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404 MEMBER INFORMATION MATERIALS

EFFECTIVE DATE: May 13, 2016

REFERENCES: ACOM Chapter 404, ACOM 404, Attachment A; Member Information Attestation Statement; 42 CFR 438.10(f)(4).

PURPOSE: This policy outlines the requirements for obtaining approval of member information materials from the Arizona Health Care Cost Containment System (AHCCCS).

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

Definitions

- A. File and Use - A process whereby the Division submits qualifying member information materials to AHCCCS prior to use, and can proceed with distributing the materials without any expressed approval from AHCCCS within 15 calendar days.
- B. Member Information Materials - Any materials given to Division members or potential enrollees. Member information includes but is not limited to:
 - 1. Informational material such as health and wellness brochures, member newsletters, videos, form letter templates, and mass communications such as voice informational material sent to the member's phone and the Division's website context (Member Information Page),
 - 2. Retention materials sent to current members to target and maintain eligibility, and
 - 3. Instructional material such as member handbooks and provider directories and other new member materials.
- C. Vital Materials - Include at a minimum: notices for denials, reductions, suspensions or terminations of services, consent forms, communication requiring a response from the member, detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, and all grievance and request for hearing information as described in the "Enrollee Grievance System Standards" section of the Division's contract with AHCCCS.

Member Information Materials

- A. The Division complies with ACOM Chapter 404 Member Information, for all materials intended for members including, but not limited to e-mail and voice-recorded messages.
- B. The Division makes every effort to ensure that all information prepared for distribution is easily understood.

- C. The Division makes every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.
- D. All materials are labeled with the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) name and/or logo.
- E. Member information materials are also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of members (e.g., visually limited or have limited reading proficiency.)
- F. The Division shall inform all members of any changes considered to be significant, 30 calendar days prior to the implementation date of the change per the federal law listed in references above. These changes may include:
 - 1. Cost sharing,
 - 2. Prior Authorization,
 - 3. Service delivery, or
 - 4. Covered services.
- G. In addition, the Division will make a good faith effort to give written notice to members within 15 calendar days after receipt or issuance of a provider termination.
- H. The Division will submit the following information to AHCCCS prior to releasing member information materials:
 - 1. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its members or potential members:
 - a. Member information materials must be submitted via electronic mail to AHCCCS 15 calendar days before it is to be released.
 - b. If a 15 day notice is not possible, the Division shall request an expedited review.
 - c. An expedited review request must be clearly marked as expedited, the reason for the shortened timeframe, and a date the material is to be released.
 - 2. A description of the process for disseminating the material.
 - 3. The reading level of the material as measured on the Flesch-Kincaid scale.
 - 4. Translations of the material into other languages are not required to be submitted.

Language and Oral Interpretation Requirements

A. Language

1. All member information materials shall be translated when the language is spoken by 3,000 or 10% (whichever is less) of the members eligible for the Division who also have Limited English Proficiency (LEP).
2. All vital materials shall be translated when the Division is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Division's members speak that language and have LEP.
3. All written notices informing members of their right to interpretation and translation services, are translated when the Division is aware that 1,000 or 5% (whichever is less) of the Division's members speak that language and have LEP.
4. The Division is not required to submit to AHCCCS the member material translated into a language other than English; however, it is the Division's sole responsibility to ensure the translation is accurate and culturally appropriate.

B. Oral Interpretation

1. The Division offers interpretation services available to members free of charge.
2. This service includes interpretation for members using non-English languages or who are hearing impaired.

Materials Not Requiring Submission to AHCCCS

- A. A customized letter, e-mail, or voicemail for individual members.
- B. Information clearly and exclusively related to benefits for non-Medicaid programs.
 1. Health related brochures developed by a nationally recognized organization.
 2. See ACOM 404 Attachment A- National Organizations Recognized by AHCCCS.
- C. The Division is responsible for the content of materials developed by the organizations listed in the AHCCCS ACOM 404 Attachment A National Organizations Recognized by AHCCCS and reviews the materials to ensure:
 1. The information is accurate; and,
 2. The information is culturally sensitive.

- D. In the event the informational material provided by an approved organization references services that are not medically necessary or are not AHCCCS covered benefits. The Division:
 - 1. Will not distribute the organization's informational materials to members.
 - 2. May use the organization's material only as a reference to develop its own member information materials.
- E. The Division refers to ACOM, Chapter 404 Member Information, for updates when considering using information from a nationally recognized organization.

ALTCS Member Handbook

- A. Members will be provided with a copy of the ALTCS Member Handbook within 10 business days of ALTCS eligibility notification date.
- B. The Support Coordinator will review the Handbook with the member annually and document this review.
- C. The Handbook is available electronically with the option to print from the Division's website.
- D. Members may request a printed version of the Handbook at any time.
- E. The minimum content of the Handbook must include the information provided in Attachment B, Member Handbook Checklist.
- F. The Division will submit a request for review and approval of the Member Handbook as required in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.
- G. The Division will modify or expand content of the Handbook as requested by AHCCCS, and distribute this information in the form of inserts and supply these inserts with subsequently distributed Handbooks.

Member Newsletter requirements

- A. The Division develops and distributes, at a minimum, two member newsletters during the contract year.
- B. The newsletter includes, but is not limited to the following:
 - 1. Educational information on chronic illnesses and ways to self-manage care,
 - 2. Reminders of flu shots and other preventative measures at appropriate times,
 - 3. Medicare Part D issues,
 - 4. Cultural Competency, other than translation services,

5. Division specific issues (in each newsletter),
 6. Tobacco cessation information,
 7. HIV/AIDS testing for pregnant women, and
 8. Other information required by AHCCCS.
- C. The Division will submit draft newsletters to AHCCCS for review and approval as specified in the Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

Website

- A. The Division website shall contain the ALTCS Member Handbook, and all the information required in AHCCCS Attachment C, Contractor Website Certification Checklist and Attestation in the ACOM Policy 404.
- B. The Division website contains the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) name and/or logo.
- C. All of the required content information is located on the Division's website in a manner that members can easily find and navigate.
- D. The Division submits the Contractor Website Certification Checklist and Attestation (Attachment C) annually, as specified in the Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

Additional Requirements

- A. The Division reports member information costs on a quarterly basis as a separate line item in the quarterly financial statements.
- B. The Assistant Director (Chief Executive Officer)/designee shall sign and submit the Member Information Attestation Statement to the designated AHCCCS Operations and Compliance Officer within 45 days of the beginning of the contract year.
- C. The Division shall ensure that the information contained within the material is accurate, updated regularly and appropriately based on changes in benefits, the DES/DDD's Contract with AHCCCS, policy or other relevant updates.
 1. Any updated information shall be re-submitted and tracked on the Division's log, as described in this section,
 2. For resubmissions, the Division identifies the date the material was previously approved, the reason for the update, and clearly identifies all content revisions.
- D. The Division keeps a log of all member material distributed each year; identifying the date the material(s) were originally submitted to AHCCCS and the date of approval.

- E. The Division shall make the log available to AHCCCS upon request.
- F. Member information materials developed for services under contract with AHCCCS are not considered proprietary to the Division, and, must directly relate to the administration of the Medicaid program, or relate to health and welfare of the member.
- G. Member information materials cannot:
 - 1. Directly or indirectly refer to the offering of private insurance,
 - 2. Include inaccurate, misleading, confusing or negative information about AHCCCS or the Division, or any information that might defraud members,
 - 3. Use the word "free" in reference to covered services, or
 - 4. Have political implications.

Incentives

The Division does not participate in member incentive programs.

412 CLAIMS REPROCESSING

EFFECTIVE DATE: May 20, 2016

INTENDED USER(S): Division Claim staff

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

The Division's claims processes, as well as its prior authorization and concurrent review process, minimize the likelihood of having to recoup already-paid claims.

Payment Review

Providers may be selected for a pre or post payment review due to aberrant billing patterns or suspect activities. The following are components that may detect the possibility of aberrant billing practices.

- A. Claims Systems: The Claims Systems prevents/detects payment to providers for services not performed, not authorized, or otherwise inappropriate.
 - 1. Medicare's Correct Coding Initiative (CCI): The system performs CCI edits through the claims process system on all fee-for-service and Long Term Care (LTC) claims. Claims issues such as over utilization, bundling or unbundling, procedure codes and diagnosis codes will trigger CCI edits.
 - 2. Utilization Management (UM): Analyzing the use of authorized services reduces the possibility of abuse by a provider, member, overutilization, and underutilization. UM reports are monitored to determine if a specific provider shows unusually high or low levels of service utilization.

If trends in the initial claims adjudication process identify discrepancies, tests will be conducted to ensure the process is effective for detecting fraud and misuse.

- B. Post Payment Review (PPR):
 - 1. Audit Management System (AMS) completes the Post Payment and Retrospective Reviews for the Division.
 - 2. Refer to the Audit and Management Services-Standard Operating Procedure for; Guiding Principles, Audit Procedures and Audit Planning (phase 1-7).
 - 3. The audit is reviewed by the Division's Compliance Program. If recoupment and a Correction Action Plan (CAP) is required a

recoupment letter is sent to the provider along with a copy of the audit.

Internal Claim Review

The Division utilizes sampling and remediation in internal claim reviews.

- A. Sampling: A selection of claims, which are reviewed for financial or procedural errors, billing trends, units, rates, and services billed. *Reversals and adjustments are excluded for the sample.*
- B. Remediation: an audit team performs the review.

Recoupments

- A. Single recoupments in excess of \$50,000:

Any single recoupment in excess of \$50,000 per Provider Tax Identification Number (TIN), the Division submits a written request including a letter of explanation, electronic file, and provider notification for approval to the designated AHCCCS Operations and 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 utilized to recover the funds,
 - d. Methods to notify the affected Provider(s) prior to recoupment,
 - e. The anticipated timeline for the recoupment,
 - 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, and
 - h. Other recoupment action specific to this Provider within the contract year.
- 2. An electronic file containing the following:
 - a. AHCCCS Member ID,

- b. Date of Service,
 - c. AHCCCS Original Claim Number,
 - d. Date of Payment,
 - e. Amount Paid, and
 - f. Amount to be Recouped.
3. A copy of the provider notification that includes:
- a. How the need for the recoupment was identified,
 - b. The process that will be utilized 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, and
 - e. Listing of impacted claim Claim Reference Number (CRNs.)
- B. Recoupment of payments initiated more than 12 months from the date of original payment:

Retroactive Third Party Recoveries are when the primary insurance was not billed first, as AHCCCS is the payor of last resort, permission from AHCCCS is not needed to adjust for third party liability (TPL).

AHCCCS approval is required when initiating recoupment per Provider TIN more than 12 months from the date of original payment of a clean claim. The Division submits a written request including a letter of explanation, electronic file, and provider notification for approval to the designated AHCCCS Operations and 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 must be submitted 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 utilized 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 the following:
 - 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 provider notification that includes:
 - a. How the need for the recoupment was identified,
 - b. The process that will be utilized 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 CRNs.
- C. Cumulative recoupments in excess of \$50,000 per provider per contract year

The Division tracks recoupment efforts per Provider TIN. If recoupment amounts for a Provider TIN cumulatively exceed \$50,000 during a contract year (based on a rolling 12 month period by recoupment date), the Division reports the cumulative recoupment monthly to the designated AHCCCS Operations and Compliance Officer as outlined in the AHCCCS Claims Dashboard Reporting Guide.
- D. Recoupment Schedule: If the provider states paying recoupment in full would cause a financial hardship, the Division may request financial statements from the provider to validate the hardship. If the hardship is verified, a recoupment schedule is established.

Post Payment Review Corrective Action Plan (CAP)

A corrective action plan from the provider may be required as a result of a post payment review audit. Recommendations to the Division are provided by AMS in part of their written report and details what is needed for the Provider to meet the Qualified Vendor Agreement and Rate Book Requirements.

Included in the Recoupment letter, the provider is to provide a CAP to the Division within 30 calendar days of the letter.

When the provider does not agree a CAP is warranted, they may file a Claim Dispute.

416 PROVIDER NETWORK INFORMATION

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR.102

This Policy establishes provider information requirements and the content of the Division's website. "Provider" is defined as any person or entity that contracts with the Division to provide a covered service to members in accordance with A.R.S. §36-2901.

Provider Communications

The AHCCCS contract contains requirements for communications between the Division and its provider network. The list below identifies the required content and timing of these communications. The list does not supersede any additional requirements that may be outlined in contract.

A. Provider Manual

The Division develops, distributes and maintains a provider manual, ensuring that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual. The Division also distributes a provider manual to any individual or group that submits claim and encounter data. The Division ensures that all contracted providers meet the applicable AHCCCS requirements with regard to covered services and billing.

The provider manual provides information regarding the following:

1. Division's program and organization
2. Provider responsibility and the Division's expectation of the provider
3. Division's provider service departments and functions
4. Covered and non-covered services, and requirements and limitations including behavioral health services
5. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.
7. Dental services coverage and limitations
8. Maternity/Family Planning services

9. Primary Care Physician (PCP) assignments
10. Referrals to specialists and other providers, including access to behavioral health services
11. Grievance system process and procedures for providers and enrollees
12. Billing and encounter submission information
13. Policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
14. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e. Medicare and Medicaid)
15. Cost sharing responsibility
16. Explanation of remittance advice
17. Prior authorization and notification requirements, including a listing of services which require authorization
18. Claims medical review
19. Concurrent review
20. Fraud, waste, and abuse
21. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.
22. Minimum Required Prescription Drug List (MRPDL) information, including:
 - a. How to access the MRPDL (electronically and hard copy - by request)
 - b. How and when updates are communicated
23. AHCCCS appointment standards
24. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable
25. Eligibility verification
26. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964, and access to interpretation services for members who speak a language other than English (including Sign Language)
27. Peer review and appeal process
28. Medication management services as described in the contract
29. Member's right to be treated with dignity and respect as specified in 42 CFR 438.100

30. Notification that the Division has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102
31. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions
32. Information related to payment responsibilities as outlined in ACOM Policy 432
33. (Acute and ALTCS/EPD) Description of the Change of Contractor policies. See ACOM Policy 401 and 403.

B. Website

1. The Division maintains a website that is focused, informational, functional, and has links to the following:
 - a. RPDL (both searchable and comprehensive listing), which shall be updated twice per year or as needed and within 30 calendar days of AHCCCS notification
 - b. Provider manual
 - c. Provider directory that is current and updated within 15 calendar days of a network change, is user friendly and allows members to search by the following provider information:
 - i. Name of provider or facility
 - ii. Provider or service type
 - iii. Specialty
 - iv. Languages spoken by the practitioner
 - v. Office location (i.e., allow the member to find providers by location such as county, city or zip code)
 - d. Performance Measure Results via link to AHCCCS website
 - e. Medical Determination Criteria and Practice Guidelines
 - f. Contractor provider survey results, as available.
2. For appropriate entities, the Division website also provides the following electronic functionality:
 - a. Enrollment Verification
 - b. Claims Inquiry (adjustment requests; information on denial reasons)
 - c. Accept HIPAA compliant electronic claims transactions

d. Display Reimbursement Information.

See ACOM Policy 404, Attachment C, Contractor Website Certification Checklist and Attestation for other website-related requirements.

Forty-five (45) calendar days after the start of the contract year, the Division submits Annual Website Certification Checklist and Attestation (See ACOM 404, Attachment C, Contractor Website Certification Checklist and Attestation).

C. Required Notifications

In addition to the updates required below, the Division may require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division will provide prior notification as is deemed reasonable or prudent.

The Division provides written or electronic communication to contracted providers in the following instances:

1. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, the Division provides written notice of the reason for declining any written request for inclusion in the network.
2. Division Policy/Procedure Changes - For any change in Policy, process, or protocol (such as prior authorization, retrospective review, or performance and network standards) that affects, or can reasonably be foreseen to affect, the Division's ability to meet Contract performance standards, the Division must notify:
 - a. The designated operations compliance officer to which the Division is assigned, sixty (60) days before a proposed change
 - b. Affected provider, thirty (30) calendar days before the proposed change
3. AHCCCS Guidelines, Policy, and Manual Changes - The Division ensures that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals.
4. Subcontract Updates - If a modification to the AHCCCS Minimum Subcontract Provisions, the Division issues a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.
5. Termination of Contract - The Division provides, or requires its subcontractors to provide, written notice to hospitals and/or provider groups at least 90 calendar days prior to any contract termination without cause. Contracts between subcontractors and individual practitioners are exempted.
6. Disease/Chronic Care Management - The Division disseminates information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

436 NETWORK STANDARDS

REVISION DATE: May 13, 2016
INTENDED USER(S): Network Staff
REFERENCES: ACOM 436, ACOM 415.

The Division maintains a provider network that is sufficient to provide all covered services under the Arizona Long Term Care System to its ALTCS eligible members.

Network Oversight Requirements

The Division:

- A. Ensures networks standards are maintained including network standards delegated to Administrative Services Subcontractors.
- B. Identifies gaps and addresses short and long-term interventions in the Division's Annual Network Development and Management Plan when established network standards cannot be met.
- C. Analyzes compliance each quarter.
- D. Monitors its Administrative Services Subcontractors for compliance with this Policy.

438 ADMINISTRATIVE SERVICES SUBCONTRACTS

EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. §36-2901, ACOM Policy 317, 42 CFR 436, 42 CFR 438.230, 42 CFR 455.101 through 106, CMS document SMDL09-001.

Purpose

This policy establishes guidelines and requirements for Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and corrective action plans (CAP).

Administrative Services Subcontracts

An Administrative Services Subcontract is an agreement that delegates any of the requirements of the contract with AHCCCS, including but not limited to:

- A. Claims processing, including pharmacy claims
- B. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
- C. Management Service Agreements
- D. Service Level Agreements with the Division or one of its subcontractors
- E. DDD acute care and behavioral health subcontractors

Providers are not Administrative Services Subcontractors.

Change in Organizational Structure

A change in organizational structure is any of the following:

- A. Merger
- B. Acquisition
- C. Reorganization
- D. Change in Articles of Incorporation
- E. Joint Venture
- F. Change in Ownership
- G. State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature
- H. Change of Management Services Agreement (MSA) Subcontractor

- I. Other applicable changes which may cause:
- J. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)
- K. Changes in critical member information, including the website, member or provider handbook and member ID card
- L. A change in legal entity name

Management Service Agreement

A Management Service Agreement is a type of subcontract in which the Division delegates all or substantially all management and administrative services necessary for the provision of acute or behavioral health services as required in AHCCCS contract.

Provider

A provider is any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. Qualified Vendors are Providers.

Approval of Subcontracts

The Division submits all Administrative Services Subcontracts with the Administrative Services Subcontract Checklist to the AHCCCS Division of HealthCare Management for prior approval, 60 days before the effective date of the subcontract.

- A. The Division retains the authority to direct and prioritize any delegated contract requirements.
- B. The Division requires that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS.
- C. The Division ensures the agreement contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of AHCCCS.
- D. The Division ensures that any reorganization related to an MSA Subcontractor is submitted in accordance with ACOM Policy 317. Additionally, the Division will:
 - 1. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the public including any RFP amendments.
 - 2. Submit final, signed copies of each contract which it enters into with subcontractors and any subsequent amendments within 30 days of signature date.
 - 3. Ensure its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes.

Monitoring And Reporting

- A. The Division monitors the Administrative Services Subcontractor's performance on an ongoing basis and completes a formal review at least annually (42 CFR 438.230).
- B. The formal review includes a review of delegated duties, responsibilities, and financial position. Administrative Services Subcontractors who are state agencies or sovereign nations are not subject to a financial review.
 - 1. The Division prepares written findings of the review.
 - 2. The Division requires the subcontractor to prepare a written response to findings of non-compliance.
 - 3. The Division increases monitoring activities until compliance is achieved and maintained.
 - 4. The Division notifies AHCCCS within 30 days of the discovery of an Administrative Service Subcontractor's non-compliance.
- C. The notification includes:
 - 1. The subcontractor's name
 - 2. Delegated duties and responsibilities
 - 3. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern
 - 4. The scope and estimated impact of the non-compliance upon members
 - 5. The known or estimated length of time that the subcontractor has been in non-compliance
 - 6. The Division's Corrective Action Plan (CAP) or strategies to bring the Administrative Services Subcontractor into compliance
 - 7. Sanction actions that may be taken because of the non-compliance
 - 8. The Division informs AHCCCS of activities that are occurring to bring the subcontractor into compliance.

Administrative Services Subcontractor Evaluation Report

The Division submits the annual Administrative Services Subcontractor Evaluation Report within 90 days of the start of the AHCCCS contract.

- A. The Administrative Services Subcontractor Evaluation Report includes the following:
 - 1. The name of the subcontractor
 - 2. The delegated duties and responsibilities

3. The date of the most recent formal review of the duties, responsibilities and financial position, as appropriate, of the subcontractor.
4. A comprehensive summary of the evaluation of the performance (operational and financial as appropriate) of the subcontractor, including the type of review performed
5. The next scheduled formal review date
6. All identified areas of deficiency; including, but not limited to those which:
 - a. Affect member services; and/or
 - b. Cause a quality of care concern
7. CAP Information, including:
 - a. Any corrective action plans that occurred due to monitoring since the last Administrative Services Subcontractor Evaluation Report
 - b. Any Division or subcontractor CAPs resulting from the annual formal review; and
 - c. Date reported to AHCCCS
 - d. Current status of CAPs

Additional Requirements

- A. All Administrative Services Subcontracts reference and require compliance with the AHCCCS Minimum Subcontract Provisions available on the AHCCCS website.
- B. When a modification to the AHCCCS Minimum Subcontract Provisions occurs, the Division issues a notification and amends Administrative Services Subcontracts.
- C. All Administrative Services Subcontracts must reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and SMDL09-001. Administrative Services Subcontractors disclose to the Division the identity of any excluded person.
- D. All Administrative Services Subcontracts entered into by the Division are subject to review and approval by AHCCCS.
- E. All Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.
- F. The Division maintains a fully executed original or electronic copy of all Administrative Services Subcontracts, which is be accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.

- G. The Division ensures that all member communications furnished by the Administrative Services Subcontractor include the Division's name.
- H. Before entering into an Administrative Services Subcontract, the Division evaluates the prospective Administrative Services Subcontractor's ability to perform the delegated duties.
- I. In the event the Division terminates a subcontract, the Division ensures compliance with all aspects of the AHCCCS Medicaid Contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

Attachment A, Administrative Services Subcontract Checklist

See the ACOM webpage for Attachment A of this policy

Attachment B, Administrative Services Subcontractor Evaluation Report Template

See the ACOM webpage for Attachment B of this policy

439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: June 10, 2016

REFERENCES: 9 A.A.C. 22, Article 1; 42 CFR 438.207, 42 CFR 438.10(f) (4), 42 CFR 438.10(f) (5).

The Division ensures that performance and provider network standards are met to support a member's needs, as well as the needs of the membership as a whole. Changes to business operations or to the provider network are evaluated for the impact to members and providers.

Identifying A Provider Network and/or Business Operations Material Change

- A. For changes impacting members and/or providers, the Division evaluates the impact of the change by geographical service area and as a whole using established criteria and/or methodology for determining the impact of the change.
- B. Provider Network changes may include, but are not limited to:
 - 1. Changes in services,
 - 2. Geographic service areas, or
 - 3. Payments.
- C. Changes may also include the addition or change in:
 - 1. Pharmacy Benefit Manager (PBM),
 - 2. Dental Benefit Manager,
 - 3. Acute Health Plan,
 - 4. Provider Contracts (e.g. group homes, nursing facility), and
 - 5. Any other delegated agreements.
- D. Business Operations changes may include, but are not limited to:
 - 1. Policy,
 - 2. Process, and
 - 3. Protocol, such as prior authorization or retrospective review.
- E. Changes may also include the addition or change in:
 - 1. Claims Processing system,

2. System changes and upgrades,
 3. Member ID Card vendor,
 4. Call center system,
 5. Management Service Agreement (MSA), and
 6. Any other Administrative Services Subcontract.
- F. The Division will submit approval for a material change to AHCCCS, at least 60 days in advance of the material change.
- G. Any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided will be communicated to affected providers at least 30 days in advance of the change as identified in Operations Policy Manual Chapter 60, Notification to Providers.
- H. The Division will provide written notice to members within 15 days after receipt or issuance of a provider termination notice.

General Notifications

- A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:
1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration.
 2. For routine changes and updates to Division Guidelines, Policy/Provider Manual.
 3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change.
 4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.
- B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.
- C. Communication with Independent Providers is via US mail.
- D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.