.

2. The AdSS shall comply with the terms and conditions of the AHCCCS transplant specialty Contract.

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

4. The AdSS shall request transplant Reinsurance at the current AHCCCS contracted rates located on the AHCCCS website for the following transplant components:

   a. Outpatient transplant evaluation;

   b. Donor search and harvesting of the donor cells for stem cell transplants;

c. Preparation and transplant; and

d. Post-transplant care (Days 1 – 30 and Days 31 – 60).

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

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

a. Prior authorization; and

b. Care coordination.

I. TRANSPLANT CASE CREATION REQUIREMENTS

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

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

b. Supporting clinical documentation; and

c. AdSS policy supporting the transplant.

2. The AdSS, prior to submitting the request for transplant Reinsurance to the Division, shall ensure the documentation listed in item 1 of this section confirms the transplant is:
    a. Medically necessary;
    b. Covered by AHCCCS;
    c. Considered the standard of care; and
    d. Not considered experimental.
3. The AdSS shall submit the Transplant Reinsurance Crossover List, located on the AHCCCS website, to the Division for AHCCCS approval of Members requiring continuation of previously approved transplant Reinsurance.
4. The Division may deny Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean Reinsurance claims; or
    b. Failure to submit the Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

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

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

J. REQUIRED TRANSPLANT CASE COMMUNICATION

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

iii. Transplant Cases that are closed and rationale,

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

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

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

   a. Members who expired.

   b. Members removed from the transplant wait list.

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

   d. Members who terminated with the AdSS.

   e.

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

K. TRANSPLANT CLAIM REINSURANCE REIMBURSEMENT

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

b. Medicare Parts A and B.

6. The AdSS may request transplant Reinsurance reimbursement, less any payments received from Medicare, for Members with Medicare coverage under the below circumstances:

   a. If the Member has Medicare Part A and has exhausted their Medicare Part A benefit including lifetime reserve days during a transplant stage, only that stage and subsequent stages may qualify for Reinsurance.

      i. If the Member chooses not to use their available lifetime reserve days, the transplant stages will not qualify for transplant Reinsurance.

   b. If the Member has Medicare Part B only.

   c. If the Member qualifies for partial transplant coverage, an explanation of benefits (EOB) with Medicare payments must:

      i. Balance with the Medicare payments in PMMIS; and

      ii. State that the Member has exhausted Medicare Part A.

7. The AdSS shall request transplant Reinsurance reimbursement if Medicare does not cover a transplant type based on the Member's diagnoses and the transplant type is an AHCCCS covered benefit.
8. The AdSS shall not request quick pay discounts or interest to transplant Reinsurance reimbursements.
9. The Division shall retroactively reimburse transplant Reinsurance to the AdSS a maximum of 30 days from the date the Request for Transplant Reinsurance form was received and approved by AHCCCS.
10. The AdSS shall submit clean Reinsurance claims to the Division no later than 15 months from the end date of service for each transplant component in order to receive transplant Reinsurance reimbursement.
11. The Division may deny transplant Reinsurance reimbursement to the AdSS for:
    a. Failure to timely submit clean transplant Reinsurance claims; or

b. Failure to submit the Request for Request for Transplant Reinsurance form to the Division within 30 days of the first component of the transplant.

12. The AdSS shall file transplant Encounters with a CN1 code of 09 to ensure the Encounter associates to a Case.

13. The AdSS shall void and replace an incorrectly coded transplant Encounter with the correct CN1 code if there is more than 45 days before the 15 month timely filing deadline.

14. If there is less than 45 days before the 15 month timely transplant claim filing deadline, the AdSS shall

    a. Submit a request to the Division to manually associate transplant Encounters to the transplant Case; and

    b. Submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15 month timely filing deadline.

15. The AdSS shall request transplant reimbursement for adjudicated Encounters that are associated with the transplant Case.

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

L. REQUIREMENTS FOR TRANSPLANTS THAT SPAN CONTRACT YEARS

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

M. OUTLIER THRESHOLD COVERAGE FOR TRANSPLANTS

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

a. Transplant Outlier Template form located on the AHCCCS website; and

b. The documentation listed in the outlier checklist from the AHCCCS Reinsurance Processing Manual.

N. CLAIM ENCOUNTER DOCUMENTATION AND TIMEFRAMES FOR TRANSPLANT CONTRACTS

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

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

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

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

1. The AdSS shall apply the following requirements for continuous post-transplant inpatient care from the date of the prep and transplant component from day 11+ and for kidney transplants and from day 61+ for all other Case Types:
    a. The AdSS shall request reimbursement at 75% of the transplant per diem rate less the Deductible for claims or Encounters for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other Case Types for all Members.

b. The AdSS shall request outlier reimbursement when the cost threshold of the claim or Encounter for the continuous inpatient stay for day 11+ for kidney transplants and day 61+ for all other Case Types is met or exceeded.

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

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

2. The AdSS shall submit the Day 11+ or 61+ Outlier Worksheet and Instructions form, located on the AHCCCS website, to the Division to request outlier reimbursement for transplant days 11+ and 61+ paid at the per diem rate pursuant to the AHCCCS transplant specialty contract at an established cost threshold.

P. TRANSPLANT TRANSPORTATION AND LODGING REINSURANCE REIMBURSEMENT REQUIREMENTS

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

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

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

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

1. The AdSS may submit a request to the Division for authorization from AHCCCS for transplant Cases that overlap when a second transplant component is started within the timeframe of an established component.
2. If a Member requires a multi-organ transplant the AdSS shall request Reinsurance for the following:
   a. The preparation and transplant components for each organ when performed separately; and
   b. The post-transplant component that provides the AdSS with the highest reimbursement and covers the longest period of time.

c. The surgical component of the second transplant, if a second covered organ transplant is performed during the post-transplant periods of the first transplant.

3. If approved by AHCCCS, the Division shall prorate the first transplant component and provide Reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1 - 30 post-transplant component and the day 31 - 60 post-transplant component.

4. The AdSS shall follow all applicable notification and claims filing requirements when requesting authorization for Reinsurance reimbursement for multi-organ transplants that are not covered by AHCCCS.

R. MULTI-SEQUENCE TRANSPLANTS

1. The AdSS may submit a request to the Division for authorization from AHCCCS for a transplant Case that requires an additional transplant for the same transplant type and an additional transplant sequence is started within the timeframe of an established component.

2. If a Member requires a second sequence transplant, the AdSS shall request Reinsurance for the initial transplant until the prep and transplant of the additional sequence occurs.
3. If an additional sequence is performed during the post-transplant periods of the previous transplant, the Division, upon approval from AHCCCS, shall reimburse the AdSS the prorated transplant component that coincides with the prep and transplant of the following sequence.
4. The AdSS shall follow all applicable notification and claims filing requirements when requesting Reinsurance reimbursement for multi-sequence transplants.

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

1. The AdSS, prior to the Member receiving out of state transplant services, shall request approval for Reinsurance from AHCCCS if the transplant services are:
    a. At non-contracted transplant facilities; or
    b. At out-of-state contracted facilities for non-contracted transplant types.

2. The AdSS shall obtain prior approval from the AHCCCS Medical Director for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service.
3. The AdSS shall, if prior approval is not obtained for using an out of state non-contracted facility for an AHCCCS covered and contracted transplant service:
    a. Incur costs for transplant services at the out of state facility;
    b. Be ineligible for either transplant or Regular Reinsurance; and
    c. Be ineligible for costs to be excluded from any applicable reconciliation calculations.
4. The AdSS shall request Reinsurance reimbursement for an approved transplant performed out of state at a non-contracted facility at 85% of the lesser of:
    a. The AHCCCS transplant contracted rate for the same organ or tissue, if available; or
    b. The AdSS paid amount.

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

T. ENCOUNTER SUBMISSION REQUIREMENTS

1. The AdSS shall submit Encounters that associate to a Reinsurance Case to qualify for reimbursement of Reinsurance claims.
2. The AdSS shall ensure all Reinsurance-associated Encounters except as provided below for claim disputes, reach an adjudicated status within 15 months from the end date of service, or date of eligibility posting, whichever is later to be considered as timely filed:
   a. Replacements;
   b. Voids; and

c. New day Encounters.

3. The AdSS shall not manually replace or void Encounters during the Reinsurance Payment Cycle, or the AdSS may be subject to administrative action by AHCCCS.
4. The AdSS shall void Encounters that are recouped in full.

U. TIME LIMITS FOR FILING REINSURANCE CLAIMS

1. The Division shall pay the AdSS's Reinsurance claims for Regular Reinsurance Cases that are created automatically by PMMIS once the Encounter reaches an adjudicated status through the Encounter System.
2. The AdSS shall submit written requests for Reinsurance consideration for all other Reinsurance claims to the Division, except for Regular Reinsurance, using the forms and adhering to the claims submission time frames as required in this policy.
3. The AdSS shall submit Encounters that have attained clean status no later than 15 months from the end date of service.
4. The AdSS shall submit retro-eligibility Encounters that have attained a Clean Claim status no later than 15 months from the date of eligibility posting.

5. For Encounters undergoing Member appeal, provider claim dispute, grievance or other legal action, including an informal resolution originating from a request for a formal claim dispute or Member appeal, the AdSS shall ensure:
    a. The decision letter is received by AHCCCS no later than 90 days from the date of the final decision in that action; and
    b. The Encounters reach adjudicated status no later than 90 calendar days from the date of the final decision in that action, even if the 15-month deadline for attaining Clean Claim status has expired.
6. The Division shall not reimburse the AdSS Reinsurance if the AdSS fails to submit the adjudicated Encounter and the decision documentation within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director's decision, or other legal action, whichever is applicable.

V. ADMINISTRATIVE DISPUTE REQUIREMENTS

The AdSS shall follow the administrative dispute process as instructed in the AHCCCS Reinsurance Processing Manual located on the AHCCCS website, if the AdSS has exhausted Reinsurance refiling or

reconsideration processes and still disagrees with an action taken regarding a Reinsurance claim.

W. DIVISION OVERSIGHT OF THE ADSS

1. The Division shall oversee the AdSS utilizing the following methods to ensure compliance with policy:
    a. Annual Operational Review of each AdSS,
    b. Review and analyze deliverable reports submitted by the AdSS, and
    c. Conduct oversight meetings with the AdSS for the purpose of:
        i. Reviewing compliance,
        ii. Addressing concerns with access to care or other quality of care concerns,
        iii. Discussing systemic issues, and
        iv. Providing direction or support to the AdSS as necessary.

SUPPLEMENTAL INFORMATION

A. ENCOUNTER VOIDS AND REPLACEMENTS

1. When a void Encounter is submitted for a previously paid associated Reinsurance Encounter, the Reinsurance payment related to the voided Encounter will be recouped by AHCCCS.
2. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is less than the original AdSS paid amount, the difference will be recouped by AHCCCS.
3. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS paid amount, the additional amount will be paid if the replacement Encounter was adjudicated and reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.
4. When a replacement Encounter is submitted timely for a previously paid associated Reinsurance Encounter and the replaced AdSS paid amount is greater than the original AdSS

paid amount, but the replacement Encounter was not adjudicated and did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same Encounter cycle, then the original AdSS paid amount will be recouped AHCCCS.

5. When a replacement Encounter is not submitted timely, and does not adjudicate to Encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of eligibility posting, whichever is later, within the same Encounter cycle it was submitted, and any of the following scenarios occur:
   a. The original Encounter was never associated to a Reinsurance Case; or
   b. The original Encounter was never associated to a Reinsurance Case; or
   c. The original Encounter associated with a Reinsurance Case but never reached pay status (PY); or
   d. The original Encounter has a previous Reinsurance paid amount of zero ($0.00):

i. The replacement Encounter is then subject to the Reinsurance timely filing limit edits:

1) H583 Reinsurance claim received more than 15 months after end date of service; or

2) H584 Reinsurance claim received more than 15 months after eligibility posting.

6. When a Replacement Encounter is:

a. Not submitted timely; and

b. Did not adjudicate; and

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

d. The original Encounter (Encounter identified on the 837 & NCPDP) Reinsurance paid amount is greater than $0:

i. The original AdSS paid amount will be recouped by AHCCCS.

7. The replacement Encounter consists of a two-step process:

a. The original AdSS paid amount will be recouped by AHCCCS.

b. The replacement Encounter transaction or process.

B. THIRD PARTY LIABILITY

1. Failure to comply with the TPL notification requirements may result in those sanctions specified in the AHCCCS Contract.
2. Should AHCCCS or its authorized representative identify third party recovery payments received by the Contractors that do not comply with the notification requirements in this section the following actions shall occur:
   a. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.
   b. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor’s contingency fee schedule shall be added to the billing.
3. In addition, the Medicare Allowed, Medicare Paid, Third Party Payments and Value Code fields, as applicable, must be

completed when the Encounter is submitted for Reinsurance consideration.

C. MEDICARE

1. Medicare Calculations

    a. The Reinsurance system does not calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data is populated and mapped from the fields in the Encounter system.

    b. If there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter, then the Contractor must address these issues with the AHCCCS Encounter Unit.

2. PMMIS' view of Medicare

    a. The Encounter System categorizes Medicare as the type of Medicare appropriate for the stay. Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Part A dollars.

b. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Part B dollars.

c. Scenario Examples:

i. If the Member has only Medicare Part B and the Encounter is for an inpatient stay, then on the Encounter the Medicare Part B dollars should be placed under Other Coverage.

ii. If the Member has only Medicare Part B and the Encounter is for a doctor visit, then on the Encounter the Medicare Part B dollars should be placed under Medicare Coverage.

Form Type	Type of Medicare	Field on Encounter
I	Medicare Part A	Medicare
	Medicare Part B	Other Insurance
A	Medicare Part A	Does Not Apply
	Medicare Part B	Medicare
O	Medicare Part A	Other Insurance
	Medicare Part B	Does Not Apply

3. Medicare Lesser of Logic

a. The Medicare copay, Coinsurance, or Deductible, or

b. The difference between the Contractor's contracted rate and the Medicare paid amount.

4. Edit A510

   a. Medicare Deductible and Coinsurance Exceeds Allowed Amount

      i. Reinsurance Internal Pend

   b. Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.

Quick Reference

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

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

Summary of Reinsurance Coverage

Case Type	***Deductible***	***Co-Ins***
RAC-Acute Contractors	$75,000	75%
RAC-DCS/CHPContractor	$75,000	75%
Catastrophic–Biologics/ High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High$	n/a	100%
Hemophilia	n/a	85%
Von Willebrand's	n/a	85%
Gaucher’s	n/a	85%
State Only Termination	n/a	100%
High Cost Behavioral Health	n/a	75%
DES - DDD	$75,000	75%
RAC-ALTCS – EPD MC PT.A 0-1,999	$10,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	$20,000	75%
AC-ALTCS – EPD No PT.A 0-1,999	$20,000	75%
RAC-ALTCS – EPD No PT.A 2,000+	$30,000	75%

Reinsurance Contract Year	Contract Year Ending
YR 38	10/1/194 – 9/30/20
YR 39	10/1/20 – 9/30/21
YR 40	10/1/21– 9/30/22
YR 41	10/1/22 – 9/30/23
YR 42	10/1/23 – 9/30/24
YR 43	10/1/24 – 9/30/25
YR 44	10/1/25– 9/30/26

Reinsurance Reports

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

RI91L205 - Reinsurance Pend Report

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

RI81L310 - Reinsurance Remittance Advice Report

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

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

RI91L105 - Reinsurance Case Summary Report

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

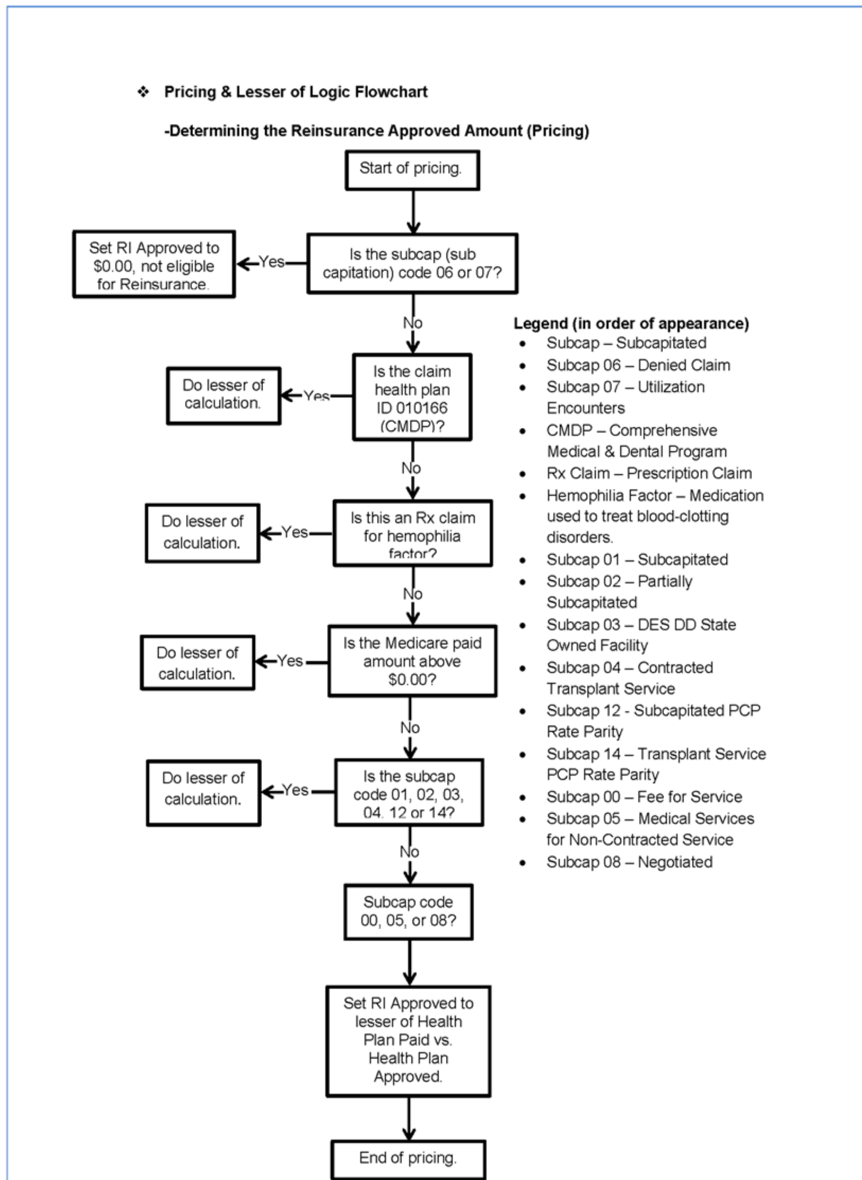
RI91L100 - Reinsurance Case Initiation Report

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

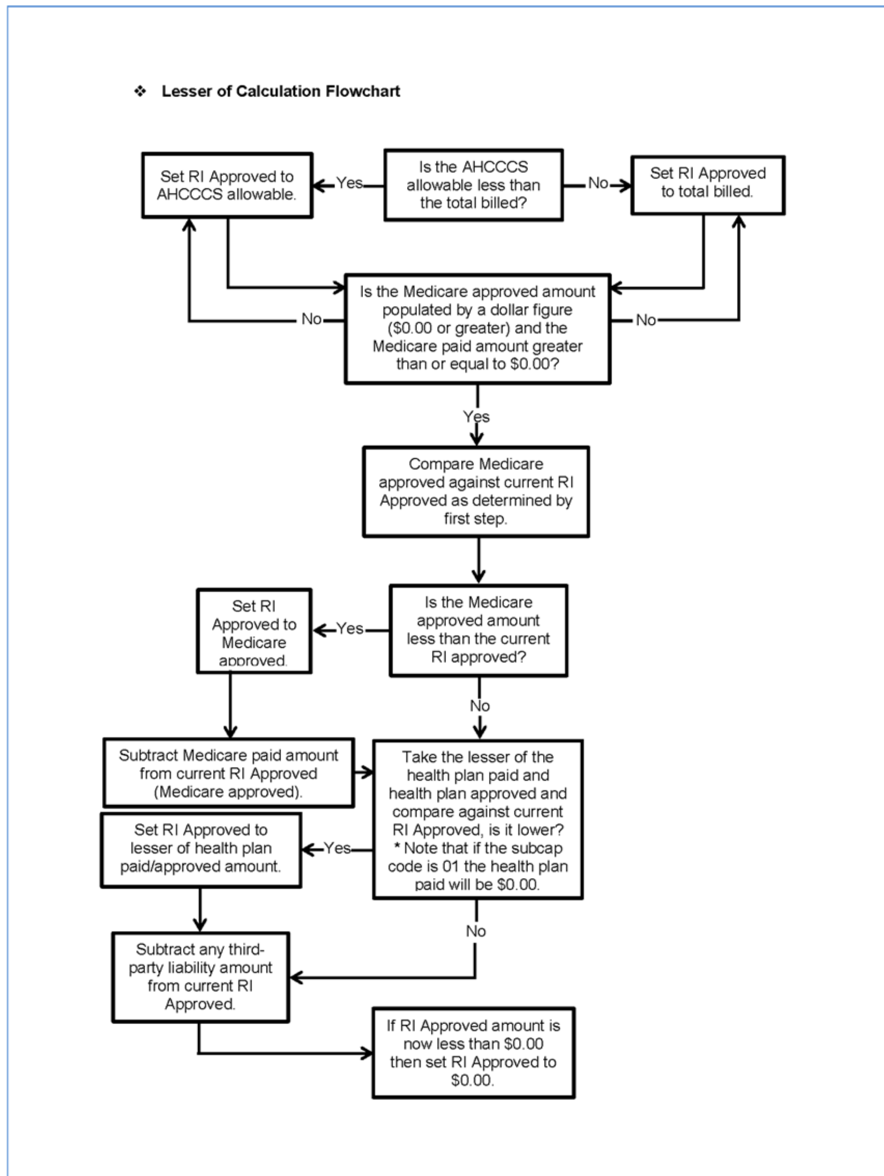
RI91L315 - Reinsurance Case Reconciliation Report

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

PRICING & LESSER OF LOGIC FLOWCHART



LESSER OF CALCULATION FLOWCHART



DISCOUNT DETERMINATION FLOWCHART