AHCCCS E.V.V.
ELECTRONIC VISIT VERIFICATION

Frequently Asked Questions (FAQ)
Contingency Planning| January 2023

Who should be involved in the contingency planning process?

The process should be driven by the member and the Health Care Decision Makers and reflect their preferences, but the conversation shall be facilitated and involve other members of the service or treatment planning team as directed by the member or Health Care Decision Maker.

If the member has services with multiple providers, do they need to develop a contingency plan for each provider?

Yes. The provider and member/Health Care Decision Maker must discuss a contingency plan for the services being provided by each agency.

How often should the provider and member discuss contingency planning?

The contingency plan must be reviewed at least every 12 months (annually) with the member and input into the EVV system. The documentation must remain on file. The EVV system requires the provider agencies to attest the plan has been reviewed at least annually for each member. AHCCCS has developed default preferences for each EVV service, but those should only be used if/when the member/Health Care Decision Maker does not have a preference. The default preferences should not be applied in lieu of provider agencies actively engaging in contingency planning with members.

How does contingency planning relate to the schedule?

If a DCW no-shows or is late (at least 60 minutes from the start time), the provider agency is expected to reschedule the visit based upon the member's contingency plan preferences. In the event a visit is late or missed; the provider agency is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. When the event occurs, members can choose to elect a different action than what was originally documented on the Contingency Plan.

Adherence to a member's contingency plan is recorded in the EVV system as the Resolution Code for when a visit is missed or late. More information on how to clear the missed or late visit exceptions is available in the Visit Maintenance and Documentation FAQ.

What happens when a member calls Sandata to help with a missed visit?

If the member contacts the provider agency and receives no response or call back within 15 minutes, the member may call Sandata. Sandata will triage the call and reach out to the provider agency or Health Plan, if necessary. You can find the exact steps Sandata will take in the AZ Member Call Workflow.

How are AHCCCS and the Health Plans going to use the data reported about contingency planning?

AHCCCS will look at the data to help inform workforce development and network adequacy planning. The scheduling data helps to identify whether visits are occurring as originally planned, while the data on the contingency plan helps to highlight how the agency was able to accommodate the member when a visit was late or missed.

What happens if the agency cannot meet the member's preferences outlined in the contingency plan on the day of the missed/late visit?

AHCCCS expects providers to take all appropriate and available measures to meet an individual member's needs and preferences to ensure the member is receiving quality and timely access to care while mitigating adverse health impacts. AHCCCS and the Health Plans will monitor the data during a baseline period in an effort to develop performance metrics that may be used to incentivize provider performance through vehicles such as value-based purchasing arrangements, Differential Adjusted Payment initiatives, or quality monitoring reviews. AHCCCS anticipates the baseline period to start after the claim enforcement period (January 1, 2023). AHCCCS does not anticipate having performance metrics at the member level, but will monitor overall provider compliance to determine whether or not a provider agency may fall within or outside the normal threshold for instances whereby the member's contingency plan was not accommodated.