Arizona Health Care Cost Containment System

AHCCCS Contractor Operations Manual

ACOM

MANUAL OVERVIEW

CHAPTER 100 - ADMINISTRATION

CHAPTER 200 – CLAIMS

CHAPTER 300 – FINANCIAL

CHAPTER 400 – OPERATIONS

OVERVIEW

Effective Date: 07/01/05, 10/01/12
Revision Date: 10/25/06, 06/01/11, 09/12/12

Staff responsible for overview: Division of Health Care Management (DHCM) Contracts & Policy

I. Purpose

The purpose of the AHCCCS Contractor Operations Manual (ACOM) is to consolidate and provide ease of access to the administrative, claims, financial, and operational Policies and requirements of the AHCCCS Administration.

The ACOM Manual applies to all Arizona Acute Care, Long Term Care (ALTCS), and Children's Rehabilitation Services Contractors (CRS), in addition to other entities that have a contract or intergovernmental agreement with AHCCCS to provide covered services (hereinafter referred to as Contractors). These include: Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Arizona Department of Economic Security, Comprehensive Medical and Dental Program (ADES/CMDP), Arizona Department of Economic Security, Division of Developmental Disabilities (ADES/DDD). This manual also applies to subcontractors who are delegated responsibilities under a contract. As necessary, the policies within the manual specify the applicability to specific Contractors. This Manual does not replace existing manuals, guides, or documents such as those listed in Section V, References.

II. Definitions

The words and phrases contained in the AHCCCS Contractor Operations Manual have the following meanings, unless a chapter or policy contains another meaning.

Acute Care Contractor	A contracted managed care organization (also known as a health plan) that provides acute care medical services to AHCCCS members who are Title XIX or Title XXI eligible, and who do not qualify for another AHCCCS program. Most behavioral health services are carved out and provided through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS).
AHCCCS Medical Policy Manual (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.

Arizona Administrative Code (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as "AHCCCS Rules" or "Rules".
Arizona Department of Health Services, Division of Behavioral Health (ADHS/BHS)	The state agency mandated to provide behavioral health services to Title XIX and Title XXI Acute care members who are eligible for behavioral health services. Services are provided through the ADHS Division of Behavioral Health and its Contractors.
Arizona Department of Economic Security, Comprehensive Medical and Dental Program (DES/CMDP)	A department within the Arizona Department of Economic Security that is responsible for managing the medical needs of foster children in Arizona under A.R.S. §8-512.
Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for licensure/certification of facilities that specifically serve individuals with a developmental/intellectual disability, providers, and the reimbursement of services for eligible Arizona residents with a developmental/intellectual disability. AHCCCS Administration contracts with ADES to reimburse services for its members with a developmental/intellectual disability.
Arizona Health Care Cost Containment System (AHCCCS)	The Administration, Contractor, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. §36-2902, et seq.
Arizona Long Term Care System (ALTCS) Contractor	An AHCCCS program which delivers long-term, acute, behavioral health care and case management services, as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
Arizona Revised Statutes (A.R.S.)	The Laws of the State of Arizona.

Centers for Medicare and Medicaid Services (CMS)	The organization within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).
Children's Rehabilitative Services (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS related services as specified in 9 A.A.C.7.
Code of Federal Regulations (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
Contractor	A organization, person, or entity that has a prepaid capitated contract with the AHCCCS administration pursuant to A.R.S. §36-2904 to provide goods and services, including behavioral health and health care services, to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
Division of Health Care Management (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, rate setting, encounters, financial/operational oversight.

III. MANUAL CONTENT

The AHCCCS Contractor Operations Manual consists of four chapters. Each chapter contains an overview, and a detailed discussion of policy information. Exhibits, which pertain to a specific policy, are located at the end of the policy section.

The Policy Manual Chapters include:

Chapter 100 Administration	Contains policies pertaining to business plan and organization.
Chapter 200 Claims	Contains policies pertaining to claim adjudication and reimbursement.
Chapter 300 Financial	Contains policies pertaining to financial information or data, including reconciliation and reporting.
Chapter 400 Operations	Contains policies pertaining to plan operations such as; member information, coordination of care, and network management.

V. Policy

The Division of Health Care Management (DHCM), in conjunction with other divisions within AHCCCS, is responsible for the formulation of policy for the AHCCCS Contractor Operations Manual. Stakeholder input is sought as appropriate. Policy changes may stem from several sources, including but not limited to recently promulgated or revised federal and state regulations, program contract changes, changes in accepted business standards of practice, and internal or external discussions.

VI. Contact

Revisions to the Manual are published on the AHCCCS web site, which can be accessed at http://www.azahcccs.gov. Updates for the web site occur on a monthly or as-needed basis.

Any questions concerning the **content** of the AHCCCS Contractor Operations Manual should be addressed to:

AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

Attention to:

Content Area	Contact	Telephone No.	E-mail
Acute Care ALTCS/EPD CRS	Diana Alvarez	602-417-4796	Diana.Alvarez@azahcccs.gov
ADHS/BHS DES/DDD DES/CMDP DCW Community First Choice	Jami Snyder	602-417-4614	Jami.Snyder@azahcccs.gov
Finance	Stephanie Lefkowski	602-417-4304	Stephanie.Lefkowski@azahcccs.gov

Any questions concerning the **technical aspects** of the AHCCCS Contractor Operations Manual should be addressed to:

Julie Ambur
AHCCCS Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034
Telephone: 602-417-4295
E-mail:Julie.Ambur@azahcccs.gov

V. References

This Manual frequently provides reference to other AHCCCS manuals, legal references or documents, which provide more detailed information. These include, but are not limited to:

- Arizona Section 1115 Waiver
- AHCCCS State Plan
- Code of Federal Regulations (CFR)
- Arizona Revised Statutes (ARS)
- Arizona Administrative Code (Rules)
- AHCCCS Contracts
    - Acute Care
    - Arizona Long Term Care System (ALTCS)
    - Behavioral Health Services (ADHS/BHS)
    - Children's Rehabilitation Services (CRS)
    - Children's Medical and Dental Program (DES/CMDP)
    - Division of Developmental Disabilities (DES/DDD)
- AHCCCS Fee-For-Service Operations Manual (AFOM)
- AHCCCS Medical Policy Manual (AMPM)
- AHCCCS Encounter Manual
- AHCCCS Reinsurance Processing Manual
- AHCCCS Claims Dashboard Reporting Guide
- AHCCCS Behavioral Health Services Guide
- AHCCCS Financial Reporting Guides
- AHCCCS Technical Interface Guidelines
- AHCCCS Operations Reporting Guidelines
- AHCCCS Guide to Languages in Notices of Action (NOA)

101 – MARKETING, OUTREACH AND RETENTION

Original Date: 10/10/1993
Effective Date 10/01/2010; 01/19/2012
Revision Date: 11/08/2010; 01/19/2012

Staff responsible for policy: DHCM Operations

I. Purpose

This policy establishes guidelines and restrictions for all AHCCCS Contractors, awarded a contract or under contract with AHCCCS to deliver health care services, for marketing and outreach activities referencing the AHCCCS program.

II. Definitions

Financial Sponsor: Any monies or in kind contributions provided to an organization, other than attendance fees or table fees, to help offset the cost of an event.

Health education: Programs, services or promotions that are designed or intended to advise or inform the Contractor's enrolled members about issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods or modes of medical treatment.

Health education materials: Materials that are designed, intended, or used for health education or outreach to the Contractor's actual members. Health education materials include, but are not limited to, condition specific brochures, member newsletters, posters, and member handbooks. Materials previously approved under the Member Information Policy should be listed in all requests as defined in Section A of this policy.

Incentives: Items that are used to encourage behavior changes in the Contractor's enrolled members or Health promotion incentives to motivate members to adopt a healthy life style and/or obtain health care services. These may include:

- infant car seats;
- discounts for merchandise or services; and
- manufacturer or store coupons for savings on products; or
- services or any other objects that are designed or intended to be used in health education or outreach.

Incentives may not be used in conjunction with the distribution of alcohol or tobacco products.

Marketing: Any medium of communication that is written, oral, personal, or electronic, including any promotional activities, intended to increase a Contractor's membership or to "Brand" a Contractor's Name or organization.

Marketing materials: General audience materials such as general circulation brochures, Contractor's Web site and other materials that are designed, intended, or used for increasing Contractor membership or establishing a brand. Such marketing materials may include, but are not limited to: scripts or outlines for member services representatives, provider directories, brochures or leaflets that are distributed or circulated by any third party (including providers), and posters. All Marketing materials must include a health message.

Outreach: Any means of educating or informing the Contractor's enrolled members about health issues. See also "health education" and "retention".

Outreach materials: Materials that are designed, intended, or used for health education or outreach to the Contractor's enrolled members. See "Health education materials".

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

Promotional materials: See "marketing materials".

Provider: A hospital and hospital staff, a physician and physician office staff, a pharmacy and a pharmacist, and/or ancillary service providers and their staff.

Retention: Outreach activities specifically designed to target and maintain current membership.

III. Policy

Contractors are limited to marketing through health related events including events that have a health educational component and sponsorships.

Marketing is information intended for the general public about the existence of the Contractor and the availability of the Contractor as an enrollment option for people upon being deemed eligible for AHCCCS.

Outreach is communication with enrolled members for the purpose of retaining the member as an enrollee, and improving the health status of enrolled members via the adoption of healthy lifestyles and/or improved management of chronic illness.

Retention activities are designed to prevent members from losing their AHCCCS enrollment. Retention efforts must be directed to members currently enrolled with the Contractor who are determined to be at risk for attrition through Annual Enrollment Choice (AEC), expressed intent (member initiated contact including survey response), or analysis of membership trends such as decreased utilization of preventive services. Assisting one's own members with the

redetermination process is permissible, but only to the extent that the member allows the assistance.

For Marketing, Outreach and Retention, Contractors may only utilize approved materials and mediums for disseminating information as identified in this policy and comports with the Member Information Policy. See restrictions below.

AHCCCS must approve all marketing, outreach and retention activities and materials. In addition to approval of advertising copy, approval of the publication in which the ad will be placed is also required.

Medicare Advantage marketing that is targeted to AHCCCS dual members requires Marketing Committee approval only when CMS does not approve, such as a document marketed under the Medicare Advantage File & Use marketing rules. This applies only to marketing as defined by this policy.

IV. Procedure

A. Contractor Submissions

1. Materials

The use of materials, including those pertaining to health education, incentives, marketing, outreach, and promotions, must be prior approved by the AHCCCS Marketing Committee. Member materials that have been previously approved under the Member Information Policy may be used during marketing activities only if included in a specific activity request submitted to AHCCCS.

Contractors shall review all their materials on a regular basis in order to revise materials, if necessary, to reflect current practices. Any changes or amendments to previously approved marketing materials (e.g., prior leaflet approved, but subsequently modified) must also be submitted in advance to AHCCCS for approval.

2. Events

Contractors may participate in health-related marketing and outreach events that are listed in Figure 1 in the "PRE-Approved" column. Events that are listed in the "PRE-Approved" column must either be health related or have a health education component (events where health education is a component, i.e., celebration events – Angeles Del Barrio, etc.). Contractor's participation in events must be substantive; an unmanned booth with handouts is not acceptable.

Contractors may not attend events that are listed in the "Not-Approved" column in Figure 1, or any event determined by AHCCCS to not be in the best interest of the State of Arizona.

If the Contractor is not certain if an event would qualify in the "PRE-Approved" column, the Contractor must submit to the AHCCCS Marketing Committee a request for

approval prior to the event. The request shall include the Name of the Event, the location and the address.

Example:

Roosevelt Shot Clinic (Name of Event)
Phoenix Ranch Market (Location)
1602 E Roosevelt St (Address)
Phoenix, AZ 85006
9AM-1PM (Start and End Time)
Flu Shots (Service)

We will distribute the following:
Tooth Brush Approved 12/10/08

We will be handing out the tooth brush kits as the Roosevelt Clinic has been stressing dental hygiene this month.

Figure 1

PRE-Approved Events (Must Be Health Related)	**Not-Approved**
Back to School Events (not on K-12 school grounds)	Events that are not health related or do not have a health education component
College/University Events	Events on K-12 grounds
DES Health and/or Resource Events – if open to all AHCCCS plans	DES offices (except those listed on the approval list)
WIC Health and/or Resource Events – if open to all AHCCCS plans	WIC Offices (except those listed on the approval list)
Events where health education is a component (i.e. celebration events – Angeles Del Barrio, etc.)	Job Fairs
Community Center/Recreational Events (i.e. Golden Gate, Boys and Girls Club, YMCA, parks and senior center)	County/State Fairs
Community/Family Resource Events (i.e. food banks, food distribution locations, homeless and/or women's shelters)	Bi-national Health Events (i.e. Mexican consulate on their premises)
Provider Events (i.e. doctors, hospitals, and/or specialist) that the Contractor is contracted with	Political Events
Faith Based Events	Pharmacy Events not open to all contractors
Farmers Market Events	KidsCare Specific Events
Health Educational Forum (community sponsored) (i.e. nutritional, health benefits, and prevention topics)	Swap Meets
Safety Events (i.e. sun safety, water safety, and fire safety)	
Immunization Clinics	
Senior Events	
Shopping Mall Events	
AHCCCS Contractor's Event that is created and sponsored on its own for its own members only	

The Contractor shall submit to the AHCCCS Marketing Committee all marketing outreach events that the Contractor was a participant. Participation includes but is not limited to having a booth at the event, financially contributing to the event and/or having a presence at the event.

The Contractor shall submit on the 10th of every month a report of the previous months activities; using the excel format in Attachment B. The report will include; the Name of the Event, the location, the address, the date, the start and end time of the event and any services provided by the Contractor in chronological order. Contractors may only distribute materials previously approved within the prior two years.

Monthly reports must be submitted electronically to:

Chairman, Marketing Committee
Division of Health Care Management
Email: MarketingCommittee@azahcccs.gov

The AHCCCS Marketing Committee will review the Contractor's monthly submission to determine if the Contractor's participation in any events were in violation of this policy. If AHCCCS determines the Contractor was in violation of this policy, the Contractor may be subject to sanctions. Failure to disclose an event attended may also result in Administrative Action.

3. Sponsorships

Contractors may participate as financial sponsors of health-related marketing and outreach events that are listed in Figure 1 in the "PRE-Approved" column. In addition to the information required to be submitted for events, the request must include the dollar amount of the participation, and either a copy or description of any materials (including websites) on which the contractors name or logo will appear prior to production. If there is a potential for television advertising of the event, the use of the contractor's name or logo is prohibited.

4. Sponsorship requests shall be submitted, separately by type, for approval 30 days prior to dissemination or the event. If 30 day notice is not possible, the request must indicate the reason for the shortened timeframe. Requests must be submitted electronically to:

   Chairman, Marketing Committee
   Division of Health Care Management
   Email: MarketingCommittee@azahcccs.gov

5. Health Plan Logos and Health Plan Name Inclusion

Health Plan logos can be included on event flyers or websites that are produced by hosting organizations without prior approval (Contractors must monitor and police logo use to prevent misuse). Flyers or websites will require prior approval by AHCCCS if the Contractor is providing financial support for the event.

B. AHCCCS Approval

AHCCCS will attempt to approve or deny the request within 15 working days of receipt of the complete request. Approval shall only apply to the form of communication or specific date described with the initial submission. Modifications of any type would need to be resubmitted.

If a Contractor wishes to contest AHCCCS' decision, it may do so by filing a grievance in accordance with Title 9, Chapter 34 of the Arizona Administrative Code (9 A.A.C. 34).

C. Restrictions

The following restrictions apply to all marketing, outreach and retention activities.

1. The following shall *not* be allowed:
    a. Incentive items such as t-shirts, buttons, balloons, key chains, etc. unless the intent of such a give-away is outreach in nature (i.e., for educating members about the benefits of safety, immunizations, or well-care). All incentive items must be prior approved by the AHCCCS Marketing Committee.
    b. Solicitation of any individual face-to-face, door-to-door, or over the telephone;
    c. References to competing plans;
    d. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;
    e. Television advertising;
    f. Direct mail advertising;
    g. Marketing of non-mandated services. Medicare Advantage marketing that is targeted to AHCCCS dual members requires Marketing Committee approval only when CMS does not approve, such as a document marketed under the Medicare Advantage File & Use marketing rules. This applies only to marketing as defined by this policy.
    h. Utilization of the word "free" in reference to covered services;
    i. Listing of providers in marketing and open enrollment materials who do not have signed contracts with the Contractor;
    j. Use of the AHCCCS logo;
    k. Inaccurate, misleading, confusing or negative information about AHCCCS or the Contractor; and any information that may defraud members or the public;
    l. Discriminatory marketing practices as specified in the Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5, 9 A.A.C. 31, Article 5.
2. AHCCCS reserves the right to impose additional restrictions.
3. The Contractor shall ensure that:
    a. Any outreach or incentive item given away by the Contractor to its members shall not exceed $50.00. Any marketing item given away to the general public by the Contractor shall not exceed $10.00. (The total cost of all marketing and outreach/incentive items given to each member household, at each event, may not exceed $50.00.)

b. All materials identify the Contractor as an AHCCCS provider and are consistent with the requirements for information to members described in the contract and AHCCCS policies.
c. All materials that have been produced by the Contractor and refer to contract services shall specify: "Contract services are funded in part under contract with the State of Arizona".
d. Marketing materials that are distributed by the Contractor shall be distributed to its entire contracted geographic service area. Exclusion of any particular group or class of members would be considered to be a discriminatory marketing practice and subject to sanction.
e. Outreach materials cannot include the words such as "join", "enroll", "sign up" or similar verbiage unless approved through the Committee. If the Contractor intends to use such language in the materials or script, the request for approval must explain how the message is related to an Outreach goal.
f. Contractors may not encourage or induce the member to select a particular Contractor when completing the application and may not complete any portion of the application on behalf of the potential enrollee. This prohibition covers all situations, whether sponsored by the Contractor, their parent company, or any other entity.
g. Subcontractors are advised that they must comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.

D. Temporary Restrictions

Any activities, materials, or mediums in violation of this policy will be subject to sanction regardless of previous approval or terms of privately held contractual agreements. AHCCCS will review the ban of the following activities on an annual basis.

1. The following shall *not* be allowed:
    a. Radio advertising;
    b. Billboards;
    c. Bus Advertisements (including bus stops and city and school busses);
    d. School based events;
    e. KidsCare Marketing.

E. Contractor Responsibilities

1. All Contractors will be required to report their marketing, outreach and retention costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any marketing costs included in an allocation from a parent or other related corporation.

   All marketing costs allocated and otherwise will be excluded in the determination of capitation rate ranges. Additionally, any Contractor not in compliance with the AHCCCS viability criteria indicators, as defined in the contract, may be restricted from further marketing until the Contractor is in compliance with the viability criteria indicators.

2. The Contractor CEO (or designee) shall sign the Marketing Attestation Statement within 45 days of the beginning contract year. See Attachment A.

3. Marketing materials that have received approval from AHCCCS must be resubmitted to DHCM for re-approval every two years.

F. Sanctions/ Penalties

Any violation of this policy may result in the sanctions as described in ACOM Sanction Policy.

IV. References

- 42 CFR 438.104, 42 CFR 438.10, 42 CFR 431.12, 42 CFR 431.307
- Arizona Revised Statute §36-2988.I
- Arizona Administrative Code 9 A.A.C. 22, Article 5, 9 A.A.C. 28, Article 5
- AHCCCS contract

JANICE K. BREWER, GOVERNOR
THOMAS J. BETLACH, DIRECTOR

801 EAST JEFFERSON, PHOENIX, AZ 85034
PO BOX 25520, PHOENIX, AZ 85002
PHONE: 602-417-4000
WWW.AZAHCCCS.GOV

ATTACHMENT A

MARKETING ATTESTATION STATEMENT

The oral and written information given to potential members by the Contractor is accurate in order for members to make an informed decision on whether to enroll with a specific Contractor.

All information potential members are given has been approved by the AHCCCS Marketing Committee and is in compliance with the AHCCCS Division of Health Care Management Marketing, Outreach, and Retention Policy.

_____
Signature of Authorized Representative

_____
Title

_____
CONTRACTOR

_____
Date

Please sign, date, and then return to:

Michael Veit, MD 5700
AHCCCS Contracts and Purchasing
701 E. Jefferson St.
Phoenix AZ 85034

ATTACHMENT B – Monthly Marketing Report. Click on “Attachment B” or the title below to go to the Excel Monthly Marketing Report.

ACOM 101 Attachment B: Monthly Marketing Outreach Activities Report

Contractor Name: _____

Reporting Month: _____

Date of Submission: _____

Name of Event	Type of Event (must correspond to list on figure 1 of the policy)	Location	Address of Event	Date/Time of Event	Services Provided by Contractor

Reviewed 1-19-2012

102 - RESERVED

103 - FRAUD AND ABUSE

Effective Date: 10/01/94, 10/25/12, 12/01/12
Revision Date: 11/01/12, 02/07/13

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to Acute Care, Behavioral Health Services, Long Term Care System Elderly and Physically Disabled (ALTCS/EPD),Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and ALTCS Division of Developmental Disabilities (DDD) Contractors (hereafter referred to as Contractors). This policy also applies to subcontractors who are delegated responsibilities under a contract. Its purpose is to prevent the occurrence of provider and member fraud and abuse of members within the AHCCCS program. The AHCCCS Office of Inspector General (AHCCCS-OIG) is the office of primary responsibility for conducting investigations and inquiries relating to fraud, waste and abuse as it pertains to providers and members.

The objectives of this policy are to:

1. Facilitate the reporting of potential fraud and abuse cases to AHCCCS for investigation;
2. Require Contractors to work with AHCCCS (i.e., via workgroup) to further develop prevention and detection mechanisms (i.e., best practices) for Medicaid managed care;
3. Explain the role AHCCCS-OIG and the Contractors play in relation to all areas of fraud and abuse within the System;
4. Explain the Contractors' obligations to screen owners, employees and subcontractors.

II. Definitions

Abuse of a Member — Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual or emotional abuse or sexual assault (A.R.S. §46-451 and §13-3623).

Abuse By a Provider — Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program (42 CFR 455.2).

Fraud by a Member or Provider	Intentional deception or misrepresentation made by a person or persons with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law (42 CFR 455.2).
Compliance Officer	The on-site official designated by each Contractor to implement, oversee and administer the Contractors' compliance program including fraud and abuse control. The Compliance Officer shall be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.
Credible Allegation of Fraud	An allegation, which has been verified by the State, from any source, including but not limited to the following: (1) fraud hotline complaints; (2) claims data mining, and (3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis [42 C.F.R. 455.2].
Provider	Any entity or individual providing health care or other services.

III. Policy

A. Prevention/Detection

Contractors shall have in place internal controls, policies and procedures that are capable of preventing, detecting, and reporting fraud and abuse activities. For example, operational policies and controls such as claims edits, prior authorization, utilization and quality review, provider profiling, provider education, post-processing review of claims, adequate staffing and resources to investigate unusual incidents, and corrective action plans can assist Contractors in preventing and detecting potential fraud and abuse activities.

More detailed descriptions of the controls that Contractors should consider are contained in the document AHCCCS Contractors Fraud and Abuse Prevention/Detection Summary (Attachment A).

B. Reporting

If a Contractor discovers, or is made aware, that an incident of potential/suspected fraud and abuse has occurred, the Contractor shall immediately report the incident to AHCCCS by completing the confidential AHCCCS Referral For Preliminary Investigation form (Attachment B). Timely reporting of fraud and abuse improves the likelihood of a successful investigation and prosecution.

The Contractor shall refrain from recoupment or other offset remedies against a provider upon the referral to AHCCCS-OIG of a suspected provider fraud case. AHCCCS-OIG will contact the Contractor when the investigation concludes and will advise the Contractor as to whether recoupment or other offset remedies at the Contractor level are appropriate and approved.

The same form shall be used for abuse of member referrals as well as referrals for provider and member fraud.

1. Abuse of Member Referrals

   The form and its attachments shall be submitted to:

   AHCCCS, Division of Health Care Management
   Clinical Quality Management Unit
   701 E. Jefferson, Mail Drop 6700
   Phoenix, AZ 85034
   FAX (602) 417-4162
   Secure email: CQM@azahcccs.gov

2. Fraud by Providers or Members

   The form and its attachments shall be submitted to:

   AHCCCS, Office of Inspector General
   701 E. Jefferson, Mail Drop 4500
   Phoenix, AZ 85034
   FAX (602) 417-4102

Contractors may also submit Reports of Fraud, Abuse of the Program or Abuse of a Member, through the forms provided on AHCCCS Public Website at: http://www.azahcccs.gov/fraud/reporting/reporting.aspx.

All pertinent documentation and/or investigative reports that would assist AHCCCS in its investigation shall be attached to the forms.

In the event that AHCCCS-OIG, either through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. Furthermore, the Contractor is fully subrogated to AHCCCS for all civil recoveries.

C. Contractor Compliance Officer Responsibilities Related to Fraud and Abuse

1. Oversee, monitor and be the focal point for the Contractor's compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting such as provider registration, prior authorization and contracts

2. Maintain and monitor a tracking system of fraud and abuse

3. Have the authority to independently refer potential member and provider fraud and abuse cases to AHCCCS

4. Be an on-site management official who reports directly to the organization's CEO, CFO, COO or equivalent, on a regular periodic basis, regarding all fraud and abuse issues including policy matters, cases and training

5. Have direct access to the CEO and/or the governing body, senior management and legal counsel

6. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation

7. Ensure an internal reporting procedure that is well defined and made known to all employees

8. Periodically review and revise the fraud and abuse policies to meet changing regulations or trends

9. Regularly attend and participate in AHCCCS, Office of Inspector General work group meetings

10. Respond promptly to requests for information from the AHCCCS Office of Inspector General

11. Follow the AHCCCS requirements when AHCCCS-OIG suspends a provider due to a credible allegation of fraud

12. Cooperate with AHCCCS-OIG regarding any suspected cases of member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702

13. Ensure that the Contractor is in compliance with its federal and contractual obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion Checks, and Criminal Convictions Checks, and

14. Complete the Annual Attestation of Disclosure of Ownership & Control and Disclosure of Information on Persons Convicted of a Crime and submit to AHCCCS Attachment C)

D. AHCCCS-OIG Responsibilities Related to Fraud and Abuse

1. Investigate all cases of suspected member and provider fraud, under the authority of A.R.S. §36-2918 and A.R.S. §36-2905.04

2. Issue Civil Monetary Penalties pursuant to A.R.S. §36-2918 and A.A.C. R9-22 Article 11

3. Oversee, monitor and be the focal point for the AHCCCS' compliance program, with the authority to review all documents and functions as they relate to fraud and abuse prevention, detection and reporting in areas such as provider registration, claims processing and contracts

4. Maintain and monitor a tracking system of fraud and abuse

5. Ensure all employees, providers and members receive adequate training/information by overseeing a comprehensive training program, which addresses fraud and abuse prevention, recognition and reporting, and encourages employees, providers, and members to report fraud and abuse without fear of retaliation

6. Suspend providers when there is a credible allegation of fraud

7. Interact and work cooperatively with the Contractors to combat fraud, waste and abuse at all levels in the System

8. Interact and work cooperatively with other law enforcement agencies in the prevention and detection of fraud, waste and abuse

9. Investigate cases of potential member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702

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

11. Ensure that AHCCCS is in compliance with its federal obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion Checks, and Criminal Convictions Checks, and all other federal requirements related to Provider Screening and Enrollment

In addition to the specific requirements stated above, it is required that Contractors be in compliance with all State and Federal regulations related to fraud and abuse not directly detailed in this policy.

IV. References

- Section 1903(q) of the Social Security Act
- Title 42 of the Code of Federal Regulations (42 CFR) 1007.1 through 1007.21
- 42 CFR 455.1 through 455.23
- 42 CFR 455 Subpart B and E
- A.A.C. R9-22 Article 5
- A.A.C. R9-22 Article 11
- A.R.S. §46-451
- A.R.S. §13-3623
- A.R.S. §36-2918
- A.R.S. §36-2905.04
- A.R.S. §36-2903.01(L)
- State Medicaid Director Letter 09-001
- State Medicaid Director Letter 08-003
- Deficit Reduction Act, Section 6032
- Acute Care Contract, Section D
- ALTCS EPD Contract, Section D
- ALTCS DDD Contract, Section D
- CMDP Contract, Section D
- CRS Contract, Section D
- ADHS\DBHS Contract, Section D
- ACOM Policy 103, Attachment C, Annual Attestation of: Disclosure of Ownership & Control and Disclosure of Information on persons Convicted of a Crime

ATTACHMENT A

AHCCCS CONTRACTORS FRAUD & ABUSE PREVENTION/DETECTION ACTIVITIES SUMMARY

PREVENTION / DETECTION / CONTROL	PURPOSE
AHCCCS CONTRACTORS: ◈ Each Contractor shall have a corporate culture, which encourages its employees to detect and report fraud and abuse. ◈ Contractors shall establish procedures for the prevention, detection and reporting of fraud and abuse. ◈ Should a Contractor be made aware of any activities that may involve member or provider fraud, the fraud section shall immediately notify AHCCCS as described in AHCCCS policy. ◈ Contractors shall assist governmental agencies as practical in providing information and other resources during the course of investigations of possible fraud and abuse.	◈ Create an environment conducive to preventing and detecting fraud and abuse.
CONTRACTOR EMPLOYEES: ◈ Contractors shall implement lines of reporting for possible fraud and abuse that are well defined and made known to all employees through new employee orientation. ◈ Employees that interact with providers and members shall be trained in fraud and abuse detection and reporting. These employees must be familiar with the types of fraud and abuse which could be encountered and the steps to report any such noted fraud or abuse. ◈ Those employees that interact with providers and members shall watch for signs of potential fraud and abuse such as the abuse, neglect or exploitation of an eligible person and/or the loss, theft, misappropriation, or overpayment of AHCCCS and/or Contractor funds.	◈ Increase employees' awareness of what fraud is, how to find it, their responsibilities, and how to report it.

MEMBER SERVICES: ◈ Through the member handbooks, Contractors can encourage members to report providers that may be providing unnecessary or inappropriate services. Include directions of how to report information to the Contractor. ◈ Establish a member complaint system, which logs and documents all complaints. All complaints should be reviewed timely and resolved. Any complaints, which involve fraud or abuse, should be handled in accordance with the Contractors' reporting structure. ◈ Member handbooks shall include a definition of member fraud and abuse with reference to penalty for fraud and abuse under law.	◈ Identify possible fraud from member reporting and member complaints. ◈ Discourage member fraud by informing members of penalties associated with fraud and abuse.
PROVIDER SERVICES: ◈ The credentialing/certification process (including re-credentialing) must ensure a careful review of all participating providers. Providers considering participation in the contract must complete a pre-application, which is reviewed by Contractor personnel. ◈ Credentialing criteria include, but are not limited to (1) a complete, accurate and verified application, (2) a current Arizona professional license, (3) proof of completion of education and training commensurate with the provider's field of practice, (4) a review of any history of limitations, suspensions or restrictions of privileges, and (5) a review of any felony convictions, substance abuse, and suspensions or terminations from the Medicaid or Medicare programs and/or debarment from the Department of Health and Human Services. ◈ Contractors shall monitor providers for non-compliance with Contractors' and/or AHCCCS rules, policies and procedures.	◈ Prevent fraudulent use of the Medicaid system by disbarred, unlicensed, unqualified, and otherwise inappropriate providers. ◈ Avoid possible fraud by monitoring providers for compliance with Contractor and AHCCCS rules, policies & procedures.

GRIEVANCE SYSTEM: Grievances and complaints are tracked by type and referred to appropriate personnel.	◈ **Detect possible abuse of members, by a provider, or patterns of inappropriate utilization, referrals, etc.**
CONTRACTING WITH PROVIDERS: ◈ Provider contracts must include specific sections describing the provider's responsibilities to (1) comply with all applicable Federal, State and local laws, rules and regulations, (2) notify the Contractor of any credentialing/licensure change, (3) maintain professional standards, (4) maintain and furnish records and documents as required by law, rule and regulation, and (5) abide by applicable laws, rules, regulations and contract provisions to avoid termination of the contract, and (6) other AHCCCS subcontract provisions, as appropriate. ◈ By educating providers to bill correctly, Contractors can discourage the submission of claims for non-covered or unnecessary services. ◈ Provider manuals shall include a section about fraud and abuse, which includes references to provider fraud and abuse and member fraud, and abuse. The manual should describe how providers can report potential cases of fraud and abuse to the Contractor. ◈ Contracts shall also include anti-kickback language and reference to self-referrals in each of its standard contract forms.	◈ Reduce possibility of provider fraud by making provider aware of applicable rules, regulations, etc. during contract process. ◈ **Avoid possible fraud by educating providers about how to bill appropriately**
PRIOR AUTHORIZATION: ◈ The Prior Authorization Department shall be the beginning of a continuous series of review for medical services. These responsibilities include, but are not limited to, verifying (1) member eligibility, (2) medical necessity, (3) appropriateness of service being authorized, (4) the service being requested is a covered service, and (5) appropriate provider referral. ◈ Any portion of the prior authorization request, which is deemed an "unusual incident", shall immediately be written up and referred to the appropriate personnel.	◈ To avoid possibility of member or provider abuse, such as over or under utilization.

CLAIMS SYSTEM: ◈ Claims Edits: During the initial processing of a claim, the claim shall be reviewed for items such as member eligibility, covered services, excessive or unusual services for sex or age, duplication of services, prior authorization, invalid procedure codes, and duplicate claim. Any unusual items should cause the claim to pend for review. Also, claims over a certain amount should automatically be pended for review. ◈ Post Processing Review of Claims: After claims are paid, retrospective review of a sample of claims is done to determine the following: (1) reasonable charges were made for services provided, (2) the appropriateness of inpatient and outpatient care, (3) the appropriate level of care, (4) excessive diagnostic testing or ancillary referrals. ◈ Contractors shall also conduct audits of claims payments to attain a reasonable assurance that payments are being prepared correctly for claims submitted from authorized providers for eligible AHCCCS members.	◈ Prevent/detect payments to providers for services not performed, not authorized, or otherwise inappropriate. ◈ Test for validity of the original claims process for detecting fraud and misuse.
UTILIZATION/QUALITY MANAGEMENT: Utilization/Quality Management controls include (1) prior authorization and/or pre-admission review, (2) admission review, (3) concurrent review, (4) discharge review, and (5) retrospective review. Utilization reports (provider and member profiling) shall be monitored to determine if a specific provider or member shows unusually high or low levels of service utilization. If at any time during the utilization/quality management process an "unusual incident" should be suspected or discovered, the matter would be immediately referred to the appropriate personnel. Regularly scheduled medical record audits and site reviews are conducted.	◈ To reduce possibility of provider and member abuse, such as over or under utilization.

C O N F I D E N T I A L

OPI Case #_____

AHCCCS REFERRAL FOR PRELIMINARY INVESTIGATION

Suspected Program Fraud or Abuse and Member Fraud: Refer to: Director, Office of Inspector General, 701 E. Jefferson, Mail Drop 4500 Phoenix, AZ 85034 (602) 417-4045 / **FAX** (602) 417-4102, **or Toll Free** 1-800-654-8713 ext. 7-4045

SEE DEFINITIONS AND EXAMPLES OF FRAUD & ABUSE ON THE REVERSE SIDE

Referral Source

Name & Title of Individual Referring: _____

_____

Date of Referral _____

Phone Number _____ Return Call Needed to Referring Individual __YES __NO

Referring Individual is Affiliated With: NAME_____

- ❑ AHCCCS Contractor
- ❑ Government Agency
- ❑ Health Care Provider
- ❑ Recipient/Recipient Family
- ❑ Other (Anonymous, Citizen, etc.) _____

Name of Individual actually reporting the incident, (if different that of the referring individual above):

_____**Phone Number**_____

Provider/Caregiver ~ Recipient ~ AHCCCS Contractor *allegedly involved* in the Issue:

Provider/Caregiver or AHCCCS Contractor Information:

NAME_____ **AHCCCS Provider ID #** _____

Address and Phone # _____

Recipient/Member Information (if applicable and available):

NAME_____ **AHCCCS ID or Social Sec. #** _____

Date of Birth_____ **Address and Phone #** _____

NARRATIVE DESCRIPTION OF ISSUE: *(Please include the **Who, What, Where**, and **When** of the issue).*
PLEASE DO NOT USE ABBREVIATIONS
*Dollar Loss to the program (if known) $*_____

(Narrative may be continued on the reverse side.)

Narrative continued:

AGENCIES NOTIFIED: ❑ APS ❑ CPS ❑ ADHS LICENSURE ❑ POLICE ❑ Other _____

Comments:_____

DEFINITIONS

AHCCCS CONTRACTOR **means an AHCCCS Contractor, Arizona Department of Health Services/ Behavioral Health Services, Regional Behavioral Health Authorities, Children's Rehabilitation Services and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services.**

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. It includes any act that constitutes fraud under applicable Federal or State law.** ***[42 CFR § 455.2]***

ABUSE **means provider practices that are inconsistent with sound fiscal, business, or medical practice, and result in an** unnecessary **cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.** ***[42 CFR § 455.2]***

ABUSE OF A MEMBER **means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.** ***[A.R.S. §46-451; 13-3623]*** *REPORT MEMBER ABUSE TO: AHCCCS/DHCM-CQM, 701 E. JEFFERSON, MD-6500, Phoenix, AZ 85034*

EXAMPLES OF FRAUD AND ABUSE

FALSIFYING CLAIMS/ENCOUNTERS

Alteration of a Claim
Upcoding
Incorrect Coding
Double Billing
Unbundling
Billing for Services/Supplies Not Provided
Misrepresentation of Services/Supplies
Substitution of Services
Submission of Any False Documents

ADMINISTRATIVE / FINANCIAL

Kickbacks/Stark Violations
Fraudulent Credentials
Fraudulent Enrollment Practices
Fraudulent Recoupment Practices
Embezzlement

Delivery of Services

Denying Access to Services/Benefits
Limiting Access to Services/Benefits
Failure to Refer to a Needed Specialist
Underutilization
Overutilization

ABUSE OF A MEMBER

Physical Abuse
Neglect
Mental Abuse
Emotional Abuse
Sexual Abuse
Discrimination
Providing Substandard Care
Financial Exploitation

Member Fraud

Eligibility Determination Issues:
Resource Misrepresentation (Transfer/Hiding)
Residency
Household Composition
Income
Citizenship Status
Misrepresentation of Medical Condition

Please note, the above lists only a *few* examples of potential fraud and abuse scenarios.

ATTACHMENT C:

ANNUAL ATTESTATION OF: DISCLOSURE OF OWNERSHIP & CONTROL
AND
DISCLOSURE OF INFORMATION ON PERSONS CONVICTED OF A CRIME

AHCCCS

Contractor's Name **Date:**

_____ _____

1. ☐ ***Disclosure of Ownership and Control*** (42 CFR 455.104) (SMDL #09-001)

   - The Contractor attests that it has requested and obtained the required information on ownership and control from any individual, corporation, provider, or fiscal agent.

   Or

   ☐ ***Disclosure of Ownership and Control*** (42 CFR 455.104) (SMDL #09-001)

   - The Contractor attests that it is an agency of the State of Arizona and as such, has no person or corporation with an ownership or control interest in the Contractor, as defined in 42 CFR 455.101.

2. ☐ ***Disclosure of Information on Persons Convicted of Crimes*** (42 CFR 455.101; 106; 436) (SMDL #09-001)

   - The Contractor attests that on a monthly basis, it has confirmed the identity of and determined the exclusion status of all persons associated with the Contractor and fiscal agents which have an ownership or control interest or managing employee interest.

   And

   - The Contractor attests that they have immediately notified AHCCCS of any person who has been excluded through these checks.

_____
(Signature) (Date)

Reference: Contract Section D, Program Requirements, Corporate Compliance Paragraph

104 – BUSINESS CONTINUITY AND RECOVERY PLAN

Effective Date: 10/01/04, 10/01/12
Revision Date: 01/01/11, 09/27/12

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care System (ALTCS), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and Division of Developmental Disabilities (DDD) Contractors; (hereinafter referred to as Contractors).

AHCCCS requires in contract that each of its Contractors have a Business Continuity and Recovery Plan. The purpose of this policy is to outline the required components of the Plan and also suggested checklists and plan testing methods.

AHCCCS is mandated to provide health care benefits to its enrollees. It does so through contracts with Acute and ALTCS Contractors, the CRS Contractor, and ADHS/BHS and through a network of providers for fee-for-service enrollees. In order to provide benefits, the Contractor 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 Business Continuity and Recovery Plan is part of the Federal Government's Continuity of Operations requirements.

II. Definition

Continuity of Operations (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.
Contractor	Refers to Acute Care and Long Term Care (ALTCS) Contractors, Arizona Department of Health Services/Behavioral Health Services (ADHS/BHS), Children's Rehabilitation Services (CRS), and any other entity that has a contract or Intergovernmental Agreement with AHCCCS to provide covered services.

III. Policy

A. Each Contractor shall have a Business Continuity and Recovery Plan.

B. The Business Continuity and Recovery Plan shall be reviewed at least annually and updated as needed by the Contractor.

C. The Contractor shall ensure that its staff is trained and familiar with the Plan.

D. The Plan should be specific to the Contractor's operations in Arizona and reference local resources. Generic Plans which do not reference operations in Arizona and the Contractor's relationship to AHCCCS are not appropriate.

E. The Plan shall contain a listing of key customer priorities, key factors that could cause disruption, and what timelines Contractors will be able to resume critical customer services. Examples of these priorities are: Providers receipt of prior authorization approvals and denials, members receiving transportation, timely claims payments, etc.

F. The Plan shall contain specific provisions for recovery of key customer priorities.

G. The Plan shall contain specific timelines for resumption of services. The timelines should note the percentage of recovery at certain hours, and key actions required to meet those timelines. An example of this would be: Telephone service restored to prior authorization unit within four hours, to Member Services within 24 hours, to all phones in 24 hours, etc.

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

- Electronic/telephonic failure at the Contractor's main place of business.
- Complete loss of use of the main site and any satellite sites.
- Loss of primary computer system/records, or networks.
- How the Contractor will communicate with AHCCCS during a business disruption. The name and phone number of a specific contact in the Division of Health Care Management is preferred. The Plan should direct the Contractor staff to contact AHCCCS Security at 602-417-4888 in the event of a disruption outside of normal business hours.

I. The Plan should include provisions for periodic testing, at least annually. Results of the tests shall be documented.

J. All Contractor Plans shall be subject to review and approval by AHCCCS Administration. A summary of the Plan, with emphasis on the components from Paragraph H of this section, shall be submitted to the Division of Health Care Management 15 days after the start of the contract year and annually thereafter. The summary shall be no longer than five pages and include timelines for recovery.

K. Each Contractor shall designate a staff person as Business Continuity Planning Coordinator and furnish AHCCCS with that contact information.

IV. References

The Federal Emergency Management Agency (FEMA) has a website which contains additional information on Business Continuity Planning, including a checklist for reviewing a Plan. AHCCCS encourages the Contractor to use relevant parts of this checklist in the evaluation and testing of its own Business Continuity Plan. The website is located at http://www.fema.gov.

V. Authority

AHCCCS Acute Care, DES/CMDP, ALTCS, ADHS/BHS, CRS, and DES/DDD Contracts require Contractors to have a Business Continuity and Recovery Plan.

105 – GRADUATE MEDICAL EDUCATION LOANS

Effective Date: 03/01/2007
Revision/Review Date: 04/12/2012

Staff responsible for policy: DHCM Reimbursement

I. Purpose

This policy establishes guidelines for the approval, issuance and repayment of interest-free loans as authorized by A.R.S. § 36-2921 for establishment of graduate medical education (GME) programs.

II. Definitions

AHCCCS Inpatient Hospital Days of Care: Has the meaning given at A.A.C. R9-22-701.

Graduate Medical Education Program: Has the meaning given at A.R.S. § 36-2903.01(H)(9)(e).

Hospital: Has the meaning given at A.A.C. R9-22-101(B).

Primary Care Area: A geographic area of the state defined under the Arizona Department of Health Services, Primary Care Area Program.

Primary Care Discipline: Any of the fields of medicine described by A.R.S. § 36-2901(12).

Population-to-Primary-Care-Provider Ratio: A statistic determined under the Arizona Department of Health Services, Primary Care Area Program and published by the ADHS for all counties and Primary Care Areas in the state.

III. Policy

A. General

Subject to available funds, the Administration may issue interest-free loans of not more than five hundred thousand dollars to one hospital per county per fiscal year to fund costs for the establishment of a GME program in that county and reasonable costs for the first two years of its operation.

B. Eligible Hospitals

To be eligible to receive a loan under this policy, a hospital must:

1. Be physically located in Arizona;

2. Be affiliated with an accredited allopathic or osteopathic medical school having a physical presence in Arizona and licensed by the state of Arizona to grant degrees; and

3. Establish a new GME program that meets the requirements of paragraph C.

C. Eligible Programs

To be eligible for loan funding under this section, a GME program must:

1. Be structured to accommodate at least six resident positions at a hospital not currently operating a GME program, or at least four resident positions at a hospital currently operating one or more GME programs in medical disciplines different from the newly established program; and

2. Be accredited by a nationally recognized accrediting body, or

3. Have applied for accreditation and can reasonably expect to receive accreditation within one year of the loan issuance.

D. Application

The Administration will accept applications on an annual basis. A hospital wishing to be considered for a loan must submit to the Administration by September 1st of each year all of the following:

1. A completed loan application on a form provided by the Administration.

2. Evidence of program accreditation or evidence of application for program accreditation.

3. A copy of the medical school affiliation agreement or the letter of understanding which documents the duties and responsibilities of both the medical school and the program.

4. A pro forma budget detailing expected program costs for the first five years of the program's operation.

For state fiscal year 2007 only, applications must be received by May 1st, 2007.

E. Determination of Application Approval or Denial

The Administration will determine approval or denial of a loan application in the following manner:

1. Where more than one application is received from the same county, the Administration will apply the following preferences in the following order of priority until one application per county remains:

    a. Preference will be given to hospitals in the Primary Care Area having the highest Population-to-Primary-Care-Provider Ratio.

    b. If more than one application remains within a county, preference will be given to programs that are accredited as of the date of application for a loan.

    c. If more than one application remains within a county, preference will be given to programs in the primary care disciplines.

    d. If more than one application remains within a county, preference will be given to applicants who have not previously received a loan from the Administration.

    e. If more than one application remains within a county, preference will be given to the hospital having the higher Medicaid utilization ratio, determined as follows:

        Using the hospital's most recent Medicare Cost Report information on file with the Administration as of the date of application and the Administration's inpatient hospital claims and encounter data for the time period corresponding to the hospital's Medicare Cost Report information, the total AHCCCS inpatient hospital days of care will be divided by the total Medicare Cost Report inpatient hospital days.

2. The Administration will rank the remaining applications according to the following order of priority:

    a. Preference will be given to hospitals in counties with a population of less than five hundred thousand persons according to the most recent federal decennial census.

    b. Thereafter, the applications will be ranked in descending order according to the Population-to-Primary-Care-Provider Ratio for each hospital's Primary Care Area.

3. Subject to available funds, the Administration will offer loans in descending order beginning with the highest ranked application. The Administration will deny applications when no funds remain for the fiscal year. An applicant whose application is denied due to unavailability of funds for the current fiscal year may reapply for the following fiscal year.

F. Determination of Loan Amount

The Administration will offer loan amounts based on the number of resident positions reasonably expected to be filled in the first two years of the program's operation, which expectation must be supported by the pro forma budget and the program plan submitted for purposes of accreditation. The loan amount offered will be the lesser of one hundred thousand dollars per resident or five hundred thousand dollars, but in no case less than two hundred thousand dollars.

G. Loan Approval and Issuance

By November 1st of each year, the Administration will notify each loan applicant of approval or denial of the loan application and, for approved applications, the approved amount of the loan. The Administration will issue a warrant for the approved amount of the loan following execution of a promissory note for the full amount of the loan.

For state fiscal year 2007 only, the Administration will notify each loan applicant by June 30th, 2007.

H. Loan Repayment

Repayment of the loan must begin within 90 days following receipt of the first federal payment for direct GME or five years after the date of loan issuance, whichever is earlier. Repayment will be in annual installments and must be completed no more than ten years after the date of loan issuance. Each installment will be equal to the loan amount divided by the number of years remaining of the ten-year time limit for full repayment.

A hospital may elect to begin repayment prior to the required date and may elect to repay the loan in full at any time prior to the date that repayment in full is required.

IV. References

- A.R.S. § 36-2921
- A.R.S. § 36-2903.01(H)(9)(e)
- A.R.S. § 36-2901(12)
- A.A.C. R9-22-101(B)
- A.A.C. R9-22-701
- Arizona Department of Health Services, Primary Care Area Program

106 – RESERVED

107 CONTRACTING WITH MEDICARE SPECIAL NEEDS PLANS

Effective Date: April 1, 2012
Revision Date:

Staff responsible for policy: DHCM Administration

I. Purpose

This Policy applies to organizations, whether or not they are existing Acute Care or ALTCS Contractors, that currently have contracts, or will be pursuing contracts, with the Centers for Medicare and Medicaid (CMS) to operate as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) in calendar year 2013. Beginning January 1, 2013, federal regulations require that all D-SNPs have a contract in place with the State Medicaid Agency which outlines for CMS and the State the specific dual eligible population the D-SNP will serve as well as care coordination and cost sharing obligations. D-SNPs are a type of Medicare Advantage plan which limits enrollment to Medicare beneficiaries who are also receiving Medicaid benefits. The purpose of this Policy is to maximize care coordination for AHCCCS acute care and ALTCS members who are dual eligibles.

To further align care coordination of dual eligibles, the AHCCCS Administration also intends to submit a Dual Demonstration Project Proposal to CMS which outlines additional proposals for integration and care coordination of dual eligible members for the time period of January 2014 through December 2016.

II. Definitions

Acute Care Duals: AHCCCS beneficiaries who are determined eligible for AHCCCS acute care benefits, including but not limited to AHCCCS members eligible under 1931, SSI MAO, and AHCCCS Care, who are enrolled in Medicare Part A and/or Part B.

ALTCS Duals: Persons who have been determined eligible for the ALTCS EPD or DD Program because they require an institutional level of care and meet financial and other eligibility criteria for Title XIX eligibility and who are also enrolled in Medicare Part A and/or Part B.

III. Policy

A. AHCCCS Acute Care Duals

In spring 2013 AHCCCS will award acute care contracts to successful bidders of the Request for Proposal (RFP) process for provision of acute care services beginning October 1, 2013. To maximize care coordination of AHCCCS dual eligible members in anticipation

of the upcoming RFP process, AHCCCS will sign contracts for the time period of January 1, 2013 through December 31, 2013 with:

1) 2012 Medicare approved D-SNPs, which are NOT current Acute Care Contractors, to continue operation of D-SNPs in those counties in which they currently operate 2012 Medicare approved D-SNPs. The AHCCCS contracts will be effective from January 1, 2013 through December 31, 2013 only. AND
2) Current Acute Care Contractors which operate 2012 Medicare approved D-SNPs to continue operation of D-SNPs in all such counties, regardless of whether or not the D-SNP operates in a county in which it also has an acute care contract. AHCCCS contracts with current Acute Care Contractors operating D-SNPS will be effective only from January 1, 2013 through December 31, 2013.

Beginning January 1, 2014, AHCCCS will align care of dual eligibles and will not contract with any D-SNPs operating in counties in which they do not *also* have an acute care contract. Alignment of dual eligible members in the same plan for both Medicare and Medicaid services provides members with one entity that coordinates all aspects of care, thus decreasing fragmentation of care and reducing confusion for members, providers, and contractors related to service delivery.

B. ALTCS-EPD Duals

In May 2011 AHCCCS awarded new contracts for the ALTCS-EPD Program covering the time period of October 1, 2011 through September 30, 2014, with the possibility for two 1-year contract extensions. As a condition of receiving an award in Maricopa and Pima counties, bidders were required to have an aligned Medicare Advantage Plan or a D-SNP in those counties. To further enhance care coordination of ALTCS dual eligible members, AHCCCS will sign contracts for the time period of January 1, 2013 through December 31, 2013 with:

1) 1) 2012 Medicare approved D-SNPs, which are NOT current ALTCS Contractors, to continue operation of D-SNPs in those counties in which they currently operate 2012 Medicare approved D-SNPs. The AHCCCS contracts will be effective from January 1, 2013 through December 31, 2013 only. AND

2) Current ALTCS Contractors which operate 2012 Medicare approved D-SNPs to continue operation of D-SNP plans in all such counties, regardless of whether or not the D-SNP operates in a county in which it also has an ALTCS contract. AHCCCS contracts for current ALTCS Contractors operating D-SNPS will be effective only from January 1, 2013 through December 31, 2013 only.

Beginning January 1, 2014, AHCCCS will align care of dual eligibles and will not contract with any D-SNPs operating in counties in which they do not *also* have an ALTCS contract. Alignment of dual eligible members in the same plan for both Medicare and Medicaid services provides members with one entity that coordinates all aspects of care, thus decreasing fragmentation of care and reducing confusion for members, providers, and contractors related to service delivery.

C. ALTCS-DD Duals

ALTCS services for persons who are Developmentally Disabled (DD) are provided by the Department of Economic Security (DES), Division of Developmental Disabilities (DDD) as specified in State Law. Therefore, D-SNPs do not have contracts directly with the State Medicaid Agency for serving DD members. If CMS recommends D-SNP contracting for DD ALTCS members, AHCCCS will explore whether alignment of Medicare and Medicaid services can be achieved and pursue contracting when feasible.

IV. Data Sharing

Claims data for Medicare beneficiaries enrolled in Medicare Advantage plans is not currently available to states. Therefore, AHCCCS may require that all current AHCCCS Contractors operating D-SNPs submit Medicare claims to AHCCCS. This data will be used by AHCCCS for care coordination and other operational activities related to dual eligible members.

V. Care Coordination

All D-SNPs must ensure timely coordination of care with the member's Acute Care or ALTCS Contractor.

VI. Process

AHCCCS has developed a contract template for use by each D-SNP. All contracts must describe the following:

1. The MA organization's responsibility, including financial obligations, to provide or arrange for Medicaid benefits;
2. The category(ies) of eligibility for dual-eligible beneficiaries to be enrolled under the SNP, as described under by the Social Security Act at sections 1902(a), 1902(f), 1902(p), and 1905;
3. The Medicaid benefits covered under the SNP;
4. The cost-sharing protections covered under the SNP;
5. The identification and sharing of information on Medicaid provider participation;
6. The verification of enrollee's eligibility for both Medicare and Medicaid;
7. The service area covered by the SNP; and
8. The contract period for the SNP.

D-SNPs may review the contract template and submit their proposed agreement with tracked changes to Katrina Cope at Katrina.Cope@azahcccs.gov. D-SNPs are required to submit a contract with the State Medicaid Agency to CMS by July 1, 2012. To ensure that AHCCCS has adequate time to review the D-SNP contracts, all contracts must be received no later than April 30, 2012.

Questions concerning this Policy may be directed to Katrina Cope at (602) 417-4173.

VII. References

- Section 1859(f) of the Social Security Act
- Section 164 of the Medicare Improvement for Patients and Providers Act
- Section 3205 of the Affordable Care Act
- 42 Code of Federal Regulations 422.107
- Medicare Managed Care Manual Chapter 16-B: Special Needs Plans

201 - MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

Effective Date: 10/01/97, 02/01/13, 07/01/13
Revision Date: 06/01/01, 03/11/10, 01/03/13, 06/06/13, 07/18/13

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to Acute, ADHS/DBHS, ALTCS/EPD, CRS, DES/CMDP (CMDP), and DES/DDD (DDD) Contractors, hereafter known as Contractors. The purpose of this policy defines cost sharing responsibilities of Contractors for their members that are Medicare beneficiaries receiving Medicare Parts A and/or B through Original FFS Medicare or a Medicare Advantage Plan.

This reimbursement policy will maximize cost avoidance efforts by Contractors and provide a consistent reimbursement methodology for Medicare cost sharing.

II. Definitions

Cost Sharing	Refers to Contractors' obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.
In-Network Provider	A provider that is contracted with the Contractor to provide services.
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. Types of Medicare Advantage plans include Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).
Medicare Part A	Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.
Medicare Part B	Coverage for medically-necessary services like doctors' services, outpatient care, home health services, and other medical services

Medicare Part D	Medicare prescription drug coverage.
Non-QMB Dual	An individual who is eligible for Medicaid and has Medicare coverage, but who is not eligible for QMB benefits.
Out of Network Provider	A provider that is neither contracted with nor authorized by the Contractor to provide services to its members.
Qualified Medicare Beneficiary (QMB) Dual	An individual who is eligible for QMB benefits as well as Medicaid benefits.

III. Policy

A. Covered Services

1. QMB Duals

QMB Duals are entitled to all AHCCCS and Medicare Part A and B covered services. Contractors are responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. The Contractor only has responsibility to make payments to providers registered with AHCCCS to provide services to AHCCCS eligible members. The payment of Medicare cost sharing must be provided regardless of whether the provider is in the Contractor's network or prior authorization has been obtained.

QMB Dual Cost Sharing Matrix

Covered Services	Contractor Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	Cost sharing responsibility only	YES	YES
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	YES
Emergency Services	Cost sharing responsibility only	YES	YES

*Subject to Contractor policy

2. Non-QMB Duals

The Contractor is responsible for the payment of the Medicare cost sharing for AHCCCS covered services that are rendered by a Medicare provider within the Contractor's network.

Non-QMB Dual Cost Sharing Matrix

Covered Services	Contractor Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	No cost sharing responsibility	NO	NO
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES*	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	NO*
Emergency Services	Cost sharing responsibility only	YES	YES

*Unless authorized by the AHCCCS Contractor

B. Limits on Cost Sharing

The Contractor shall have no cost sharing obligation if the Medicare payment exceeds the Contractor's contracted rate for the services. The Contractor's liability for cost sharing

plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service. There is no cost sharing obligation if the Contractor 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 Contractor shall pay 100% of the member copayment amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

C. Prior Authorization

The Contractor can require prior authorization, but if the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing, even if the Contractor determines otherwise. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service.

D. Out of Network Services

For QMB Dual members, the Contractor has cost sharing responsibility regardless of whether the services were provided by an in or out of network provider. For AHCCCS covered services rendered by an out of network provider to a non-QMB Dual, the Contractor is not liable for any Medicare cost sharing unless the Contractor has authorized the member to obtain services out of network. If a member has been advised of the Contractor's network, and the member's responsibility is delineated in the member handbook, and the member elects to go out of network, the Contractor is not responsible for paying the Medicare cost sharing amount.

E. Part D Covered Drugs

Federal and State laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.

F. Institutional Status Reporting – Part D Co-Pays

(Acute, ADHS/DBHS, CMDP & CRS) When a dual eligible member is inpatient in a medical institution or nursing facility and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to CMS, the Contractor must notify the AHCCCS, Member Database Management Administration (MDMA), using the form provided in Attachment A of this Policy, as soon as it determines that a dual eligible person is expected to be in a medical institution that is

funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

a. Members who have Medicare Part "D" only:
b. Members who have Medicare Part "B" only;
c. Members who have used their Medicare Part "A" life time inpatient benefit; and
d. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.

Types of Medical Institutions
For purposes of the medical institution notification, medical institutions are defined as:

- Acute hospitals,
- Psychiatric hospital – Non IMD,
- Psychiatric hospital – IMD,
- Residential treatment center – Non IMD,
- Residential treatment center – IMD,
- Skilled nursing facilities, and
- Intermediate Care Facilities for the Intellectually Disabled.

ALTCS/EPD and DDD are not required to provide this information as the State is already aware of the institutional status of these members and provides this information to CMS.

IV. References

- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Revised Statutes §36-2946 A and §36-2972 C
- Arizona Administrative Code R9-29 Articles 3 and 4
- Medicaid Managed Care Regulations
- Social Security Act, 1905(p)(3)
- Attachment A, AHCCCS Notification To Waive Medicare Part D Co-Payments
- Social Security Act, 1860D-14
- Social Security Act, 1902(q)(1)(B)
- 42 CFR 435.1010
- Medicare Prescription Drug Benefit Manual, Chapter 13, Section 60.2
- Medicare Managed Care Manual Chapter 16-B, Section 80.4.3
- 42 USC §1396 u-5d

Attachment A, AHCCCS Notification To Waive Medicare Part D Co-Payments

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

AHCCCS NOTIFICATION TO WAIVE MEDICARE PART D CO-PAYMENTS

Fax to AHCCCS Member Database Management Administration (MDMA)*: *(602) 253-4807

Member Name: **AHCCCS ID**:

Date of Birth:

Type of Medical Institution	Date of Admission	AHCCCS Provider ID#	Name of Medical Institution

Comments:

Date: **Contractor Name**:

Submitted By:

Title:

Phone #:

202 – RESERVED

203 – CONTRACTOR CLAIMS PROCESSING BY SUBCONTRACTED PROVIDERS

Effective Date: 02/01/97; 04/13/2012
Revision Date: 11/01/02, 6/15/05, 04/13/12

Staff responsible for policy: DHCM

I. Purpose

This policy applies to all Contractors with subcontracts that require claims and encounters to be adjudicated and paid by or under the direction of a subcontracted provider group.

Per the AHCCCS contract Section D, Subcontracts, "No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract". Accordingly, AHCCCS holds its Contractors 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 subcontract arrangements.

II. Definitions

ACOM: AHCCCS Contractor Operation Manual

Subcontracted Provider Group: Any health plan subcontracted provider, provider group, or provider management company responsible for the coordination of health care service delivery to AHCCCS members.

III. Policy

A. Contractors shall obtain prior approval from AHCCCS of all subcontracts that call for claims processing to be performed by or under the direction of a subcontracted provider group. The subcontract shall be submitted to AHCCCS Division of Health Care Management for prior approval at least 60 days prior to the beginning date of the subcontract.

B. The Contractor shall ensure they have a mechanism in place to inform providers of the appropriate place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

C. Date of Receipt: The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified mailing address. The Contractor shall forward all claims received to the subcontracted provider group responsible for claims adjudication.

D. Timeliness of Claim Submission and Payment: Unless a subcontract specifies otherwise, Contractors with 50,000 or more members shall ensure that 95% of all clean claims are

paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Unless a subcontract specifies otherwise, Contractors with fewer than 50,000 members shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service. Claim payment requirements pertain to both contracted and non-contracted providers.

E. Interest Payments: Effective for all non-hospital clean claims with dates of service October 1, 2004 and thereafter, in the absence of a contract specifying other late payment terms, a Contractor is required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45 day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 293.01. When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Reporting Manual.

F. Electronic Processing Requirements: Contractors are required to accept and generate required HIPAA compliant electronic transactions from to/any provider interested and capable of electronic submission or electronic remittance receipt; and must be able to make claims payments via electronic funds transfer. (See Section D, Paragraph 38 for requirements)

G. The Contractor shall require the subcontracted provider group to submit a monthly claims aging summary to the Contractor to ensure compliance with claims payment timeliness standards. The Contractor may consider requiring such reports to be consistent in format with the AHCCCS required reports.

H. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule. The schedule for review shall be submitted to AHCCCS, Division of Health Care Management for prior approval. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

I. The Contractor shall monitor the volume of encounters received from the subcontracted provider group so that encounters are forwarded in accordance with AHCCCS' standards and thresholds.

J. The Contractor shall ensure the subcontracted provider group's remittance advice meets the requirements in the AHCCCS RFP including, but not limited to:

1. The remittance advice shall contain sufficient detail to explain the payment including the composition of the net amount of the payment. In addition, if payment is being denied, there must be sufficient detail to explain the reasons for denial.

2. Provider claims dispute rights shall be referenced.

K. The Subcontractor shall adhere to the Coordination of Benefits/Third Party Liability requirements per the RFP, Section D. The Subcontractor shall adhere to all requirements per the ACOM *Member Notice for Non-Covered Services Policy.*

L. The Subcontractor shall adhere to all Health Insurance, Portability and Accountability Act (HIPAA) requirements according to Public Law 107-191, 110 Statutes 1936.

IV. References

- Acute Care Contract, Section D, Subcontracts, Claims Payment/Health Information System, Coordination of Benefits/Third Party Liability

- ALTCS Contract, Section D, Subcontracts, Claims Payment/Health Information System, Coordination of Benefits/Third Party Liability

- Arizona Administrative Code R9-22, Article 7: Payments by Contractors

204 – RESERVED

205 – GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT GUIDELINES FOR NON-CONTRACTED PROVIDERS

Effective Date: 05/01/2006, 04/01/2013
Revision Date: 04/04/2013

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors. The purpose of this policy is to provide ground ambulance transportation reimbursement guidelines. It is limited to AHCCCS Contractors and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

Note: A contract agreement between parties would **not** be subject to this policy.

Refer to the AHCCCS Medical Policy Manual Chapter 300, Policy 310-BB, Transportation for a general description of the transportation policy.

II. Definitions

For purposes of this policy the following definitions apply:

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 that 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.
Ambulance	Under AR.S. §36-2201, ambulance means **"**Any publicly or privately owned surface (ground), water or air vehicle that contains a stretcher and necessary medical equipment and supplies pursuant to section §36-2202 and that is especially designed and constructed or modified and equipped to be used,

	maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. "Ambulance" does not include a surface vehicle that is owned and operated by a sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in–transit care of its employees or a vehicle to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or qualified ambulance attendants as defined in A.R.S. §36-2201."
Basic life support (BLS)	Under 42 CFR 414.605, BLS is transportation by ground ambulance vehicle and 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 an emergency medical technician-basic (EMT–Basic).
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.
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.
Emergency Medical Condition	Emergency medical condition is defined as the treatment for a medical condition, including emergency labor and delivery which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possess an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical attention to result in: 1. Placing the member's health in serious jeopardy 2. Serious impairment to bodily functions or 3. Serious dysfunction of any bodily organ or part.

Emergency Medical Services

Emergency medical services means services provided for the treatment of an emergency medical condition.

EMT-Basic (EMT-B)

The EMT-B provides basic life support without providing invasive procedures or cardiac monitoring or ALS procedures.

Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), bureau of emergency medical services, the EMT-basic is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-B curriculum. In addition to the examples of BLS services/procedures in Section III(A)(2)(a), the following are examples of member conditions requiring the basic skill level of the EMT-B:

1. Labor and delivery in route to medical care (no history of complications)
2. ETOH (intoxication) and passed out due to intoxication.

EMT-Paramedic (EMT-P)

The EMT-P is educated and capable to perform invasive procedures, heart monitoring and administer a wide variety of drugs and other ALS procedures.

Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), Bureau of Emergency Medical Services, the EMT-P is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-P curriculum. In addition to the examples of ALS services/procedures noted in Section III(A)(1)(a)(4)(a) of this policy, the following are examples of member conditions requiring the advanced skill level of the paramedic:

1. Gun shot/stab wounds/major trauma
2. Impending birth/complications of pregnancy
3. Chest pain /heart attack

4. Hemorrhage/shock/profuse bleeding
5. Unconscious/coma/uncontrolled seizures/severe head injury
6. Unresponsive/"found down"
7. Diabetic coma
8. Stroke
9. Respiratory distress (respiratory arrest/asthma).

III. Policy

A. Ground Emergency Ambulance Transportation

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by AHCCCS Contractors a percentage proscribed by law of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the AHCCCS Capped Fee for Service (FFS) Schedule will be used.

Criteria and reimbursement processes for Advanced Life Support (ALS) and Basic Life Support (BLS) are as follows.

1. Advanced Life Support (ALS) level

    a. In order for ambulance services to be reimbursable at the ALS level, all of the following criteria must be satisfied**:**
        1) The ambulance must be ALS licensed and certified in accordance with A.R.S. §36-2212 and 9 A.A.C.13**,** Articles 10 and 11
        2) ALS certified personnel such as the EMT-P described in Section II are present
        3) ALS services/procedures are medically necessary, based upon the member's symptoms and medical condition (refer to examples in Section II under EMT-P) at the time of the transport and
        4) ALS services/procedures and authorized treatment activities were provided.
            a) ALS services/procedures performed by an EMT-P include but are not limited to:
                i. Manual defibrillation/ cardioversion
                ii. Endotracheal intubation
                iii. Esophageal obdurate airway
                iv. Monitor central venous line
                v. Cardiac pacing
                vi. Chest decompression
                vii. Surgical airway
                viii. Intraosseous line
                ix. Gastric suction

x. Parenteral fluid, as a directed medical therapy and not for the purpose of maintaining an intravenous line
xi. Medication administration excluding oxygen
xii. Required, medically necessary pre-hospital phlebotomy
xiii. Placement/establishment of a peripheral venous catheter
xiv. Basic cardiac monitoring

b) Services/procedures that do not qualify as ALS include, but are not limited to:
i. Parenteral fluid, for the purpose of maintaining an open line or other non-therapeutic rate of fluid administration
ii. Oxygen delivery (by any means)
iii. Pulse oximetry
iv. Blood glucose testing
v. Assisting a member in the administration of their own home medications

b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
1) Medical condition, signs and symptoms, procedures, treatment
2) Transportation origin, destination, and mileage (statute miles)
3) Supplies and
4) Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

2. Basic Life Support (BLS) level

a. In order for ambulance services to be reimbursable at the BLS level, all of the following criteria must be satisfied**:**
1) The ambulance must be BLS licensed and certified in accordance, A.R.S. §36-2212 and 9 A.A.C.13**,** Articles 10 and 11
2) BLS certified personnel, for example, the EMT-B described in Section II are present
3) BLS services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport and

4) BLS services/procedures and authorized treatment activities were provided.

BLS services/procedures performed by an EMT-B include but are not limited to:

a) Monitoring intravenous lines during interfacility transfers
b) Blood glucose monitoring
c) Utilizing the automatic external defibrillator (AED)
d) Assisting a patient to take the following prescribed medications (must be the patient's prescription)
   i. Nitroglycerin
   ii. Auto injectable epinephrine
   iii. Bronchodilating inhalers

b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
   1) Medical condition, signs and symptoms, procedures, treatment
   2) Transportation origin, destination, and mileage
   3) Supplies and
   4) Necessity of attendant, if applicable.

   Claims submitted without such documentation are subject to denial.

   Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

B. Nonemergent Ground Ambulance Transportation Payment Guidelines

1. All Hospital-to-Hospital transfers for the Contractor will be paid, minimally**,** at the BLS rate, unless the transfer requires ALS level of service. This includes transportation between general and specialty hospitals.

2. At the Contractor's discretion, nonemergent ambulance transportation, other than the scenario described in #1 above, may not require prior authorization or notification, but is subject to review for medical necessity by the Contractor. Medical necessity criteria is based upon the medical condition of the member and includes ground ambulance services provided because the member's medical condition was contradictory to any other means of transportation. This may include after hour calls. An example would be as follows: an ambulance company receives a call from the emergency room to transport a nursing facility member back to the facility and the Contractor can not be reached.

3. Transportation reimbursement will be reduced to the level of the appropriate alternative transportation when services provided do not qualify as ALS or BLS (Refer to Section II, Definitions), or the ALS/BLS services rendered at the time of transport are deemed not medically necessary. If the transportation vendor does not have established non-ALS or non-BLS levels, claims will be paid at the AHCCCS established capped-fee-for-

service amount for the appropriate alternative transportation service for example: taxi or van (ambulatory, wheelchair or stretcher).

4. Nonemergent transportation by ambulance is appropriate if:
   a. Documentation that other methods of transportation are contraindicated and
   b. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.
5. Nonemergent transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) 410.40 (Coverage of Ambulance Services)
- 42 CFR 414.605 (Definitions)
- A.R.S. §36 Chapter 21.1 Articles 1, 2 (Emergency Medical Services)
- 9 A.A.C. 13, Article 10 (Ambulance Service Licensure)
- 9 A.A.C. 13, Article 11 (Ambulance Registration Certificate)
- 9 A.A.C. 22, Article 2 (Transportation Services)
- 9 A.A.C. 25 ((Department of Health Services Emergency Medical Services)
- AMPM, Chapter 300, Policy 310-BB, Transportation

206 – RESERVED

301 – PROSPECTIVE TITLE XIX WAIVER GROUP (TWG) MEDICAL EXPENSE DEDUCTION (MED) RECONCILIATION POLICY

Effective Date: 10/01/10
Revision Date: 3/24/08, 12/17/09, 8/27/10, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the Title XIX Waiver Group (TWG) Medical Expense Deduction (MED) prospective population reconciliation for those AHCCCS Acute Care Contractors (hereafter referred to as Contractors) contracted to provide medical services for the TWG MED population. This reconciliation applies to CYE '11. This reconciliation will not occur after CYE '11 as the program terminated effective 9/30/11

The TWG MED reconciliation is based upon prospective net revenue as described in this policy. AHCCCS will reimburse/recoup 100% of a Contractor's reasonable costs in excess of a 3% profit or loss, as determined by fully adjudicated encounter data, subcapitated expenses, and paid reinsurance amounts.

II. Definitions

Net TWG MED Capitation: MED Prospective Capitation plus Delivery Supplement payments less the administrative % and the premium tax %.

III. Policy

A. General

1. The TWG MED reconciliation shall relate to medical expenses during the prospective period of enrollment (including subcapitated expenses) net of reinsurance for the TWG MED population. The amount of the reimbursement to be reconciled against will be net of the administrative percentage and premium tax components included in the capitation rate (see Attachment A for calculation).

2. The reconciliation will limit the Contractor's profits and losses to 3% of the Contractor's net TWG MED capitation. Any losses in excess of 3% will be reimbursed to the Contractor, and likewise, profits in excess of 3% will be recouped.

B. AHCCCS Responsibilities

1. No sooner than six months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation of actual medical cost experience to capitation and reinsurance paid:

   Prospective Capitation + Delivery Supplement payment - administration % - premium tax % (see Attachment A for calculation)

   Less: Total medical expenses (net of reinsurance)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual medical cost experience.

3. AHCCCS will compare adjudicated encounter and subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

4. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

5. A second and final reconciliation will be done no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

6. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped through a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify Title XIX Waiver Group MED transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. Contractor shall monitor the estimated TWG MED reconciliation receivable/payable and record appropriate accruals on financial statements submitted to AHCCCS on a quarterly basis.

3. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date specified with the initial reconciliation. It is also the responsibility of the Contractor to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the contract year being reconciled. Any encounter data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

4. Submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be adjusted (voided or void/replaced) and adjudicated no later than 120 days from the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- Acute Care Contract, Section D, Compensation

V. Note

Administration percentage by contract year:
- CYE '11 – 8.0%

Premium tax – 2%

Attachment A – Sample TWG Reconciliation

Health Plan
Prospective Title XIX Waiver Group MED Reconciliation - EXAMPLE
For Contract Year Ended X/XX/XX

		MED
Gross TWG MED Revenue [1]	$	30,000,000.00
Premium Tax [7]	$	(600,000.00)
Admin %	$	(2,177,777.78)
TWG MED Revenue Net of Admin and Premium Tax*	$	27,222,222.22
HP Paid Encounters [2]	$	(26,800,000.00)
HP Reported Subcapitated Expenditures [3]	$	(105,000.00)
Exclusion of Subcap Code 01 Encounters [6]	$	548,000.00
Reinsurance Paid [4]	$	3,225,000.00
Net Profit/(Loss)	$	4,090,222.22
% of Rev Net of Admin		15.03%
MM [5]		60,000

Net Capitation	$	27,222,222.22
Total Profit/(Loss)	$	4,090,222.22
Risk Band Corridor - 3% or (3%)	$	816,666.67
TWG MED Amount Due To (From) Health Plan	$	(3,273,555.56)

Assumptions:

(1) Gross TWG MED revenue includes prospective capitation and delivery supplement paid for the period 10/1/xx - 9/30/xx.

(2) Health Plan Encounters includes all prospective TWG MED adjudicated encounters for the period 10/1/xx - 9/30/xx.

(3) Subcapitated Expenditures is data submitted by the Health Plans for the prospective TWG MED time period.

(4) Reinsurance Paid includes all payments to the Health Plan for the period of 10/1/xx - 9/30/xx.

(5) Member Months are actual TWG MED prospective member months paid for the period of 10/1/xx-9/30/xx.

(6) Subcap Code 01 Encounters have been excluded from the data because the health plans are required to self report sub-capitated expenses as noted in #3 above. Subcap Code 01 and CN 05 Encounters are for the period of 10/1/xx - 9/30/xx.

7) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate**		
Cap Rate before Admin and Prem Tax		$100.00
Add Admin Amount per Policy	+$100 * 8%	$8.00
Subtotal	+$100 + $8.00	$108.00
Add Premium Tax (PT) of 2.0% [7]	+$108/.98 - $108	$2.20
Gross Capitation Rate	+$108.00 + $2.20	$110.20

*** Calculating the Net Revenue**	
Gross Capitation Rate	$110.20
Deduct Premium Tax (Gross x 2%) [7]	$2.20
Deduct Admin Amount per Policy ((Gross-PT) - ((Gross-PT)/1.08))	$8.00
Net Capitation Revenue (Gross-PT-Admin)	$100.00

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

301A – PROSPECTIVE TITLE XIX WAIVER GROUP (TWG) NON-MED RECONCILIATION POLICY

Effective Date: 10/01/2011
Revision Date: 8/27/2010, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the Title XIX Waiver Group (TWG) non-Medical Expense Deduction (non-MED) prospective population reconciliation (TWG non-MED Reconciliation) for those AHCCCS Acute Care Contractors (hereafter referred to as Contractors) contracted to provide medical services for the non-MED population.

The TWG non-MED reconciliation is based upon prospective net capitation and prospective expenses as described in this policy. AHCCCS will recoup/reimburse 100% of a Contractor's costs in excess of a 2% profit or loss, as determined by fully adjudicated encounter data, self reported subcapitated expenses, and paid reinsurance amounts.

II. Definitions

Net TWG non-MED Capitation: Non-MED Prospective Risk Adjusted Capitation plus Delivery Supplement payments, less the administrative and the premium tax components. The administrative component will be equivalent to the percentage listed in section V. This PMPM is multiplied by the actual prospective TWG non-MED member months for the period being reconciled to arrive at the administrative component amount used in the reconciliation calculation.

Reinsurance: Reinsurance will be based on the actual reinsurance revenue received by the Contractor for the dates of being reconciled.

III. Policy

A. General

1. The prospective TWG non-MED reconciliation shall relate to medical expenses during the prospective period being reconciled (including subcapitated expenses) net of reinsurance. The amount of the reimbursement to be reconciled against will be net of the administrative and premium tax components included in the capitation rate (see Definitions and Attachment A for calculation).

2. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net prospective TWG non-MED capitation. Any losses in excess of 2% will be reimbursed to the Contractor, and profits in excess of 2% will be recouped.

B. AHCCCS Responsibilities

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

   Prospective Risk Adjusted Capitation + Delivery Supplement payment - administration - premium tax (see Definitions and Attachment A for calculation)

   Less: Total medical expenses (net of reinsurance – see Definitions)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual medical cost experience.

3. AHCCCS will compare fully adjudicated encounter and subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

4. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

5. A second and final reconciliation will be done 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. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

6. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped through a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify prospective TWG non-MED transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

2. Contractor shall monitor the estimated prospective TWG non-MED reconciliation receivable/payable and record appropriate accruals on financial statements submitted to AHCCCS on a quarterly basis.

3. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date specified with the initial reconciliation. It is also the responsibility of the Contractor to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. Any encounter data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

4. Submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be adjusted (voided or void/replaced) and adjudicated no later than 120 days from the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- Acute Care Contract, Section D, Compensation

V. Note

Administration:

- CYE ’11 – Contractor CYE ’09 Bid Administration PMPM less 5.88%
- CYE ’12 – Contractor CYE ’09 Bid Administration PMPM less 5.88%

Premium tax – 2%

Attachment A – Sample TWG non-MED Reconciliation

Health Plan
Prospective Title XIX Waiver Group non-MED Reconciliation - EXAMPLE
For Contract Year Ended 9/30/XX

				non-MED
TWG non-MED Risk Adjusted Capitation Revenue [1]			$	30,000,000.00
Premium Tax [7]			$	(600,000.00)
Admin %			$	(2,049,933.60)
TWG non-MED Revenue Net of Admin and Premium Tax*			$	27,350,066.40
HP Paid Encounters [2]			$	(26,800,000.00)
HP Reported Subcapitated Expenditures [3]			$	(105,000.00)
Exclusion of Subcap Code 01 Encounters [6]			$	548,000.00
Reinsurance Paid [4]			$	3,225,000.00
Net Profit/(Loss)			$	4,218,066.40
% of Rev Net of Admin				15.42%
MM [5]				60,000
Net Capitation	$	27,350,066.40		
Total Profit/(Loss)	$	4,218,066.40		
Risk Band Corridor - 2% or (2%)	$	547,001.33		
TWG Non-MED Amount Due To (From) Health Plan	$	(3,671,065.07)		
Premium Tax	$	(74,889.73)		
Net TWG Non-MED Amount Due To (From) Health Plan	$	(3,745,954.80)		

Assumptions:

(1) TWG non-MED revenue includes prospective risk adjusted capitation and delivery supplement paid for the period being reconciled.

(2) Health Plan Encounters includes all prospective TWG non-MED adjudicated encounters for the period being reconciled.

(3) Subcapitated Expenditures is data submitted by the Health Plans for the prospective TWG non-MED time period.

(4) Reinsurance Paid includes all payments to the Health Plan for the period being reconciled.

(5) Member Months are actual TWG non-MED prospective member months paid for the period being reconciled.

(6) Subcap Code 01 Encounters have been excluded from the data because the health plans are required to self report sub-capitated expenses as noted in #3 above. Subcap Code 01 and CN 05 Encounters are for the period being reconciled.

7) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate**		
Cap Rate before Admin and Prem Tax		$100.00
Add CYE09 Bid Admin PMPM less 5.88%	+$100+8.75-(8.75*.0588)	$8.24
Subtotal		$108.24
Add Premium Tax (PT) of 2.0% [7]	+$108.24/.98-$108.24	$2.21
Gross Capitation Rate		$110.44

*** Calculating the Net Revenue**	
Gross Capitation Rate	$110.44
Deduct Premium Tax (Gross x 2.0%)) [7]	$2.21
Deduct Admin	$8.24
Net Capitation Revenue (Gross-PT-Admin)	$100.00

Source: TWG Cap and MM Paid - DOS, ReportAHAHG296
TWG Medical Expenses - DOS, Report AHAHG294
Health Plan Self Reported Subcapitated Expenses
TWG Reinsurance Paid from DBF

302 - PRIOR PERIOD COVERAGE RECONCILIATION: ACUTE CARE CONTRACTORS

Effective Date: 10/01/10
Revision Date: 03/15/08, 12/09/09, 8/25/10, 4/17/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to PPC reconciliations for CYE '11 and forward for all AHCCCS Acute Care Contractors.

Due to the uncertainty regarding actual utilization and medical cost experience during the PPC period, AHCCCS intends to limit the financial risk to its Contractors. For CYE '11 and forward, AHCCCS will reconcile the PPC period for all risk groups, except the Title XXI members, SOBRA Family Planning, and State Only Transplants. Effective 10/01/11 and forward, the Title XIX Waiver Group MED population will no longer be reconciled, as the program terminated 9/30/11.

II. Definitions

PPC Capitation: Capitation payment for the period of time from the 1st day of the month of application or the 1st eligible month, whichever is later, to the day a member is enrolled with the Contractor. Also, the period of time between the date a MED member was approved and the date the member met spenddown, or 1st day of the month the member reduced resources whichever is later.

PPC Period: The period from the effective date of eligibility to the day a member is enrolled with a Contractor.

PPC Medical Expense: Total expenses covered under the Acute Care Contract for services provided during the PPC time period.

Title XIX Waiver Group Member (TWG): All Medical Expense Deduction (MED) and Non-MED (AHCCCS Care) members who do not meet the requirements of a categorically linked Medicaid program. The Title XIX MED program terminated 9/30/11.

III. Policy

A. General

1. For CYE '11 the reconciliation shall relate solely to aggregate adjudicated PPC medical expenses for the following capitation risk groups: TANF, SOBRA, SSI w/Med, SSI w/o Med, and the Title XIX Waiver Group (MED and non-MED). For CYE 12 and forward the reconciliation shall relate solely to aggregate adjudicated PPC medical expenses for the following capitation risk groups: TANF, SOBRA, SSI w/Med, SSI w/o Med, and Title XIX Waiver Group Non-MED. The reconciliation will exclude Title XXI, SOBRA Family Planning, and State Only transplant members for all contract years.

2. For all contract years, administrative, premium tax and non-operating expenses shall be excluded.

3. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's net PPC capitation for all covered risk groups combined (See Attachment A for calculation). Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. The full PPC period is eligible for this reconciliation.

B. AHCCCS Responsibilities

1. No less than six months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation.

2. AHCCCS will compare fully adjudicated encounter information to financial statements and other Contractor submitted files for reasonableness.

3. AHCCCS will provide to the Contractor the data used for the initial reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through a future monthly capitation payment.

4. A second and final reconciliation will be done no less than 12 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. AHCCCS will provide to the Contractor the data used for the final reconciliation and provide a set time period for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

5. Any amount over or underpaid as a result of the final reconciliation will be paid or recouped with a future monthly capitation payment.

C. Contractor Responsibilities

1. Contractors shall submit encounters for PPC medical expenses and those encounters must reach fully adjudicated status by the required due dates. AHCCCS will only utilize fully adjudicated encounters reported by the Contractor to determine the medical expenses used in the reconciliation.

2. The Contractor shall maintain financial statements that separately identify all PPC transactions, and shall submit such statements as required by contract and in the format specified in the Reporting Guide.

3. The Contractor shall monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financials statements submitted to AHCCCS on a quarterly basis.

4. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments via the initial reconciliation by the due date provided. It is also the responsibility of the Contractor to correct (including adjudication of corrected encounters) any identified encounter data issues no later than 12 months after the end of the contract year being reconciled. Reconciliation data issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

5. Submit data as requested by AHCCCS for reconciliation purposes. (e.g. encounter detail file, etc.)

6. For all reconciliations, if the Contractor performs recoupments on the related claims, the related encounters must be corrected (voided or void/replaced) and adjudicated no later than 120 days after the date of the recoupment. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

D. Reconciliation Calculation for All Covered Risk Groups

PPC Capitation – Administration% (See Section V) – Premium Tax %

Less: Total Medical Expense

Equals: Profit/Loss to be reconciled
See Attachment A for calculation

1. AHCCCS will utilize fully adjudicated encounters reported by the Contractor to determine the actual medical cost expense. AHCCCS may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation.

2. PPC Capitation and Medical expense to be included in the reconciliation are based on the **DATE OF SERVICE** for the contract year being reconciled.

IV. References

Acute Care Request for Proposal, Section D

V. Note

Administration percentage by contract year:
- CYE '11 – 8.0%
- CYE '12 – 8.0%

Premium tax – 2%

Attachment A – Sample PPC Reconciliation

CONFIDENTIAL

Attachement A

HEALTH PLAN
PRIOR PERIOD COVERAGE RECONCILIATION - EXAMPLE
FOR CONTRACT YEAR ENDED XX/XX/XX

PPC	TANF <1	TANF 1-13	TANF 14-44F	TANF 14-44M	TANF 45+	SSI/W	SSI W/O	SOBRA MOTHERS	MED (CYE '11 Only)	Non-MED	TOTAL
PPC Revenue	$ 315,000.00	$ 100,000.00	$ 308,000.00	$ 80,000.00	$ 40,000.00	$ 4,000.00	$ 15,000.00	$ 75,000.00	$ 80,000.00	$ 500,000.00	$ 1,517,000.00
Less: Premium Tax [3]	$ 6,300.00	$ 2,000.00	$ 6,160.00	$ 1,600.00	$ 800.00	$ 80.00	$ 300.00	$ 1,500.00	$ 1,600.00	$ 10,000.00	$ 30,340.00
Less: Admin %	$ 22,866.67	$ 7,259.26	$ 22,358.52	$ 5,807.41	$ 2,903.70	$ 290.37	$ 1,088.89	$ 5,444.44	$ 5,807.41	$ 36,296.30	$ 110,122.96
PPC Revenue Net of Admin and Premium Tax *	$ 285,833.33	$ 90,740.74	$ 279,481.48	$ 72,592.59	$ 36,296.30	$ 3,629.63	$ 13,611.11	$ 68,055.56	$ 72,592.59	$ 453,703.70	$ 1,376,537.04
Less: Expenditures HP Paid	$ 275,000.00	$ 90,000.00	$ 280,000.00	$ 74,000.00	$ 37,000.00	$ 4,500.00	$ 16,000.00	$ 65,000.00	$ 70,000.00	$ 200,000.00	$ 1,111,500.00
Net Profit/(Loss)	$ 10,833.33	$ 740.74	$ (518.52)	$ (1,407.41)	$ (703.70)	$ (870.37)	$ (2,388.89)	$ 3,055.56	$ 2,592.59	$ 253,703.70	$ 265,037.04
% of Rev Net of Admin	3.79%	0.82%	-0.19%	-1.94%	-1.94%	-23.98%	-17.55%	4.49%	3.57%	55.92%	19.25%

Net Capitation	$ 1,376,537.04
Total Profit/(Loss)	$ 265,037.04
Risk Band Corridor - 2% or (2%)	$ 27,530.74
PPC Amount Due To (From) Health Plan	$ (237,506.30)
Premium Tax	$ (4,845.13)
Net PPC Amount Due To (From) Health Plan	$ (242,351.42)

For all Covered PPC Risk Groups:
Assumptions:

1) PPC Revenue includes applicable PPC Capitation with dates of service in the contract year to be reconciled.
2) PPC Expenditures include applicable adjudicated encounters based on the date of service for the contract year being reconciled.
3) The Health Plan is responsible for a premium tax to the Department of Insurance of 2% on all payments received by the HP from AHCCCS.

*** Building the Gross Capitation Rate All PPC Covered Risk Groups**

Cap Rate before Admin and Prem Tax		$100.00
Add Admin Amount Per Policy	+$100 * 8.0%	$8.00
Subtotal	+$100 + $8.00	$108.00
Add Premium Tax (PT) of 2%	+$108.00/.98	$2.20
Gross Capitation Rate	+$108+$2.20	$110.20

*** Calculating the Net Revenue**

Gross Capitation Rate	$110.20
Deduct Premium Tax (Gross x .02))	$2.20
Deduct Admin ((Gross-PT) - ((Gross-PT)/1.08))	$8.00
Net Capitation Revenue (Gross-PT-Admin)	$100.00

302A - PRIOR PERIOD COVERAGE (PPC) RECONCILIATION - ALTCS CONTRACTORS

Effective Date: 10/01/06, 10/01/10
Revision Date: 08/15/09, 8/18/10, 6/22/12
Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all AHCCCS ALTCS EPD Program Contractors for CYE11 forward.

The Program Contractors are paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during the PPC period.

Annually, AHCCCS will prepare a reconciliation of Net PPC Revenue paid to the Program Contractors to the actual PPC Medical Expenses as determined by fully adjudicated encounter data. Any profits or losses in excess of the stated percentages will be recouped or reimbursed from/to the Contractor, respectively.

II. Definitions

PPC Period	The period from the effective date of eligibility to the day a member is enrolled with a Program Contractor.
PPC Medical Expense	Total Covered Medical Expenses for services provided during the PPC time period.
PPC Revenue	PPC Capitation.
Net PPC Revenue	Effective 10/01/10 through 9/30/11 PPC capitation paid to the Program Contractor less a 7.5% administrative add on and 2% premium tax (PPC Revenue X (.98/1.075)). For CYE12 and forward, PPC capitation paid to the program Contractor less 6.0% administrative add on and a 2% premium tax (PPC Revenue X (.98/1.06)).

III. Policy

A. General

The reconciliation shall relate solely to aggregate PPC Covered Medical Expenses as determined by fully adjudicated encounter data.

For CYE11, the reconciliation will limit the Program Contractor's profits and losses to 10% of the Contractor's Net PPC Revenue. Any profits in excess of 10% will be recouped from the Contractor and, likewise, any losses in excess of 10% will be reimbursed. For CYE12 and forward, the reconciliation will limit the Program Contractor's profits and losses to 5% of the Contractor's Net PPC Revenue. Any profits in excess of 5% will be recouped from the Contractor, and likewise, any losses in excess of 5% will be reimbursed.

B. AHCCCS Responsibilities

1. For CYE11, approximately 15 months after the end of the contract year to be reconciled, AHCCCS shall perform a reconciliation of medical cost experience to Net PPC Revenue. For CYE12, approximately 12 months after the end of the contract year to be reconciled, AHCCCS shall perform a reconciliation of medical cost experience to Net PPC Revenue:

   PPC Capitation - administration - premium tax (see Definitions and Attachment A for calculation)

   Less: Total medical expenses (see Definitions)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual medical cost experience.

3. AHCCCS will compare encounter information to financial statements for reasonableness.

4. AHCCCS will provide to the Contractor the data used for the reconciliation and provide a set time period for review and comment by the Program Contractor. Upon completion of the review period, AHCCCS will evaluate Program Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process distributions/recoupments through a future monthly capitation payment.

C. Program Contractor Responsibilities

1. The Program Contractor shall maintain financial statements that separately identify all PPC Revenue and Expense as outlined in the ALTCS Financial Reporting guide, and shall submit such statements as required by contract.

2. It is the Program Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments before the reconciliation 15 or 12 month run date. It is also the responsibility of the Program Contractor to have any encounter data issues identified, corrected and fully adjudicated within 15 months (CYE11) or 12 months (CYE12) of the end of the contract year being reconciled for the encounters to be included in the reconciliation

IV. References

- ALTCS Contract, Section D, Compensation

V. Note

Administration percentage by contract year

- CYE11 – 7.5%
- CYE12 – 6.0%

Premium tax – 2%
Attachment A – Sample PPC Reconciliation for CYE11
Attachment B – Sample PPC Reconciliation for CYE12 and forward

ATTACHMENT A - SAMPLE PPC RECONCILIATION CYE11

Prior Period Coverage Reconciliation CYEXX

		PROGRAM CONTRACTOR
PPC REVENUE		
PPC CAPITATION	$	214,000
TOTAL PPC REVENUE		214,000
LESS: 7.5% ADMIN ADD-ON & 2% Premium Tax (Subtotal-(subtotal*(.98/1.075)))		18,912
NET PPC REVENUE	**$**	**195,088**
PPC MEDICAL EXPENSE	$	135,000
OVER/(UNDER) PAYMENT	$	60,088
10% ALLOWANCE OF NET PPC REVENUE		19,509
PAYMENT/(RECOUPMENT)	**$**	**(40,580)**
PREMIUM TAX 2%		**(828)**
TOTAL PAYMENT/(RECOUPMENT)	**$**	**(41,407)**

ATTACHMENT B - SAMPLE PPC RECONCILIATION CYE12 and Forward

Prior Period Coverage Reconciliation CYEXX

		PROGRAM CONTRACTOR
PPC REVENUE		
PPC CAPITATION	$	214,000
TOTAL PPC REVENUE		214,000
LESS: 6.0% ADMIN ADD-ON & 2% Premium Tax (Subtotal-(subtotal*(.98/1.06)))		16,151
NET PPC REVENUE	**$**	**197,849**
LESS: PPC MEDICAL EXPENSE	$	135,000
OVER/(UNDER) PAYMENT	$	62,849
5% ALLOWANCE OF NET PPC REVENUE		9,892
PAYMENT/(RECOUPMENT)	**$**	**(52,957)**
PREMIUM TAX 2%		**(1,080)**
TOTAL PAYMENT/(RECOUPMENT)	**$**	**(54,037)**

303 - Home and Community Based Services (HCBS) Reconciliation - ALTCS

Effective Date: 10/01/11
Revision Date:

Staff responsible for policy: ALTCS Finance

I. Purpose

Reconcile the assumed HCBS member months used for capitation rate development against actual HCBS placement. This policy applies to all AHCCCS ALTCS EPD Contractors for CYE 12 (Oct. 1, 2011 – Sept. 30, 2012) and forward.

HCBS Assumed Mix and Recoupment: The Contractor's capitation rate is based in part on the assumed ratio ("mix") of HCBS member months to the total number of member months (i.e. HCBS + institutional). At the end of the contract year, AHCCCS will compare the *actual percent of* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. Member months for those members who received acute care services only are not included in this reconciliation. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage. This reconciliation will be made in accordance with the following schedule:

Percent over/under assumed percentage:	**Amount to be recouped/reimbursed:**
The First 0 - 1.0 percentage points	0% of capitation over/under payment
>1 percentage point	50% of capitation over/under payment

II. Definitions

HCBS Placement types:

- Home
- Adult Foster Care
- Assisted Living Centers
- Assisted Living Home
- Adult Therapeutic Foster Care
- Adult Development Home
- Behavioral Health Therapeutic Home
- Behavioral Health Level II
- Behavioral Health Level III
- Child Developmental Foster Home
- Behavioral Health Services Center
- Group Home for Developmentally Disabled

- Traumatic Brain Injury Treatment Facility
- Rural Substance Abuse Transitional Agency

Institutional Placement types:

- Institution
- Level I Behavioral Health Center
- Psychiatric Hospital

III. Policy

A. General

1. The reconciliation shall relate solely to HCBS assumed member months and actual placement data as determined by monthly placement reports.

2. The reconciliation will limit Contractor's profit and losses to the schedule as detailed above.

B. AHCCCS Responsibilities

1. AHCCCS shall, at the end of the contract year, run placement reports by member by month to be used for the development of the schedule of HCBS and Institutional placement mix. The placement report will provide for the most up to date placement information, including any retroactive changes as reported by Contractors.

2. Approximately four (4) months after the contract year to be reconciled, AHCCCS shall perform the HCBS reconciliation.

3. The reconciliation for the HCBS mix shall be based on the schedule of HCBS and Institutional placement mix, capitation rates developed for the contract year and the actual member months.

4. A reconciliation spreadsheet will be forwarded to the Contractors for review.

5. Distributions will be made to the Contractor after the Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

6. In the event a Contractor is required to reimburse AHCCCS, such reimbursement will be collected by AHCCCS through a reduction to the Contractor's prospective capitation payments after the Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

C. Contractor's Responsibilities

1. Contractors shall review monthly placement information and make corrections to placement during the contract year.

2. It is the Contractor's responsibility to identify to AHCCCS any placement data issues or necessary adjustments via electronic Member Change Report (EMCR) with the appropriate contract type changes to the Division of Health Care Management (DHCM).

3. It is the Contractor's responsibility to review and approve via signature the HCBS reconciliation and return the approval to AHCCCS per instructions provided with the reconciliation spreadsheet.

IV. References

ALTCS Request for Proposal, Section D, Compensation**.**

304 - PREMIUM TAX REPORTING POLICY

Effective Date: 10/01/11
Revision Date: 10/01/08, 10/01/10, 4/25/12

Staff responsible for policy: DHCM Finance

I. PURPOSE

This policy outlines the procedures necessary for AHCCCS Contractors to report and pay Premium Tax to the Arizona Department of Insurance (DOI) on a quarterly basis.

Under A.R.S. §36-2905 and §36-2944.01, each AHCCCS Contractor is required to pay to the DOI a tax equal to 2% of the total capitation, including reinsurance, and any other reimbursement **paid** to the Contractor by AHCCCS from and after October 1, 2003.

Each Contractor will report and pay premium tax to the DOI for all payments received from AHCCCS during the quarter. The tax is based on date of payment, not date of service. AHCCCS administration will report to the DOI the total payments to each Contractor for the calendar year by February 15th of the following year.

II. DEFINITIONS

ACH – Automated Clearing House

AHCCCS - Arizona Health Care Cost Containment System

AHCCCS Contractors - Acute Care Health Plans, Arizona Long Term Care System Program Contractors, Department of Economic Security/Division of Developmental Disabilities, Children's Rehabilitative Services, Comprehensive Medical Dental Program, and Arizona Department of Health Services – Division of Behavioral Health

BHS – Behavioral Health Services within the Department of Health Services

CMDP – Comprehensive Medical Dental Program within the Department of Economic Security

Contractor – Under the definitions in 36-2901, "Contractor" means an entity paid by AHCCCS on a prepaid, capitated basis, which means the entity receives payment notwithstanding the amount of services provided to a member.

Capitation – Payment to a contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.

CRS – Children's Rehabilitative Services

CYE – Contract year ending/ended

DBF - Division of Business and Finance within AHCCCS

DDD – Division for the Developmentally Disabled within the Department of Economic Security

DHCM – Division of Health Care Management within AHCCCS

DOI – Arizona Department of Insurance

EPD – Elderly and physically disabled

FFS – Fee for service

HCBS – Home and Community-based Services

IGA (Inter Governmental Agreement) – An agreement between two state agencies whereby one state agency provides goods and/or services to another.

Payment – a payment that is made to the Contractor

PPC – Prior-Period Coverage

Recoupment – A payment that has been refunded by the Contractor to AHCCCS

SOC – Share of Costs

TWG – Title XIX Waiver Group

VD – Ventilator Dependent

III. POLICY

A. Quarterly Submission of Premium Tax to DOI

Each AHCCCS Contractor is required to file a quarterly tax report (http://www.id.state.az.us/taxunit/e-qtr.pdf) and pay estimated premium taxes based on estimated payments received for the current quarter. See Attachment A for information on how payments will be handled. The premium tax is based on date of payment, not date of service. The tax payments are due on or before March 15, June 15, September 15 and December 15 of each year. The amount of the payments shall be an estimate of the tax due for the quarter that ends in the month that payment is due. If a Contractor has no tax to report, the Contractor must file a form stating $0 tax due.

Contractors are required to periodically monitor the DOI website for updated forms and instructions.

B. Payments include:

- capitation revenue
- delivery supplemental payments
- reinsurance
- Reconciliation payments/recoupments (PPC, TWG, HCBS, SOC, Revenue, etc.)
- Monies withheld due to sanctions or other liens shall not reduce the taxable amount due. These amounts will be added back into the total payments.

C. Payments to Contractors; Inclusion/Exclusion of Premium Tax:

- Any capitation payments/recoupments related to dates of service prior to October 1, 2003, will not have the premium tax included. The Contractor will not be reimbursed for the premium tax associated with these payments. However, the Contractor will be responsible for reporting and paying premium taxes associated with payments/recoupments made after October 1, 2003 (regardless of the dates of service). All capitation rates effective October 1, 2003 and forward, include the premium tax in the rate.
- Reconciling payments and supplemental payments will have the premium tax included in the payment.
- Reinsurance payments include the premium tax for all payments/recoupments made after October 1, 2003, regardless of the dates of service. For recoupment of payments made prior to October 1, 2003, the premium tax will not be recouped.

D. Payments Excluded from Premium Tax:

- *Tribal Case Management* – Tribal Contractors only receive payment for case management services, and payments are paid on a fee-for-service basis. Additionally, Tribal Case Management only receives payments on behalf of a member for a month in which some case management service is provided to the member. In other words, if no services are provided to a member for a month, they do not receive the monthly case rate for that member. Thus, this is not capitation as defined, and payments are therefore not subject to premium tax.
- *Federally Qualified Health Centers (FQHC)* – Contract with AHCCCS Contractors to provide services to members, and is not itself considered a direct Contractor with AHCCCS that receives capitation from AHCCCS.
- *Health Care Group (HCG)* – HCG is eligible under §36-2901, paragraph 6, subdivision (b), (c), (d) or (e), which is not included within the scope of the legislation.
- *Fee for Service (FFS)* – ADHS, DES – Payments are based on services provided to FFS members

- *Third Party Liability* – If a Contractor pays a claim and finds that there is another party that is responsible for paying the claim, the Contractor or AHCCCS (via the AHCCCS contracted TPL administrator) will subrogate the claim to the third party and will recover the amount that had been paid from the third party. The recovery of the expense is not subject to premium tax.
- *Fraud and Abuse* – Recovery of overpayment made by a Contractor to a provider. This is considered a contra-expense and is not subject to premium tax.
- *Indian Health Services* – Payments are paid on a fee-for-service basis.
- *Breast & Cervical Cancer Administration Payment* – Payments to contractors are in response to billings from the entity for administration services rendered and are not based on member capitation. Therefore, this entity is not considered a Contractor.
- *State Only Transplant Payments* – Any payments made for Individuals who are eligible under one of the Title XIX eligibility categories, are found eligible for a transplant, and subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11

E. Quarterly Reporting to AHCCCS

In addition to filing the original Form E-QTR, AHCCCS Contractor Quarterly Premium Tax Report, and tax payment with the DOI, each Contractor will submit a copy of the premium tax report(s) filed with the DOI to:

Finance Manager, DHCM
AHCCCS
701 E. Jefferson, M/D 6100
Phoenix, AZ 85034

The copy of the quarterly premium tax report(s) shall be due to DHCM on the same date the original quarterly premium tax report is due to the DOI. On a semi-annual basis DHCM will compare the copy of the report to AHCCCS Contractor payment records. AHCCCS will work with the Contractor to research and resolve any discrepancies.

F. Annual Reporting to DOI by Division of Health Care Management

No later than January 31 of each year, the Division of Business and Finance (DBF) shall provide a report to DHCM listing all payments AHCCCS made to Contractors for the preceding calendar year. By February 15 succeeding the end of a calendar (tax) year, DHCM will report the total amount AHCCCS paid to Contractors, by health plan to:

Compliance Section Manager, Financial Affairs Division
Arizona Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018-7256

The DOI will compare this information to the quarterly reports submitted by the contractors. The DOI will issue an assessment of additional tax and may impose penalties and interest to a Contractor that underpaid the tax during the preceding calendar year. The penalty may be as much as 5% of the amount of tax paid late, with a minimum penalty of $25. Interest is 1% of the tax paid late per month. The DOI will issue refunds to any Contractor that overpaid the tax for the calendar year period.

IV. PAYMENT OPTIONS

A. Payment by check can be mailed, delivered by overnight courier or hand delivered. The DOI accepts U.S. Postal Service postmark as evidence of filing. Postage meter stamps do not apply. Filings received by overnight courier must include an airbill or receipt bearing the date that the item was picked up by the courier from the originating sender. Hand deliveries must be received before 5:00 P.M. on the due date.

B. To electronically pay taxes, fees or related penalty or interest, please use the NAIC OPTins system. Please use the following for all instructions on electronic payments: HTTP://WWW.ID.STATE.AZ.US/FORMS/TAX_FORMS/E-ACH.INSTRUCTION.PDF .

C. Payment is due on or before the due date for filing. When a due date falls on a weekend or a state holiday, it is extended to the following business day.

V. TIMELINESS

The submission of late reports shall constitute failure to report subject to the Civil Penalty and Interest for Late Tax Payment provisions described in the premium tax reporting instructions. (http://www.id.state.az.us/forms/tax_forms/E-QTR.INSTRUCTION.pdf)

VI. ADJUSTMENTS TO QUARTERLY PREMIUM TAX PAYMENTS

The tax form includes a line to make overpayment or underpayment adjustments to the previous quarter for the first three quarters of the calendar year. Adjustments to the December 15 payment will not be reported on the March 15 tax report.

The DOI will reconcile all tax payments received to the data provided by AHCCCS before April 1 of the following calendar year and will issue an assessment with a Notice of Right of Appeal if the Contractor has underpaid the tax for the calendar year period.

If a Contractor receives a significant payment from AHCCCS after a tax report is filed but before the end of the tax period, the contractor should promptly file an amended tax report for that period along with documentation supporting the amended filing and additional tax payment.

VII. REFERENCE

- A.R.S. §§ 36-2905 and §36-2944.01
- Quarterly Tax form: http://www.id.state.az.us/taxunit/e-qtr.pdf
- Instructions: http://www.id.state.az.us/forms/tax_forms/E-QTR.INSTRUCTION.pdf
- Attachment A – Matrix of Reimbursement for Premium Tax Collection
- Electronic Payments/E-ACH: http://www.id.state.az.us/forms/tax_forms/E-ACH.INSTRUCTION.pdf

Attachment A

Matrix of Managed Care Contracting and Reimbursement
Premium Tax Collection
Effective 10/01/11

Reimbursement	Acute Care	ALTCS EPD/VD	ALTCS DES/DDD	CMDP	CRS	ADHS/BHS	Handling of P.T.
Prospective Capitation	Yes	Yes	Yes	Yes	Yes	Yes	1
PPC Capitation	Yes	Yes	No	Yes	No	No	1
Delivery Supplement	Yes	No	No	No	No	No	1
DDD/BHS Capitation	No	No	Yes	No	No	No	5
Regular Reinsurance	Yes	Yes	Yes	Yes	Yes	No	4
Catastrophic Reinsurance	Yes	Yes	Yes	Yes	Yes	No	4
Transplant Reinsurance	Yes	Yes	Yes	Yes	No	No	4
BH Reinsurance	No	Yes	No	No	No	No	4
PPC Reconciliation	Yes	Yes	No	Yes	No	No	2
HCBS Reconciliation	No	Yes	No	No	No	No	2
SOC Reconciliation	No	Yes	No	No	No	No	2
Miscellaneous Reconciliations, as applicable	Yes	Yes	Yes	Yes	Yes	Yes	2
Acute Program Tiered Prospective Reconciliation	Yes	No	No	No	Yes	Yes	2
Targeted Case Management	No	No	Yes	No	No	No	1
Rural Hospital Payments	Yes	No	No	No	No	No	2

Attachment A

Status of how premium tax will be handled:

1. All rates effective 10/1/03 and thereafter have the 2% premium tax included in rate.

2. Premium tax will be added to the payment manually.

3. ALTCS performs the reconciliation and develops a rate that is used for a mass adjustment. The 2% premium tax will be included in the rate.

4. Reinsurance will have 2% premium tax directly included in all payments/recoupments made after 10/1/03. Tribal and FFS payments will be excluded from Premium Tax.

5. Rate is set for DDD which includes 2% premium tax. The component for BHS is paid to BHS, of which the 2% is not included. DDD receives the tax that is related to the BHS payment and will be responsible for payment.

Payments Not liable for Premium Tax

- Tribal Case Management - ALTCS
- Federally Qualified Health Centers (FQHC)
- Health Care Group (HCG) – no federal participation
- Fee for Service (FFS) – AHCCCS and DDD
- Third Party Liability
- Fraud and Abuse
- Indian Health Services
- State Only Transplant capitation payments

305 – PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

Effective Date: 10/01/08
Revision Date: 10/01/08

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all AHCCCS contractors that are required to both maintain a performance bond and meet a minimum equity requirement. The purpose of this policy is to establish standards for Contractors to meet the performance bonding and equity requirements. These standards will continue to ensure a Contractor's ability to meet its claims payment obligations, while addressing the individual differences among Contractors and enrollment growth.

II. Definitions

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

Member: For purposes of this policy, a member is defined as any acute care member enrolled at the end of the period, excluding SOBRA Family Planning members.

Performance Bond: In general, a performance bond is an instrument that provides a financial guarantee in the amount of one month's capitation. Refer to the *AHCCCS Performance Bond Policy* for definitions of acceptable instruments

III. Policy

A. Performance bonding requirements:

The initial amount of the Performance Bond shall be equal to 80% of the total capitation payment expected to be paid to the Contractor in the first month of the contract year, or as determined by AHCCCS. The total capitation amount shall include delivery supplemental payments, less premium tax. This applies to all AHCCCS lines of business except Department of Developmental Disabilities, Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), Arizona Department of Health Services Division of Behavioral Health (BHS), and Medicare Advantage Plans. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall evaluate the enrollment statistics of the Contractor on a monthly basis to determine if the Performance Bond must be increased. When the amount of the performance bond falls below 70% of one month's capitation, then the amount of the instrument must be increased to at least 80% of one month's capitation. Contractors must increase the amount of the performance bond within 30 days of notice from AHCCCS.

B. Equity per member requirements:

Formula:
Unrestricted equity, less on-balance sheet performance bond, divided by the number of non-SOBRA Family Planning Extension Services members enrolled at the end of the period.

Acute Requirement:

Contractors with 0-99,999 members:	$150
Contractors with 100,000+ members:	$100

Long Term Care Requirement:

All contractors	$2,000

C. Remediation when a Contractor fails to meet the equity per member requirement:

If a contractor's equity per member falls below the requirement, then AHCCCS will review the causes for the lack of compliance. AHCCCS may require the Contractor to comply with the following measures:

- ✓ Submission of corrective action plan to increase equity
- ✓ Monthly financial reporting, if not already required
- ✓ Increase the amount of the performance bond
- ✓ Capital infusion to bring equity into compliance
- ✓ Enrollment Cap

In addition, if the contractor fails to comply with the above requirements, AHCCCS may apply sanctions as delineated in the *Sanctions Policy.*

D. Restrictions on equity:

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

1. Assets recorded as "due from affiliates" which are resulting from transactions other than cash/bank account sweep arrangements

2. Goodwill and adjustments to other assets resulting from a purchase, including those resulting from purchases and revaluations recorded in accordance with SFAS No. 141, *Business Combinations* and EITF 88-16, *Basis in Leverage Buyout Transactions*

3. Guarantees of debt

4. On balance sheet performance bonds

5. Other assets determined to be restricted by AHCCCS

E. Requirements for Contractors with restricted equity:

If a Contractor's equity is not supported by unrestricted cash or investments, and the Contractor does not meet the equity per member requirements, then the contractor may be required to maintain a performance bond in an amount greater than 80% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

IV. Division of Health Care Management (DHCM) Monitoring Responsibilities

1. DHCM financial consultants will be responsible for monitoring compliance with equity per member requirements on a quarterly basis. Analyses will be performed to determine the equity per member sufficiency. Deficiencies and requests for remediation will be communicated in writing to the contractor. The contractor will be required to submit a plan to increase the equity within 30 days.

2. The financial consultant responsible for performance bonds will monitor compliance with performance bond requirements on a monthly basis. AHCCCS will notify the contractor of required changes to the amount of the performance bond. Contractors will have 30 days to comply with new requirements.

V. References

Acute Care contract, Section D
ALTCS contract, Section D

306 – PERFORMANCE BOND

Effective Date: 10/01/08
Revision Date: 10/01/08

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all Health Plans and Program Contractors that require a Performance Bond.

The AHCCCS Request for Proposal (RFP) requires the posting of a Performance Bond (PB), Section D, as long as the Contractor has AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the effective date of their contract, whichever is later, to guarantee (1) payment of the Contractor's obligations to providers and non-contracting providers and (2) performance by the Contractor of its obligations under this Contract.

II. Definitions

1. United States Treasury Notes & Bonds
   This type of security is backed by the full faith and credit of the United States Government. These are notes with maturities ranging from two to thirty years. Interest is paid semiannually on the anniversary of the issue date and six months later. They are considered coupon securities even though they are now mostly issued in book entry form. Ownership is simply entered in the computers of the Federal Reserve. Interest is paid by the Federal Reserve issuing credits to the member banks that the notes are recorded through, and the banks credit the customer's account.

2. United States Treasury Bill (T-Bills)
   This type of security is backed by the full faith and credit of the United States Government, just like the Notes and Bonds. The only differences are that T-Bills are much shorter in term, three and six months, and they are sold at a discount. This means that less than the face amount is paid at original purchase and the face amount is recovered at maturity. The interest earned is part of the face amount and is earned on the amount paid for the T-Bill.

3. Federal Farm Credit Banks Funding Corporation (FFCB)
   The FFCB is 37 banks that issue two types of securities that can be substituted for the PB, Consolidated Systemwide Bonds and Consolidated Systemwide Notes. The securities are the joint and several obligations of all 37 member banks of the FFCB. It is felt that Congress will not allow this alliance to fail because of the farming community's dependence for funds.

4. Federal Home Loan Banks (FHLB)
The FHLB serves the same function for the Savings and Loan industry as the Federal Reserve for the banking industry. It is owned by the member Savings and Loan and issues coupon bonds much like the Federal Reserve.

5. Federal National Mortgage Association (FNMA)
The securities issued by FNMA are often called "Fannie Mae's". FNMA issues two types of securities, bonds and mortgage bonds. The coupon interest bonds are the securities acceptable for the PB. The mortgage bonds are not acceptable because of the repayment of the principal over the life of the bonds.

6. Federal Home Loan Mortgage Corporation (FHLMC)
The securities issued by FHLMC are often called "Freddie Mac's". Bonds issued by FHLMC are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

7. Government National Mortgage Association (GNMA)
The securities issued by GNMA are often called "Ginnie Mae's". Bonds issued by GNMA are mortgage type bonds that are repaid to principal and interest over the life of the bond, and the mortgages that secure the bond. This causes the principal to draw down over the life of the bond, and the life of the PB.

8. Municipal Bonds
Bonds issued by a municipality. The two types are General Obligation Bonds, backed by the full faith and credit of the issuer, and Revenue Bonds, repaid by the revenue generated by the project the bonds fund. Recent bankruptcies of some cities and the fact that most of these bonds are not insured makes repayment of principal somewhat endangered.

9. Corporate Bonds
The most common form of bonds this category represents is debentures. Debentures are bonds drawn on the general credit and good name, of the issuing company. Rating services, Moody and S&P, and reporting companies, Dun and Bradstreet, try to continually assess the bonds value, and their issuing companies, but are limited to historic data. In the case of D&B the rating of America West Airlines was rated as good up to two months before the company filed for bankruptcy protection. This causes most users of the services to become aware of critical situations only after it is too late to do anything. This is another category of securities that is considered a good investment but does not meet the much higher standards that need to be applied in meeting the PB.

10. Commercial Paper
Short-term notes issued by corporations that are much like corporate bonds. The major difference is that commercial paper must be issued for less than 270 days; this allows the corporation to avoid registration of the security. Being like corporate bonds, commercial paper holds the same drawbacks but with no advantages as a PB for AHCCCS. Also, because these notes are short-term they do not lend themselves to the 15 month time frame required by the PB.

11. Stocks (Equity Investments)
Stocks, even in the most stable credit worthy companies, vary in value every day. This would require a considerable cushion above the required PB amount to compensate for market fluctuations. Also it would require AHCCCS to monitor the value of each stock posted as a PB. This would require the resources normally found only with large investors or brokers. This monitoring is well beyond the intent of the PB.

12. Banker's Acceptance (BA)
Bankers' Acceptance are notes from other than a bank that are guaranteed by the issuing bank. They are short-term in nature, less than 270 days to elude regulation.

13. Mutual Funds
Mutual Funds are an equity ownership in the fund rather than ownership in any of the securities held by the fund. The principal may be in jeopardy of loss through the mutual fund's investment losses or administration expenses. Even when the fund is dominated by or wholly made up of treasury securities the fund's owner does not own the securities.

III. Policy

Per Contract with AHCCCS, Section D, the initial amount of the Performance Bond to be equal to 80% of the total capitation payment expected to be paid in the first month of the new contract, or as determined by AHCCCS. Thereafter, AHCCCS shall evaluate the enrollment statistics of the contractor on a monthly basis and determine if adjustments are necessary in accordance with the *Performance Bond and Equity Per Member Policy*.

The following are general requirements for all PB's:

1. The amount, duration or scope of the PB may not be changed or discontinued without prior approval of AHCCCS Division of Health Care Management (DHCM).
2. A contact person must be listed and their phone number.
3. Any security agreement must be disclosed.
4. AHCCCS will confirm the PB with the appropriate institution at least annually.

Listed are several specific ways to satisfy the PB:

1. Cash Deposits, or
2. An Irrevocable Letter of Credit issued by:
   A. A bank insured by the Federal Deposit Insurance Corporation, or
   B. A savings and loan association insured by the Federal Savings and Loan Insurance Corporation, or
   C. A credit union insured by the National Credit Union Administration, or
3 Surety Bond of standard commercial scope issued by a surety or insurance company doing business in Arizona, or
4. Certificate of Deposit, or
5. County resolution, or
6. An acceptable substitute in lieu of one of the above agreed to by AHCCCS.

Cash Deposit

I. Deposit of Funds

A. Any funds to be deposited with the State Treasurer shall be sent to the AHCCCS Division of Health Care Management (DHCM) in the form of a check. Along with the check should be a letter describing:
   1. The application of funds (Acute, ALTCS or any combination of both),
   2. A primary contact and phone number, for any issues concerning the deposit, and
   3. Instructions for the interest from the deposit: interest to be disbursed must also include directions of where the interest is to be sent.

B. After the funds have been deposited, AHCCCS DHCM will send a copy of the State Treasurer's "Securities Safekeeping" form that records the deposit.

C. Based on instructions with the deposit, a warrant will be issued each month for the interest on the account.

D. The State Treasurer will furnish statements of the account only upon written request. This request may be made at any time.

II. Withdrawal of Funds

A. To withdraw principal funds, send a letter to AHCCCS DHCM requesting the withdrawal. The letter must include:
   1. The amount of the withdrawal
   2. The program that the funds are being withdrawn from (Acute or ALTCS)
   3. The date that the funds should be withdrawn, (allow a minimum of ten working days)
   4 The manner the warrant from the State Treasurer's office is to be handled:

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

B. AHCCCS DHCM will forward the warrant in the manner requested in the withdrawal letter.

Letter of Credit

I. Establishment of Letter of Credit

A. Before a Letter of Credit can be accepted as a PB it must be approved by AHCCCS for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union or savings and loans doing business in the State of Arizona and insured by the appropriate Federal Institution;
2. For an amount that meets or exceeds the PB dollar requirement;
3. For a time period that meets or exceeds the AHCCCS contract term plus three months;
4. AHCCCS DHCM must receive a signed extension 30 days prior to the expiration date;
5. A statement that the PB cannot be changed in the amount, duration or scope, or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues that are necessary for the AHCCCS PB; it will not include review for any other matters.

C. AHCCCS DHCM will forward the letter of credit to our outside counsel for review.

D. AHCCCS DHCM will respond in writing that the PB is acceptable or changes need to be made for acceptance.

E. After the agreement is executed, send a statutory notice of deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parties. Make copies for your file prior to sending the original to AHCCCS DHCM.

II. Return of Letter of Credit original

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

1. Termination of the Letter of Credit, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS,
4. Statutory Notice of Release form

Surety Bond

I. Establishment of Bond

A. Before a Surety Bond can be accepted as a PB it must be approved by AHCCCS for form and amount. Requirements include:

1. Be of standard commercial scope and issued by a bank, credit union, savings and loans, or insurance company authorized to do business in the State of Arizona and insured by the appropriate Federal Institution;
2. For an amount that meets or exceeds the PB dollar requirement;
3. For a time period that meets or exceeds the AHCCCS contract term plus three months;
4. AHCCCS Division of Health Care Management (DHCM) must receive a signed extension 30 days prior to the expiration date;
5. A statement that the PB cannot be changed in the amount, duration or scope or discontinued without the authorization of AHCCCS DHCM.

B. Send a copy of the agreement to be executed to AHCCCS DHCM thirty working days prior to the execution date. AHCCCS will review the agreement and advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues necessary for the AHCCCS PB; it will not include review for any other matters.

C. AHCCCS DHCM will forward the surety bond to our outside counsel for review.

D. AHCCCS DHCM will respond in writing whether the PB is acceptable or changes need to be made for acceptance.

E. After the agreement is executed, send a Statutory Notice of Deposit form and the original to AHCCCS DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parities. Make copies for your file prior to sending the original to AHCCCS DHCM.

II. Return of Surety Bond original

The original Surety Bond will be returned to the makers upon:

1. Termination of the Surety bond, or
2. Termination of the AHCCCS contract, or
3. Satisfying the PB requirement with another acceptable form as outlined by AHCCCS, or
4. Statutory Notice of Release

Certificate of Deposits

I. Types of Certificate of Deposits

Only Certificates of Deposit from banks, savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the PB.

II. Assignment to Arizona State Treasurer

All Certificate of Deposit must be assigned to the Arizona State Treasurer in compliance with Arizona Revised Statute Section 35-155. This can be accomplished with the "Assignment to Arizona State Treasurer" form.

III. Deposit of the Certificate of Deposit

A. 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 AHCCCS DHCM. A letter should accompany the Certificate of Deposit describing the form of PB the Certificate of Deposit is satisfying (Acute or ALTCS) and a contact person. Also, a Statutory Notice of Deposit form should accompany the Certificate of Deposit.

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

C. After the Certificate of Deposit has been deposited with the State Treasurer it is the Health Plan's responsibility to monitor the maturity date. No notification should be expected from the State Treasurer's office or AHCCCS DHCM. Evidence of the renewal of each CD must be sent to AHCCCS DHCM within 5 days of the renewal date.

IV. Withdrawal of a Certificate

Send a letter to AHCCCS DHCM requesting the release of a specific Certificate of Deposit giving:

1. The institution of the Certificate of Deposit,
2. The certificate number,
3. The amount of the Certificate of Deposit,
4. The program the Certificate of Deposit is being withdrawn from,
5. The manner the Certificate of Deposit is to be returned to the Plan,
6. A contact person, and
7. Statutory Notice of Release form.

Securities

I. Acceptable Securities

The following list is an outline of the acceptable and unacceptable securities that may be posted as a PB. The listing is not comprehensive but it includes the most common securities.

Acceptable:

A. United States Treasury Bills
B. United States Treasury Notes
C. United States Treasury Bonds
D. Federal Farm Credit Banks Funding Corporation Bonds
E. Federal Home Loan Bank Bonds
F. Federal National Mortgage Association (Fannie Mae) Coupon Interest Bonds

Unacceptable:

A. Federal Home Loan Mortgage Corporation
B. Government National Mortgage Association
C. Municipal Bonds
D. Corporate Bonds
E. Commercial Paper
F. Stocks
G. Letter of Credit from other than a bank, savings and loan or credit union
H. Bankers Acceptance
I. Mutual Funds

II. Deposit of Security as Performance Bond

A. Execute a "Statutory Deposit Custody Agreement" with the State Treasurer's appointed custodian.

B. The face amount of the security or principal amount of the purchase price, whichever is lower, must be equal to or greater than the PB requirement. On an ongoing basis, the lower of cost or market must be equal to or greater than the PB requirement.

C. After deciding on one of the securities to be used as a PB, fill out a "Notice of Statutory Deposit Delivery" form and submit the form and security if not in Book Entry form, to AHCCCS DHCM. Include a letter that details the reason for the deposit of the security and a contact person.

D. AHCCCS DHCM will forward the Notice of Statutory Deposit Delivery form (and security if applicable) to the State Treasurer's appointed custodian who will then,

1. Effect the transfer from the purchasing agent, or
2. Make the purchase as directed

E. The security will remain in the safekeeping of the State Treasurer's appointed custodian. Any interest distributions will be accomplished through instructions to the appointed custodian and require no intervention by AHCCCS DHCM. (Only interest on Coupon Interest Bonds is available for distribution, interest on Discount Interest Bonds must remain in the account to satisfy the maturity amount).

F. Confirmation statement to be received by DHCM from State Treasurer's appointed custodian acknowledging transaction completed.

III. Release of Security as a Performance Bond

A. Fill out a "Notice of Statutory Deposit Release" form and send it along with a letter of explanation to AHCCCS DHCM.

B. AHCCCS DHCM will forward the Notice of Statutory Deposit Release form to the State Treasurer's appointed custodian. The custodian will then release the security in the manner instructed in the Notice of Statutory Deposit Release form.

IV. References

Acute Care Contract, Section D

307 - RESERVED

308 – PAYMENTS TO FQHCS (Federally Qualified Health Care Centers) / RHCS (Rural Health Clinics)

Policy moved to FQHC / RHC Section of the website.

http://www.azahcccs.gov/commercial/FQHC-RHC.aspx

309 – RESERVED

310 - DELIVERY SUPPLEMENTAL PAYMENT

Effective Date: 10/01/08, 12/01/12
Revision Date: 11/16/09, 11/15/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the payment of the delivery supplemental payment for all Acute Care Contractors. The delivery supplement is intended to cover the costs of a pregnant woman's hospital and professional services related to the delivery of her newborn(s) and prenatal and post-partum care when billed using the global obstetrical package or with service dates within the hospital time frame. State Only Transplant and prior period coverage (PPC) members are not eligible for the delivery supplemental payment.

II. Definitions

Global Obstetrical (OB) Package	Includes ***all*** OB visits prior to delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.

III. Policy

A. General

1. When the Contractor has an enrolled pregnant woman who delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to women who deliver in a prior period coverage time period.

2. All newborns must be reported within six months of birth in order for the Contractor to receive a delivery supplemental payment.

    1. All births must be reported by the woman's Contractor via the AHCCCS website. Births reported by any State Agency will not be eligible for a delivery supplemental payment.

IV. References

Acute Care Contract, Section D

311 – ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION

Effective Date: 10/01/11
Revision Date: 11/08/12

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to all Acute Care Contractors, excluding Children's Rehabilitation Services (CRS) and Comprehensive Medical and Dental Program (CMDP).

The Acute Program Tiered Prospective Reconciliation applies to dates of service effective October 1, 2011 through September 30, 2013 and is based upon prospective expenses and prospective net capitation as described in this policy. AHCCCS will recoup/reimburse a percentage of the Contractor's 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 expense reports.

II. Definitions

Administrative Component — The administrative component will be equivalent to the amount of administration built into the capitation rate for the year being reconciled. For CYE '12 and CYE'13, the administrative component is equal to the sum of: (1) The CYE '09 bid administrative PMPM – 5.88%, multiplied by the actual prospective member months for the respective contract year for the tiered reconciliation risk groups excluding SOBRA Family Planning, and (2) 8% of the pre-premium tax prospective capitation payments for SOBRA Family Planning and payments for Delivery Supplement.

Non-Capped Newborn Expenses — In accordance with the Acute Care contract, Contractors must notify AHCCCS of a newborn born to an AHCCCS mother within one day of the date of birth. When notification is received timely, the Contractor receives capitation retroactive to the birth date. When notification is received late, the Contractor receives capitation beginning on the date of notification, but expenses must be covered by the Contractor 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.
Premium Tax Component	The premium tax component is equal to the tax imposed pursuant to A.R.S. §36-2905 for prospective capitation and the Delivery Supplement payments made for the tiered reconciliation risk groups for the contract year and that are subject to reconciliation. The rate of tax imposed under A.R.S. §36-2905 is 2% as of the effective date of this policy, October 1, 2011.
Prospective Expenses	Expenses reported through fully adjudicated encounters and subcapitated expenses incurred by the Contractor for covered services with dates of service during the contract year (excluding expenses incurred during PPC).
Prospective Net Capitation	Prospective capitation, risk adjusted if applicable, plus Delivery Supplement payments, less the administrative and the premium tax components.
Reinsurance	For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the Contractor as the result of prospective expenses incurred by the Contractor for covered services with dates of service during the contract year being reconciled.
Subcapitated Expenses	Expenses incurred by the Contractor as payments to a provider under a subcapitated arrangement. The subcapitated expenses used in this reconciliation are reported by the Contractor through quarterly financial reports in the format required by AHCCCS.
Tiered Reconciliation Risk Groups (or Risk Groups)	Populations subject to this tiered reconciliation are limited to TANF, SOBRA, SSI with Medicare, SSI without Medicare, and SOBRA Family Planning. Expenses incurred and revenues received for covered services with dates of service during Prior Period Coverage (PPC) are excluded from this reconciliation, as are non-capped newborn expenses.

III. Policy

A. General

1. The acute program tiered prospective reconciliation shall be based on prospective, fully adjudicated medical expense encounters, and self-reported subcapitated expenses, net of reinsurance. For each contract year, the amount due from or due to the Contractor as the result of this reconciliation will be based on aggregated profits and losses across all of the tiered reconciliation risk groups. Individual risk groups will not be reconciled separately. The expenses will be reconciled against prospective capitation including Delivery Supplement payments and will be net of the administrative and premium tax components.

2. The reconciliation will limit the Contractor's profits and losses to the percent of prospective net capitation according to the following schedule:

Profit	Contractor Share	State Share	Max Contractor Profit	Cumulative Contractor Profit
<= 3%	100%	0%	3.0%	3%
> 3% and <= 5%	75%	25%	1.5%	4.5%
> 5% and <= 7%	50%	50%	1.0%	5.5%
> 7% and <= 9%	25%	75%	0.5%	6%
> 9%	0%	100%	0%	6%

Loss	Contractor Share	State Share	Max Contractor Loss	Cumulative Contractor Loss
<= 3%	100%	0%	3.0%	3%
> 3% and <= 6%	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

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

B. AHCCCS Responsibilities

1. No sooner than five and ten months after the end of the period to be reconciled, AHCCCS shall perform initial and interim reconciliations, respectively, of actual medical cost experience to prospective net capitation and reinsurance, as follows:

   Profit/Loss to be reconciled = Prospective Net Capitation – Prospective Expenses – Subcapitated Expenses + Reinsurance payments.

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

   Attachment A to this policy provides an example of the tiered prospective reconciliation calculation.

2. AHCCCS will utilize only prospective expenses supported by fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the Expenses subject to reconciliation.

3. AHCCCS will utilize amounts paid to the Contractor for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

4. AHCCCS will compare fully adjudicated encounters and self-reported subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

5. AHCCCS will provide the Contractor the data used for the initial and interim reconciliations and provide written notice of the deadlines for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through future monthly capitation payments.

6. A third and 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. AHCCCS will provide the Contractor the data used for the final reconciliation and written notice of the deadline for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

7. Any amount due to or due from the Contractor as a result of the final reconciliation that was not distributed or recouped as part of the initial and/or interim reconciliations will be paid or recouped through a future monthly capitation payment.

8. AHCCCS may include adjustments to the reconciliations to account for completion factors and payment reform arrangements approved by AHCCCS.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify all prospective risk group transactions, and shall submit such statements as required by contract and in the format specified in the Financial Reporting Guide for Acute Health Care Contractors.

2. Contractor shall monitor the estimated acute program tiered prospective reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to AHCCCS on a quarterly basis as specified in the AHCCCS Financial Reporting Guide for Acute Care Contractors.

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

4. Contractor shall submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments/refunds/recoveries on the related claims, the related encounters must be adjusted (voided or void/replaced) pursuant to the ACOM. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may

recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- Acute Care Contract, Section D
- ACOM Policy 311, Attachment A–Acute Program Tiered Prospective Reconciliation - Example
- AHCCCS Financial Reporting Guide for Acute Care Contractors

HEALTH PLAN
ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION
FOR THE CONTRACT YEAR ENDED 9/30/XX
As Of: xx/xx/xx

Prospective	TANF <1	TANF 1-13	TANF 14-44F	TANF 14-44M	TANF 45+	SSI/W	SSI W/O	SOBRA MOTHERS	SFP	TOTAL
Capitation	$ 58,400,000.00	$ 128,300,000.00	$ 132,700,000.00	$ 41,500,000.00	$ 40,000,000.00	$ 29,200,000.00	$ 112,300,000.00	$ 8,000,000.00	$ 100,000.00	$ 550,500,000.00
Delivery Supplemental	$ -	$ -	$ 18,400,000.00	$ -	$ -	$ 100,000.00	$ 700,000.00	$ 26,000,000.00	$ -	$ 45,200,000.00
Total Prospective Capitation	$ 58,400,000.00	$ 128,300,000.00	$ 151,100,000.00	$ 41,500,000.00	$ 40,000,000.00	$ 29,300,000.00	$ 113,000,000.00	$ 34,000,000.00	$ 100,000.00	$ 595,700,000.00
Admin	$ 4,400,000.00	$ 9,500,000.00	$ 11,342,560.00	$ 3,100,000.00	$ 3,100,000.00	$ 2,107,840.00	$ 8,254,880.00	$ 2,638,400.00	$ 7,259.26	$ 44,450,939.26
Premium Tax	$ 1,168,000.00	$ 2,566,000.00	$ 3,022,000.00	$ 830,000.00	$ 800,000.00	$ 586,000.00	$ 2,260,000.00	$ 680,000.00	$ 2,000.00	$ 11,914,000.00
Prospecitve Net Capitation (Net of Admin and Premium Tax)	$ 52,832,000.00	$ 116,234,000.00	$ 136,735,440.00	$ 37,570,000.00	$ 36,100,000.00	$ 26,606,160.00	$ 102,485,120.00	$ 30,681,600.00	$ 90,740.74	$ 539,335,060.74
Prospective Expenses	$ 58,615,000.00	$ 109,630,000.00	$ 126,540,000.00	$ 39,805,000.00	$ 33,630,000.00	$ 25,935,000.00	$ 113,240,000.00	$ 28,975,000.00	$ -	$ 536,370,000.00
Subcapitated Expenses	$ 1,000,000.00	$ 500,000.00	$ 500,000.00	$ 700,000.00	$ 100,000.00	$ 600,000.00	$ 900,000.00	$ 400,000.00	$ -	$ 4,700,000.00
Exclusion of Subcap Code 01 Encounters	$ -	$ -	$ 250.00	$ 10,000.00	$ -	$ -	$ 1,500.00	$ -	$ -	$ 11,750.00
Reinsurance Paid	$ 9,200,000.00	$ 4,600,000.00	$ 3,300,000.00	$ 4,900,000.00	$ 1,300,000.00	$ 300,000.00	$ 21,900,000.00	$ -	$ -	$ 45,500,000.00
Total Profit/(Loss)	$ 2,417,000.00	$ 10,704,000.00	$ 12,995,690.00	$ 1,975,000.00	$ 3,670,000.00	$ 371,160.00	$ 10,246,620.00	$ 1,306,600.00	$ 90,740.74	$ 43,776,810.74
Profit/(Loss) % of Net Capitation	4.57%	9.21%	9.50%	5.26%	10.17%	1.40%	10.00%	4.26%	100.00%	8.12%

Settlement

Prospective Net Capitation (Net of Admin and Premium Tax)	$ 539,335,060.74
Total Profit/(Loss)	$ 43,776,810.74
Profit/(Loss) % of Prospective Net Capitation	8.12%

Net Amount Due to (from) Health Plan:	$ (12,607,543.28)
Premium Tax	$ (257,296.80)
Less amounts previously paid with initial/interim reconciliations	
Net Amount Due to (from) Health Plan	$ (12,864,840.08)

Recon Amount Due to/From Calculation	Excess Profit	Recoup. %	Amount Overpaid	Recoupment	Calcs
	<=3%	0%	$ 16,180,052	$ -	$ 43,776,811
	3% < x <= 5%	25%	$ 10,786,701	$ 2,696,675	$ 27,596,759
	5% < x <= 7%	50%	$ 10,786,701	$ 5,393,351	$ 16,810,058
	7% < x <= 9%	75%	$ 6,023,356	$ 4,517,517	$ 6,023,356
	x > 9%	100%	$ -	$ -	$ -

Recon Amount Due to/From Calculation	Excess Loss	Recoup. %	Amount Underpaid	Reimburse	Calcs
	<=3%	0%	$ -	$ -	$ -
	3% < x <= 6%	50%	$ -	$ -	$ -
	x > 6%	100%	$ -	$ -	$ -

Assumptions:
1) The Prospective Title XIX Waiver Group is NOT included in this reconciliation.
2) Total Prospective Capitation includes Prospective Capitation and Delivery Supplemental Payments for dates of service within the reconciliation time frame.
3) Prospective Expenditures include adjudicated encounters for dates of service within the reconciliation time frame.
4) Reinsurance based on actual reinsurance payments for dates of service within the reconciliation time frame.
5) Admin at bid admin * (1-.0588) for all risk groups except SFP and Delivery Supplement which is at 8%. SOBRA Moms assume admin at TANF 14-44 F rate.
6) Subcapitated expenses are self reported from Quarterly Financial statements.
7) All encounters with a subcap code of 01 and a CN1 code of 05 have been excluded from this reconciliation, since these should be included in the self reported subcapitated expenses reported above.

312 – CRS PROGRAM TIERED RECONCILIATION

Effective Date: 10/01/2012
Revision Date:
Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to the CRS Contractor.

The CRS Program Tiered Reconciliation applies to dates of service beginning on October 1, 2012 through September 30, 2013 and is based upon adjudicated expenses and net capitation as described in this policy. AHCCCS will recoup/reimburse a percentage of the Contractor's profit or loss for the CRS program as described below using a tiered approach. All profit/loss sharing is based on adjudicated encounter data and subcapitated expense reports.

II. Definitions

Administrative Component	The administrative component will be equivalent to the amount of administration built into the capitation rate for the year being reconciled. For CYE '13, the administrative component is equal to 9.64%.
Premium Tax Component	The premium tax component is equal to the tax imposed pursuant to A.R.S. § 36-2905 for capitation payments made to the Contractor for the contract year subject to reconciliation. The rate of tax imposed under A.R.S. § 36-2905 is 2% as of the effective date of this policy, October 1, 2012.
Expenses	Expenses reported through fully adjudicated encounters and subcapitated expenses incurred by the Contractor for covered services with dates of service during the contract year.
Net Capitation	Capitation less the administrative and the premium tax components.
Reinsurance	For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the Contractor as the result of expenses incurred by the Contractor for covered services with dates of service during the contract year being reconciled.

Subcapitated Expenses	Expenses incurred by the Contractor as payments to a provider under a subcapitated arrangement. The subcapitated expenses used in this reconciliation are reported by the Contractor through quarterly financial reports in the format required by AHCCCS.
Tiered Reconciliation Population	The entire CRS population is subject to this tiered reconciliation.

III. Policy

A. General

1. The CRS program tiered reconciliation shall be based on fully adjudicated medical expense encounters and self-reported subcapitated expenses, net of reinsurance. The expenses will be reconciled against capitation and will be net of the administrative and premium tax components.

2. The reconciliation will limit the Contractor's profits and losses to the percent of net capitation according to the following schedule:

Profit	Contractor Share	State Share	Max Contractor Profit	Cumulative Contractor Profit
<= 3%	100%	0%	3.0%	3%
> 3% and <= 5%	75%	25%	1.5%	4.5%
> 5% and <= 7%	50%	50%	1.0%	5.5%
> 7% and <= 9%	25%	75%	0.5%	6%
> 9%	0%	100%	0%	6%

Loss	Contractor Share	State Share	Max Contractor Loss	Cumulative Contractor Loss
<= 3%	100%	0%	3.0%	3%
> 3% and <= 6%	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

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

B. AHCCCS Responsibilities

1. No sooner than five and ten months after the end of the period to be reconciled, AHCCCS shall perform initial and interim reconciliations, respectively, of actual medical cost experience to net capitation and reinsurance, as follows:

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

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

   Attachment A to this policy provides an example of the tiered reconciliation calculation.

2. AHCCCS will utilize only expenses supported by fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the expenses subject to reconciliation.

3. AHCCCS will utilize amounts paid to the Contractor for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

4. AHCCCS will compare fully adjudicated encounters and self-reported subcapitated expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated expenses included in the reconciliation.

5. AHCCCS will provide the Contractor the data used for the initial and interim reconciliations and provide written notice of the deadlines for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted. AHCCCS may then process partial distributions/recoupments through future monthly capitation payments.

6. A third and 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. AHCCCS will provide the Contractor the data used for the final reconciliation and written notice of the deadline for review and comment by the Contractor. Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or reconciliation as warranted.

7. Any amount due to or due from the Contractor as a result of the final reconciliation that was not distributed or recouped as part of the initial and/or interim reconciliations will be paid or recouped through a future monthly capitation payment.

8. AHCCCS may include adjustments to the reconciliations to account for completion factors and payment reform arrangements approved by AHCCCS.

C. Contractor Responsibilities

1. Contractor shall maintain financial statements that separately identify all CRS transactions, and shall submit such statements as required by contract and in the format specified in the Financial Reporting Guide for Acute Health Care Contractors.

2. Contractor shall monitor the estimated CRS program tiered reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to AHCCCS on a quarterly basis as specified in the Financial Reporting Guide for Acute Health Care Contractors.

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

4. Contractor shall submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

5. Contractor shall report all subcapitated expenses in a format requested by AHCCCS. Subcapitated encounters should have a subcap code of 01 and a CN 1 code of 05 and a paid amount of $0. All subcapitated encounters that do not conform to this format and have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures.

6. For all current and past reconciliations, if the Contractor performs recoupments/refunds/recoveries on the related claims, the related encounters must be adjusted (voided or void/replaced) pursuant to the ACOM. AHCCCS reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due AHCCCS. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the reconciliation and reserves the right to sanction the Contractor.

IV. References

- CRS Contract, Attachment J, Compensation
- Attachment A – Sample CRS Program Tiered Reconciliation
- Financial Reporting Guide for Acute Health Care Contractors

Attachment A

CRS
CRS TIERED RECONCILIATION
FOR THE CONTRACT YEAR ENDED 9/30/XX
As Of: xx/xx/xx

		CRS
Capitation	$	58,400,000.00
Total Capitation	$	58,400,000.00
Admin	$	5,032,072.97
Premium Tax	$	1,168,000.00
Net Capitation (Net of Admin and Premium Tax)	$	52,199,927.03
Expenses	$	52,615,000.00
Subcapitated Expenses	$	1,000,000.00
Exclusion of Subcap Code 01 Encounters	$	50,000.00
Reinsurance Paid	$	4,200,000.00
Total Profit/(Loss)	$	2,834,927.03
Profit/(Loss) % of Net Capitation		5.43%

Settlement

Net Capitation (Net of Admin and Premium Tax)	$	52,199,927.03
Total Profit/(Loss)	$	2,834,927.03
Profit/(Loss) % of Net Capitation		5.43%

Net Amount Due to (from) Health Plan:	$	(373,464.98)
Premium Tax	$	(7,621.73)
Less amounts previously paid with initial/interim reconciliations		
Net Amount Due to (from) Health Plan	$	(381,086.71)

Recon Amount Due to/From Calculation	Excess Profit	Recoup. %	Amount Overpaid	Recoupment	Calcs
	<=3%	0%	$ 1,565,998	$ -	$ 2,834,927
	3% < x <= 5%	25%	$ 1,043,999	$ 261,000	$ 1,268,929
	5% < x <= 7%	50%	$ 224,931	$ 112,465	$ 224,931
	7% < x <= 9%	75%	$ -	$ -	$ -
	x > 9%	100%	$ -	$ -	$ -

Recon Amount Due to/From Calculation	Excess Loss	Recoup. %	Amount Underpaid	Reimburse	Calcs
	<=3%	0%	$ -	$ -	$ -
	3% < x <= 6%	50%	$ -	$ -	$ -
	x > 6%	100%	$ -	$ -	$ -

Assumptions:

1) Total Capitation includes Capitation for dates of service within the reconciliation time frame.
2) Expenditures include adjudicated encounters for dates of service within the reconciliation time frame.
3) Reinsurance based on actual reinsurance payments for dates of service within the reconciliation time frame.
4) Admin at 9.64%.
5) Subcapitated expenses are self reported from Quarterly Financial statements.
6) All encounters with a subcap code of 01 and a CN1 code of 05 have been excluded from this reconciliation, since these should be included in the self reported subcapitated expenses in #5 above.

313 – CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE - AHCCCS BENEFICIARIES

Effective Date: 11/01/12
Revision Date:

Staff responsible for policy: DHCM Finance

I. Purpose

This policy applies to Acute Care and Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD) Contractors pursuing and becoming Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan), serving dual eligible Medicaid and Medicare enrollees. This policy outlines the steps necessary to gain state certification and the ongoing requirements to stay certified by AHCCCS. State certification is required as part of the CMS Medicare Advantage application.

Under Arizona State Law, certification of Contractors serving persons who are eligible for Medicaid, including persons eligible for both Medicare and Medicaid (dual eligible members), can be completed by Arizona Health Care Cost Containment System (AHCCCS) instead of licensure through the Arizona Department of Insurance (DOI). Contractors serving dual eligible members can choose to be licensed by DOI, rather than certified by AHCCCS, if desired. However, if a Contractor does serve more than dually eligible Medicare and Medicaid members under its Medicare Plan, the Contractor is required to obtain certification by DOI and not AHCCCS. Also, Contractors that are applying to become stand-alone Prescription Drug Plans (PDPs) shall apply for certification with the DOI. For current AHCCCS Contractors 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 Contractors if they are currently a Medicaid Contractor in that same geographic service area (GSA). However, due to the timing of the MA Plan application process, AHCCCS may provide a conditional certification that would allow an Offeror to start the process of becoming an MA Plan during the AHCCCS bid process for a new contracting cycle. The certification would be conditional upon being awarded a contract in that GSA for the new contracting period. Conditional approval in a particular GSA will be revoked if the Offeror is not awarded a contract in that GSA. Likewise, conditional approval will be made final in a particular GSA if the Offeror is awarded a contract in that GSA.

Definitions

Dual Eligible Member (for purposes of this policy)	A member enrolled with an AHCCCS Contractor for Medicaid services who is also a Medicare beneficiary. These persons are considered full dual eligible members. A full dual eligible member s 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).
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 ACOM Policy 305 for further clarification.
Medicare Advantage Plan (MA 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.
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.
Performance Bond	In general, a performance bond is an instrument that provides a financial guarantee in an amount specified by AHCCCS in this policy. Refer to the ACOM Policy 306 for definitions of acceptable instruments. As it pertains to a Medicare Advantage Plan, AHCCCS will not accept a County Resolution to satisfy the Performance Bond requirement, which

is acceptable for other Contractors as noted in the ACOM Policy 306.

II. Policy

A. Contractor Responsibilities

Contractors pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Form and request to the Division of Health Care Management, Finance Unit, at least 30 days prior to the date the certification is required to 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, Contractors shall submit the following in narrative form:

- Timing of start-up
- Geographic service areas that certification is being requested for
- Projected enrollment at start up and at the end of year one by geographic service area
- Projected amount and description of how equity per member requirements will be met initially and ongoing
- Projected amount, and description of how performance bond requirements will be met initially and ongoing.
- Statement of understanding regarding ongoing monitoring and reporting

B. AHCCCS Responsibilities

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

2. Prior to the approval, DHCM staff 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.

3. Upon review and acceptance of the plan of action noted in number 2 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.

C. Financial Viability Standards and Reporting

In order to receive certification, Contractors are required to be in compliance with current financial viability, claims, and administrative standards per the AHCCCS contract.

Performance Bond
AHCCCS requires that the Contractor obtain and maintain a performance bond specifically for the purpose of the MA Plan in accordance with ACOM Policy 305.

Equity per Member
AHCCCS requires that the Contractor maintain equity per MA Dual Eligible Member in accordance with ACOM Policy 305.

Ongoing Monitoring
Each Contractor will be required to self-monitor their compliance with the equity per member and performance bond requirements and to report to AHCCCS when approaching non-compliance along with a corrective action plan. AHCCCS reserves the right to investigate issues brought to the agency's attention related to the MA Plan.

Financial Reporting
The Contractor will be required to submit quarterly financial statements and annual audited financial statements delineating the equity per member, the performance bond amount and profitability as each relates to the MA Plan portion of their membership and its relative viability standard.

Contractors shall report financial data to AHCCCS using the appropriate AHCCCS Financial Reporting Guide for the line of business to which the MA Plan is related.

IV. Reference

- A.R.S. §36.2903
- ACOM Policy 305, Performance Bond and Equity per Member Requirements
- ACOM Policy 306, Performance Bond
- Acute Care Contract
- ALTCS EPD Contract
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- AHCCCS Financial Reporting Guide for ALTCS Contractors
- AHCCCS Rules 9 A.A.C. Chapter 29

401 - CHANGE OF PLAN: ACUTE CARE CONTRACTORS (HEALTH PLANS)

Effective Date: 08/01/94
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how, when and by whom change requests will be processed for Title XIX and Title XXI members. This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The requested Contractor, and
- The AHCCCSA,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

II. Definitions

Day: A calendar day, unless otherwise specified

III. Policy

A. Criteria For Change Of Plan Approval

Plan change requests will be granted for members if certain conditions are met. These conditions are:

1. Administrative Actions Resulting in a Request for a Health Plan Change

a. A member was entitled to freedom of choice, but was not given a pre-enrollment notice or sent an auto-assignment/freedom of choice notice. Title XXI members must choose a health plan prior to eligibility being effective. If a Title XXI member is transferred from Title XIX to Title XXI, and the Title XXI member has not made a health plan choice, the Title XXI member will continue to be enrolled in the health plan they were enrolled in at the time of transfer. They will then be sent and enrollment choice notice giving them all Title XXI enrollment choices and an opportunity to select a health plan.

b. A member was entitled to participate in an Annual Enrollment Choice but:
   1) was not sent an Annual Enrollment Choice or
   2) was sent and Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.

c. Family members were inadvertently enrolled in different health plans (this paragraph does not apply to Title XXI members). A member who is enrolled in a health plan through the auto-assignment process may inadvertently be enrolled in a different health plan than other family members. In this case, the member who was inadvertently enrolled will be disenrolled from the health plan of assignment and enrolled in the health plan where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the health plan to which the new member was auto-assigned. However, the condition set forth in the paragraph shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

d. A member of a special group is not enrolled in the same health plan as the group, in accordance with the AHCCCSA's list of special group agreements (this paragraph does not apply to Title XXI members). If a member who is part of such a special group is inadvertently enrolled in the wrong health plan, AHCCCS, upon notification, will disenroll the member from the health plan and enroll the member in the special group health plan.

e. A member who was enrolled in a health plan, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled in a different health plan within 90 days from the date of disenrollment. In this case the member should be reenrolled in the health plan that the member was enrolled in the prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member in the correct health plan. Title XXI members who loose eligibility and subsequently re-apply must choose a health plan prior to being made eligible regardless of the length of time between eligibility periods.

f. A Title XIX applicant who made a pre-enrollment choice and was denied Title XIX, but determined Title XXI eligible will be granted their Title XIX pre-enrollment choice. The person will be advised of their approval for Title XXI. The member will have 16 days to make a Title XXI choice. If the member does not change their choice within this timeframe the member will remain with their Title XIX choice. If the Title XIX applicant did not pre-enroll and was subsequently approved for Title XXI, the member will be contacted to obtain a Title XXI choice.

g. Newborns will automatically be assigned to the mother's health plan. If the mother is Title XIX or Title XXI eligible she will be given 16 days from notification to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 16 days from notification to select another health plan.

h. Adoption subsidy children will be auto-assigned and the guardian will be given 16 days from notification to select another health plan.

i. 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 16 days. The member will be given an opportunity to request a plan change following auto-assignment, however, the member must request a plan change within 16 days from the interview date (application record receipt date) or receipt of the choice letter. A member who does not make a selection within 16 days will remain with the auto-assigned health plan.

j. A member whose eligibility category changed from SOBRA to the SOBRA Family Planning Extension Program may change their health plan if their current PCP will not be providing Family Planning Extension Program services.

2. Medical Continuity Of Prenatal Care

a. A pregnant member who is enrolled in a health plan through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another health plan, may be granted a medical continuity plan change if the medical directors of both health plans concur.

b. If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current plan or go to the new plan if the medical continuity plan change is granted. The member may not return to the original health plan or change to another health plan after the medical continuity plan change has been granted except during the annual enrollment choice period.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

3. Medical Continuity Of Care

a. AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all health plans serving a specific geographic area. It is impossible for the standards to cover and respond to the array of circumstances that may occur in actual delivery of, medical/health care services. In unique situations, special plan changes may be approved on a case-by-case basis if necessary to ensure the member access to medical /health care.

b. A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both health plans that supports the need for a health plan change. The health plan(s) must be reasonable in the request for documentation. However, the burden of proof that a plan change is necessary rests with the member's medical provider. The Plan change must be approved by both health plan Medical Directors.

c. When the Medical Directors of both the receiving and relinquishing health plans have discussed the request and have not been able to come to an agreement, the relinquishing health plan shall submit the request to the AHCCCS Chief Medical Officer (CMO) or designee. The AHCCCS Acute Care Change of Plan Form (ATTACHMENT A) and the supporting documentation must be sent to the AHCCCS DHCM/CQM Manager within 14 business days from the date of the original request.

   The results of the review will be shared with both Medical Directors. The relinquishing health plan will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing health plan will send the member a notice of action.

d. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

B. Responsibility For Processing, Evaluation And Approval

1. Current Health Plan Responsibilities When A Plan Change Is Not Warranted

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

1) Quality of medical care delivery

2) Transportation convenience

3) Transportation service availability

4) Physician or provider preference

5) Physician or provider recommendation

6) Physician or provider office hours

7) Timing of appointments and services

8) Office waiting time

b. Additionally, the health plan 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.

c. Quality of care and delivery of medical services issues raised by the member must be referred to the current health plan's quality management staff and/or the health plan's Medical Director for review within one day of the health plan's receipt/notification of the problem.

d. The delivery of covered services remains the responsibility of the current health plan if a plan change for medical continuity of prenatal or other medical care is not approved.

e. The current health plan must notify the member, in writing, that a plan change is not warranted. If the plan change request was the result of a member concern, as defined in section B(1)(a) of this policy, the notice must include the health plan's resolution of this concern. The notice must also advise the member of the AHCCCS and health plan grievance policy and include timeframes for filing a grievance.

f. Health plans 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.

2. Current (Sending) Health Plan Responsibilities When A Plan Change Is Warranted

a. If a member contacts the current health plan, verbally or in writing, and states that the reason for the plan change request is due to situations defined in Section A(1) of this policy, the sending/current health plan shall advise the member to telephone the AHCCCS Verification Unit at 417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

b. If the member contacts the sending/current health plan, verbally or in writing, to request a plan change for medical continuity of care as defined in A(2) or A(3) of this policy, the following steps must be taken:

1) The sending/current health plan will contact the receiving health plan to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Plan Change Request form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both health plans. When the AHCCCS Plan Change Request form is signed it is to be submitted to the AHCCCS Division of Member Services (DMS) Enrollment Unit.

2) To facilitate continuity of prenatal care for the member, health plans shall sign off and forward the AHCCCS Plan Change Request form to the AHCCCS DMS Enrollment Unit Manager within 2 working days of the member's plan change request. The timeframe for other continuity of care issues is 10 business days.

3) The Enrollment Unit Manager will review the plan change documentation and forward to the Enrollment Unit for processing.

4) The enrollment Unit will consider these plan changes as an administrative plan change.

c. The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

3. Notification Requirements

The health plan will provide notification to its physicians and members of this policy. Information regarding this policy must be included in the provider manual and in the member handbook.

4. Receiving Health Plan Responsibilities

The member must be transitioned within the requirements and protocols in the AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy and in the AHCCCS Medical Policy Manual, Chapter 500.

5. Member responsibilities

a. The member shall request a change of plan directly from AHCCCS only for situations defined in Section A(1) of this policy. The member shall direct all other plan change requests to the member's current health plan.

b. A member who has questions or concerns about the Plan Change Policy should be first advised about the options available to the member and the steps the health plan is required to take to accommodate medically necessary services. If the member continues to present questions or concerns, the member should be advised of the AHCCCS/Health Plan Grievance Policy, including timeframes for filing a grievance.

C. AHCCCS Administration Responsibilities

1. The AHCCCSA shall process change of plan requests that are listed in Section A(1) and shall send notification of the change via the daily recipient roster to the sending and receiving health plans. It is the health plan's responsibility to identify members from the daily recipient roster who are leaving the health plan.

   Additionally, AHCCCSA will send the relinquishing health plan's transition coordinator a Prior Plan letter. The Prior Plan letter is system generated and mailed on a daily basis. The letter includes the transitioning member's name, AHCCCS ID, date of birth, and the name of the receiving health plan.

   If the AHCCCSA denies a Section A(1) change of plan request, AHCCCSA will send the member a denial letter. The member will be given 60 days to file a grievance.

2. If AHCCCSA receives a letter or verbal request from a member wanting a plan change, for reasons defined in Section A(1) of this policy, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current health plan.

3. If AHCCCSA receives a letter or verbal request from a member wanting a plan change for reasons listed in Section A(2) or A(3) the information will be forwarded to the current health plan.

IV. References

- 9 A.A.C. 22, Article 5 and 9 A.A.C. 31, Articles 3 and 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500
- Attachment A

Attachment A

MEMBER REQUEST FOR PLAN CHANGE

CHANGE REASON: ☐**Medical Continuity of Prenatal Care** ☐**Medical Continuity of Care**

MEMBER INFORMATION

Member Name:		Member ID:		Phone#:	- -
Address:		Apt/Space#:		DOB:	- - Sex:
City:		State:		ZIP:	
Member's PCP:		AHCCCS ID#:		Phone#:	- -

CURRENT (Sending) Health Plan:		**Receiving Health Plan**:	
Health Plan Name:		Health Plan Name:	
Health Plan ID#:		Health Plan ID#:	
Contact Name:		Contact Name:	
Contact Phone:		Contact Phone:	
Contact Fax:		Contact Fax:	

PROVIDER REQUESTED FOR CONTINUITY

Provider Name:		AHCCCS ID#:		Phone#	- -

DOCUMENTATION OF MEDICAL CONTINUITY

(include all information supporting the need for the change)

Member requests change of plan to:

Member's effective date is: - - Rate Codes:

☐ Approved ☐ Denied ☐ Approved ☐ Denied

Medical Directo5r's Signature/Sending Plan

Medical Director's Signature/Receiving Plan

Reason stated for denial by Receiving Plan:

PLEASE ATTACH ANY RELEVANT DOCUMENTATION

☐ Documentation Attached ☐ Additional family members listed on attached page

After review by AHCCCSA this plan change has been: ☐ Approved ☐ Denied

AHCCCS Medical Director (for Designee)

Date

Any plan change request processed by the health plans must involve continuity of care issues. If a plan change is requested for any other reason, the request should be managed according to the AHCCCS Change of Plan Policy.

402 - MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE, OPEN ENROLLMENT AND OTHER PLAN CHANGES: ACUTE CARE AND ARIZONA LONG TERM CARE SYSTEM (ALTCS) CONTRACTORS

Effective Date: 08/01/95
Revision Date: 02/01/03

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to all Acute Care and Arizona Long Term Care System (ALTCS) Contractors (hereafter referred to as Contractors). This policy establishes guidelines, criteria and timeframes for how members are to be transitioned between AHCCCS Contractors. This policy delineates the rights, obligations and responsibilities of, the member's current Contractor and the requested (receiving) Contractor.

The Contractors and AHCCCS work together to ensure the smooth transition of members as they change from one Contractor to another. While administrative and financial considerations are involved, the overriding consideration should be a smooth transition for all members and ensuring that continuity and quality of care are maintained.

This policy applies to members transitioning in the following circumstances.

A. Annual Enrollment Choice

Annual enrollment choice provides AHCCCS members with the opportunity to change Acute Care Contractors once per year, subject to the availability of other contracted Acute Care Contractors in their area.

Members must notify AHCCCS of their wish to change Acute Care Contractors during the annual enrollment choice period. If the member does not participate in annual enrollment choice, and their eligibility is maintained, he/she will remain with their current Acute Care Contractor.

B. Open Enrollment

AHCCCS may also conduct an open enrollment on a limited basis as deemed necessary by the AHCCCS Administration. Members must notify AHCCCS of their wish to change Acute Care Contractors during open enrollment.

If the member does not participate in open enrollment and their eligibility is maintained, he/she will remain with their current Acute Care Contractor unless the Acute Care Contractor is no longer available in that Geographic Service Area (GSA).

C. Contractor Changes Permitted by Policy

Members who have been granted a plan change pursuant to the AHCCCS Change of Plan Policy.

D. Eligibility Changes

Members who have changed eligibility from Acute to the ALTCS or from ALTCS to Acute.

Members who have become eligible and have enrolled into the Children's Rehabilitative Services (CRS) program while maintaining enrollment with an Acute or ALTCS Contractor, or members who have lost eligibility for CRS, but remained eligible for either the Acute or ALTCS program.

Each AHCCCS Contractor will participate in the transition of members. Contractors must have in place the necessary policies and procedures for the acceptance and transfer of members.

Transition coordination activities must include, but are not limited to, compliance with AHCCCS standards and policies found in the AHCCCS Medical Policy Manual, Chapter 500. The cost of reproducing and forwarding member records will be the responsibility of the relinquishing Acute Care Contractor and its providers.

This policy does not apply to members transitioning between Indian Health Service (IHS) and a Contractor.

II. Definitions

Annual enrollment choice: The annual opportunity for a member to change his/her Acute Care Contractor. The member is given their annual enrollment choice in the 10th month following their anniversary date. If an individual member makes a timely (within the period stated on the annual choice letter) annual enrollment choice, the change in Acute Care Contractors will occur on the first of the month in which their anniversary date occurs.

Anniversary date: The first day of the month in which a case (Members who share the same household identification number or a single person household) has Acute eligibility updated. Those Title XIX members within the case who had a break in eligibility and were reenrolled within 90 days will cause the entire case to have the break in eligibility ignored when calculating the anniversary month.

Case: Members who share the same household identification number.

Children's Rehabilitative Service (CRS): serves individuals under 21 years of age who meet the criteria established by Arizona Department of Health Services. CRS has a contract with AHCCCS for the provision of care for specific conditions. Members may be concurrently enrolled with CRS and with a Contractor.

Enrollment Transition Information Form (ETI): The form the Relinquishing Contractor must complete and transmit to the Receiving Contractor for those members requiring coordination of services as a result of transitioning to another Contractor. (See AHCCCS Medical Policy Manual, Chapter 500).

Indian Health Service (IHS): Indian Health Service is a division of the U. S. Public Health Service. It administers a system of hospitals and health care centers providing health services to Native Americans and Native Alaskans.

Member Transition: The process during which members change from one Acute Care Contractor to another, change from the Acute to the ALTCS program, change from ALTCS to the Acute program, change from one ALTCS Contractor to another, or enroll or disenroll from CRS.

Open enrollment: The period of time when selected enrolled members in an affected GSA or Acute Care Contractor may select membership with another AHCCCS Acute Care Contractor if one is available in their service area.

Plan change: The process where a member changes Acute Care Contractors whether during Annual Enrollment Choice, Open Enrollment or Pursuant to the AHCCCS "Change of Plan Policy".

Receiving Contractor: The Contractor with which the member will become enrolled as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

Regional Behavioral Health Authority (RBHA): The Regional Behavioral Health Authority is an organization under contract with the Arizona Department of Health Services to coordinate the delivery of behavioral health services in a geographically specific service area of the state.

Relinquishing Contractor: The Contractor in which the member is currently enrolled. This is the Contractor that the member will be leaving as a result of annual enrollment choice, open enrollment, a plan change or a change in eligibility.

Transition coordinator: A designated Contractor health care professional who is responsible for the oversight of transition activities.

Transition plan: A documented plan (policy) which details the Contractor's protocols, standards and procedures for performing transition activities for members joining and leaving the Contractor. The Contractor's transition plan must be approved in writing by AHCCCSA prior to implementation.

III. Policy

A. Contractor Responsibilities During Annual Enrollment Choice, Open Enrollment And Other Contractor Changes

1. Relinquishing and receiving Contractors must comply with all transition policies specified in the AHCCCS Medical Policy Manual Chapter 500.

2. Relinquishing Contractors who fail to notify receiving Contractors about members that meet the AHCCCS transition notification requirements, as indicated in the AHCCCS Medical Policy Manual Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by the AHCCCS Administration. In cases where AHCCCS determines that the relinquishing Contractor has a period of responsibility following the transition date, AHCCCS will require the receiving Contractor to provide AHCCCS with information about all cost incurred by the member during the period determined by AHCCCS. Failure to provide the information to AHCCCS as specified by AHCCCS and by the date specified by AHCCCS will negate the receiving Contractor's claim to reimbursement in that case.

3. Each Contractor must develop and submit a transition plan and designate a transition coordinator who meets the requirements addressed in this policy. Contractors are also encouraged to designate an information system staff member or representative to work with transition coordinators to assist with the technical requirements necessary for member transition.

4. Contractor representatives must be accessible for members participating in annual enrollment choice or open enrollment. These representatives must have the authority to respond to member and provider concerns and facilitate problem resolution.

B. Relinquishing Contractor Responsibilities

1. Relinquishing Contractors must complete and transmit an Enrollment Transition Information (ETI) form for each member with special circumstances, as described in the AHCCCS Medical Policy Manual, Chapter 500, and must comply with the notification requirements specified in this policy. If there is no pertinent information to transmit concerning a member who is transitioning, no action is required.

2. Relinquishing Contractors that fail to notify receiving Contractors of members that meet the AHCCCS transition notification requirements as indicated in the AHCCCS Medical Policy Manual, Chapter 500, may be responsible for the cost of the member's care for medically necessary services for up to 30 days after the transition. The scope and responsibility for such cases will be reviewed and determined by AHCCCS Administration.

3. Relinquishing Contractors with transitioning members who are hospitalized at the time of transition must notify the hospital prior to transitioning the member and must comply with the requirements of the AHCCCS Medical Policy Manual, Chapter 500. For those hospitalized transitioning members in intensive care units, critical care units, and neonatal intensive care units, close consultation between attending physicians, current primary care provider (PCP) and the member's receiving Contractor and PCP is required.

4. The Relinquishing Contractor is responsible for ensuring that a transitioning member's medical records are copied and mailed when requested by the receiving Contractor's transition coordinator, the member's new PCP, or his/her designated office staff. In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing Contractor is responsible for the cost of copying and postage. Under no circumstances is the member required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving Contractor.

5. For members changing Contractors or changing to or from ALTCS, all AHCCCS Contractors must cover and deliver medically necessary services to their assigned members through the date of transition. Under no circumstances may a Contractor cancel, postpone, or deny a service based on the fact that a member will be transitioning to another Contractor except as discussed in AMPM, Chapter 500.

   Additionally, Contractors are responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the Acute Care Contractor's duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

6. The relinquishing Contractor will remain responsible for adjudicating any pending member grievances that are filed prior to the member's transition.

7. If an ALTCS member is no longer ALTCS eligible but is eligible for acute care the relinquishing Contractor is responsible for obtaining the member's choice of acute care Acute Care Contractor and notifying AHCCCS, as a part of the ALTCS disenrollment process, when the member is transitioning from ALTCS to Acute.

8. If a member enrolled in a Contractor becomes eligible and enrolls in CRS, the member's Contractor and CRSA, or its subcontractor, must cooperate in the coordination of care for the member.

9. If a member enrolled in CRS is no longer eligible for CRS, but remains eligible for the Acute or ALTCS programs, CRSA, or its subcontractor, is responsible for contacting the member's Contractor to coordinate care for the transitioning member's CRS condition.

C. Receiving Contractor Responsibilities

Receiving Contractors that fail to act upon enrollment transition information communicated by the relinquishing Contractor for members that meet the AHCCCS notification requirements, or fail to coordinate or provide the necessary covered services to transitioning members after being properly notified in a timely manner, will be subject to possible sanctions.

1. Within 10 business days for Acute Care members and 12 days for ALTCS members (allows for case management on-site visit) of the effective date of transition, the receiving Contractor must provide new members with member information as specified in the AHCCCS Member Information Policy.

2. Receiving Contractors are responsible for ensuring that:

   a) Transitioning members are assigned to a PCP in accordance with AHCCCS requirements.

   b) Transitioning members can obtain routine, urgent, and emergent medical care in accordance with AHCCCS standards.

3. When a pregnant woman who is considered high-risk and is in her third trimester or a member who is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery, the receiving Contractor is responsible for the payment of obstetrical and delivery services. If the member's current physician and/or facility selected as her delivery site are not within the receiving Contractor's provider network, the receiving Contractor 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 Contractor's contracted network.

4. For members receiving behavioral health services through an ADHS Contractor, the receiving Contractor is responsible for notification about the enrollment changes (if known), coordination of behavioral health services, and case management with the member's assigned Regional Behavioral Health Authority.

5. The receiving Contractor is responsible for maintaining ongoing communication with the transition coordinator of the relinquishing Contractor and ensuring all appropriate documents (i.e., medical records if requested, treatment plans, etc.) are received in a timely manner or as specified by both Contractors.

D. Member Responsibilities During Annual Enrollment Choice

1. Members are encouraged to thoroughly review all AHCCCS and Acute Care Contractor annual enrollment choice material, call the prospective Acute Care Contractors, and ask questions prior to making a decision.

   Members must maintain eligibility to stay enrolled with AHCCCS. If a Title XIX member loses eligibility after making an annual enrollment choice and regains eligibility prior to the 90-day reenrollment period, the member's annual enrollment choice will be honored. If the member regains eligibility after the 90-day re-enrollment period, he/she will lose their annual enrollment choice. If a Title XIX member regains eligibility after the 90-day period and did not make a pre-enrollment choice, he/she will be auto-assigned to an available Acute Care Contractor. If a Title XXI member loses eligibility after making an annual enrollment choice and regains eligibility within the 90-day period the annual enrollment choice will not be honored. The member must make another enrollment choice.

2. Members who change Acute Care Contractors during their annual enrollment choice will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month in which their anniversary date occurs. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month previous to the anniversary date. If the member does not make a choice before the last day of the month the member will not receive services from their new Acute Care Contractor (receiving Acute Care Contractor) until the first day of the month following their anniversary month. Members will continue to receive their medical care from their current AHCCCS Acute Care Contractor (relinquishing Acute Care Contractor) through the end of the month of the anniversary date.

3. Members who elect to change their Acute Care Contractor during their annual enrollment choice must notify AHCCCS of their choice. If members are satisfied with their current Acute Care Contractor and do not wish to change, no action on the part of the member is required unless their Acute Care Contractor is no longer available in the member's GSA. Members will receive instruction on how to change Acute Care Contractors or remain with their current Acute Care Contractor in the annual enrollment choice packet.

E. Transition Plan

1. Contractors must submit a transition plan to AHCCCS within the time lines set by AHCCCS. The transition coordinators will be notified, in writing, of the date the transition plan is due to AHCCCS. The transition plan must be approved by AHCCCS prior to implementation. The scope of the transition plan must address the transition of new and existing members. Contractors should refer to the authority references listed on page 10 of this policy when developing their transition plans.

2. At a minimum, transition plans must address the following areas:

   a) Transition notification requirements as indicated in the AHCCCS Medical Policy Manual

   b) Timely notification to receiving Contractors of transitioning members no later that 10 business days from the date of the potential transition listing (for annual enrollment choice and open enrollment) or the daily roster (for all other Contractor changes)

   c) PCP assignment procedures

   d) Case management assignment for Contractors

   e) General communication and coordination of member transition activities

   f) Procedures for transfer of medical records and coordination of services between PCPs

   g) Procedures for recording the number of behavioral health and nursing facility services for transitioning members

F. Transition Coordinator

Contractors must identify a representative to serve as transition coordinator. The individual appointed to this position must be a health care professional who possesses the appropriate education and experience to effectively coordinate and oversee all transition issues, responsibilities, and activities. The role of the transition coordinator includes:

1. Coordinating plan change transition activities

2. Ensuring that transition activities are accomplished in accordance with AHCCCS and Contractor policies and procedures

3. Acting as an advocate for members leaving and joining the Contractor

4. Facilitating communication between Contractors and AHCCCS

5. Assisting PCPs, internal Contractor departments, and other contracted providers with the coordination of care for transitioning members

6. Ensuring that continuity and quality of care of transitioning members is maintained during Contractor transitions

7. Participating in AHCCCS Acute Care Contractor transition coordinator's planning meetings

8. Assisting AHCCCS Administration with developing transition policy, procedures, and standards

G. Potential Transition Listing

To assist with the identification of members who have made an annual enrollment choice and will be transitioning between Acute Care Contractors as a result of the annual enrollment choice, AHCCCS will provide Acute Care Contractors with a Potential Transition Listing. This listing will be transmitted to the Acute Care Contractor via the File Transfer Protocol (FTP) server approximately two weeks before the member's enrollment effective date.

The Potential Transition Listing will include the following member information:

1. AHCCCS ID Number

2. Name and address

3. Date of birth

4. Rate code

5. Relinquishing Acute Care Contractor

6. Receiving Acute Care Contractor

7. New PCP choice by name (if identified by the member at the time of annual enrollment choice)

IV. References

- Arizona Administrative Code R9-22, Articles 5 and 7
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual, Chapter 500

403 - ENROLLMENT CHOICE IN A CHOICE COUNTY AND CHANGE OF CONTRACTOR POLICY: ARIZONA LONG TERM CARE SYSTEM (ALTCS), ELDERLY/ PHYSICALLY DISABLED (EPD) CONTRACTORS

Effective Date: 10/01/00
Revision Date: 08/01/01

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to ALTCS/EPD Contractors. This policy establishes guidelines, criteria and timeframes for how, when and by whom enrollment choice in a choice county and Contractor change requests will be processed for ALTCS members. This policy applies to Arizona Long Term Care (ALTCS) Contractors only (hereafter referred to as Contractors).

This policy delineates the rights, obligations and responsibilities of:

- The member
- The member's current Contractor
- The receiving Contractor, and
- The AHCCCS Administration,

in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

II. Definitions

ALTCS Local Office: The ALTCS local office currently responsible for the member's financial eligibility case record.

Anniversary Date: The month for which the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter.

Choice County or Geographic Service Area (GSA): A county or GSA with more than one ALTCS Contractor.

County of Fiscal Responsibility: The county that is financially responsible for the State's share of ALTCS funding.

Current Contractor: The Contractor with whom the member is enrolled at the time the change request is generated.

Day: Day means a calendar day unless otherwise specified.

Receiving Contractor: The Contractor to whom the member is being changed.

Requested Contractor: The Contractor to whom the member wants to change.

III. Policy

Some, but not all, ALTCS applicants and members who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a Contractor.

A. Enrollment Choice in a Choice County

1. Individual Entitled to Enrollment Choice

An individual is entitled to enrollment choice when:

a. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.

b. A member moves from another county to his or her own home in a choice county, unless the member's current Contractor is available in the choice county.

c. A member moves from another county to a nursing facility or alternative residential setting in a choice county and the current Contractor has chosen to negotiate an enrollment change.

d. A member is currently enrolled with a Contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another Contractor serving a choice county.

e. A former member resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.

f. A member attains the annual anniversary date.

2. Individual Who Does Not Have Enrollment Choice

This policy does not apply to the following individuals:

a. A member who is developmentally disabled

b. A member who is a Native American with on-reservation status

c. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current Contractor chooses to negotiate a change to that choice county)

d. A member who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.

e. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.

f. A member who moves to a choice county and his or her current Contractor is available in that choice county.

3. Initial Enrollment Process

The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.

Stage	Description
1	ALTCS staff provides the applicant with: • An explanation of enrollment choice • Marketing materials from the Contractors serving the choice county. • Assistance in choosing a Contractor
2	ALTCS Staff obtains an enrollment choice before the application is approved.
3	Ongoing enrollment is prospective, effective the date the application is approved. Prior period coverage is effective retroactive to the first day of the first eligible month, unless the member is being transferred from an acute Contractor to an ALTCS Contractor.

4. Re-enrollment After Disenrollment

When a member, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the member will be reenrolled with the former Contractor, if that Contractor is still available. If that Contractor is not available, the member will be given the opportunity to choose a Contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the member will be given the opportunity to choose a Contractor.

When a member is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The member may choose to enroll with a different Contractor on his/her anniversary date, which is established by the initial enrollment with that Contractor.

5. Enrollment Choice Process For Fiscal County Changes

An enrollment choice must be obtained before a member's enrollment can be changed to a Contractor serving a choice county. The enrollment choice process applies to an ALTCS member who moves to a choice county to:

a. His or her own home

b. A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a Contractor in a choice county.

The enrollment choice process consists of the following steps:

Step	Action
1	The ALTCS local office provides the member with: • an explanation of enrollment choice • marketing materials from each of the Contractors serving a choice county The member is asked to provide a choice prior to actually moving or within 10 days of our request.
2	The ALTCS local office provides the member with assistance in making the decision throughout the process.
3	When the member does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the member to provide a choice within the next 10 days.

B. Identifying & Processing Requests for Contractor Changes Within a Choice County

Generally, once enrollment occurs a member cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county Contractor to another choice county Contractor can be made for certain reasons.

1. Medical Continuity of Care Requests

In unusual situations, special Contractor changes may be approved on a case-by-case basis to ensure the member's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

The following special process is required:

Step	Action
1	The member's PCP must provide documentation to the Medical Directors of both Contractors that support the need for a Contractor change. Both Contractors must be reasonable in the request for documentation.
2	The Medical Directors of both Contractors must approve the change. • In order to provide continuity of care on a temporary basis for the member's period of illness, the current Contractor may agree to reimburse the member's provider for service rather than approve a Contractor change. • If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision.
3	When both Contractors approve the change the receiving Contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations. When the requested Contractor denies the request, the DE-621 is returned to the current Contractor who may forward the DE-621 to the AHCCCS Medical Director.

Step	Action
4	If the AHCCCS Medical Director approves the change, the DE-621 is returned to the current Contractor to negotiate the effective date of the change. The current Contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.
5	The Program Contractor Change Request Coordinator processes the change.
6	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors.

2. Valid Conditions (Excluding Medical Continuity of Care)

When any of the following conditions exist, an ALTCS local office may authorize a change of Contractors within a choice county.

a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen Contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the Contractor's marketing material or database submissions.

b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of Contractors during the application process.

c. Lack of annual enrollment choice: The member was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control (i.e., member or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).

d. Family continuity of care: The member, either through auto-assignment or the choice process, is not enrolled with the same Contractor as the other family members. To promote continuity of care, family members, such as married couples, may choose to be enrolled with the same Contractor.

e. Continuity of institutional or residential setting: The member's Contractor terminates their contract with the institutional or residential setting in which the member resides, and the member or the member's representative requests to change to a Contractor who contracts with their institutional or residential setting. The member must be enrolled and living in the facility at the time of the contract termination.

f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.

g. Failure to correctly apply the 90-day reenrollment policy: The member lost ALTCS eligiblity and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different Contractor.

3. Processing Enrollment Change Requests

The following procedures apply when a member requests a change of Contractors within a choice county

When…	**Then…**
The member makes the request for a change to the Contractor and claims a valid condition exists (see pages 7 and 9).	The Contractor will report the request to the Local ALTCS Office using the ALTCS Member Change Report Form (DE-701).
The ALTCS local office receives a change request from a Contractor or a member	The ALTCS local office will investigate the request to determine if a valid condition exists.
The ALTCS local office determines that a valid change condition exists	The ALTCS local office will change the member's enrollment to the Contractor the member chooses. The enrollment change is effective the day the change is processed by the ALTCS local office.
The ALTCS local offices determines that the nursing facility or alternative residential setting terminated the contract	The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and may change the enrollment only if approved in the response.

When…	Then…
The ALTCS local office determines that a valid situation does not exist	The ALTCS local office will: • Send the member a Denial of Program Contractor Change Request (DE-548) denying the request and giving the member the right to appeal the decision. • Refer the member to his or her current Contractor for resolution of existing issues.

C. Fiscal County and Enrollment Change Policies

1. Placements by a Contractor

When a Contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the Contractor's county), the county of fiscal responsibility and enrollment do not change.

2. Moves initiated by the member or the member's family

When a member moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following policies:

If the member moves to…	Then…
His or her own home	<u>County of Fiscal Responsibility</u> • The county of fiscal responsibility changes to the (new county) county in which the home is located. <u>Enrollment</u> • Enrollment remains unchanged if the same Contractor serves both counties • Enrollment changes if the member moves to a county served by a different Contractor. • The Enrollment Choice process must be completed prior to enrollment and fiscal county changes if the home is located in a choice county and the current Contractor is not available in that choice county.

If the member moves to…	Then…
A nursing facility or an alternative residential setting	• The county of fiscal responsibility and enrollment will remain unchanged unless the current Contractor successfully negotiates a change with a Contractor serving the new county. • The Enrollment Choice process must be completed prior to the negotiation process when the member moves to a choice county.

3. Uncoordinated Moves by the Member

The Contractor is responsible for explaining the service limitations and exclusions to members who move out of the Contractor's service area.

The current Contractor is liable only for those services authorized by an ALTCS member's case manager.

D. Member Moves to Own Home in Another County

When a member resides in his or her own home the following policies apply:

- The county of fiscal responsibility is the county where the member's or child's parents home is located.
- Enrollment is with a Contractor serving the geographic service area (or fiscal county) where the home is located.
- When the member moves to his or her own home in a choice county, and is not already enrolled with a Contractor serving that choice county, the member must be given an opportunity to choose a Contractor. The member will be enrolled with the Contractor selected through the enrollment choice process.
- The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

1. Member's Responsibilities

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Contractor Responsibilities

The current Contractor is responsible for:

a. Notifying the ALTCS local office that the member moved by sending a Member Change Report (DE-701),

b. Explaining service limitations and exclusions to a member who moves out of the Contractor's service area, and

c. Transitioning the member to the new Contractor, which includes forwarding medical records and other materials to the receiving Contractor.

3. ALTCS Local Office Responsibilities

The ALTCS local office is responsible for:

a. Completing the enrollment choice process for members changing to a choice county,

b. Changing the member's living arrangement (if appropriate) and address when the move occurs,

c. Making necessary changes in the county of fiscal responsibility and enrollment, and

d. Making changes to eligibility and share of cost arising from the change in the member's living arrangement.

4. Enrollment Change Procedures

The ALTCS local office will complete the following steps:

Step	Action
1	Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct.) • If a change is required, proceed to Step 2. • If no change is needed, update the address and living arrangement, and share of cost, if necessary.

Step	Action
2	Complete the Enrollment Choice Process if enrollment needs to be changed to a Contractor serving a choice county. When the member is unable or unwilling to make a choice the current ALTCS local office will either select a Contractor for the member or permit auto assignment to a Contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual.
3	Process fiscal county and enrollment changes.
4	Determine if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

E. Member Moves to a Nursing Facility or Alternative Residential Setting in Another County

When the current Contractor provides services to the county where the member is moving, the enrollment and county of fiscal responsibility do not change.

When the current Contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current Contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the member moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

1. Member's Responsibilities

The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Current Contractor Responsibilities

a. When the current Contractor is notified that a member has moved to another county or plans to move to another county, and the member resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:

- Retain the member and contract with an out of county provider,
- Negotiate an enrollment change, or
- Pay facility expenses for a limited number of days while plans are being made to move the member to a contracted facility. If the member refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.

b. When enrollment change is the preferred option, the current Contractor is responsible for:

- Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
- Completing a Program Contractor Change Request (DE-621) and sending it to the Contractor serving the GSA or the requested choice county Contractor, and
- Transitioning the member when a change is approved.

3. ALTCS Local Office Responsibilities

a. General Responsibilities

The ALTCS local office is responsible for:

- Assuring that the current Contractor is aware of the move or the member's plan to move, by contacting the current Contractor and advising the member to contact the current Contractor
- Informing the member that the current Contractor:
  - Must be involved in the placement change
  - Is only liable for services authorized by the case manager
- Changing the member's address when the move is verified, and
- Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.

b. Enrollment Choice for Transfers to a Choice County

When enrollment choice is requested by the current Contractor, the ALTCS local office is also responsible for:

- Informing the member about enrollment choice
- Providing marketing materials to the member
- Providing assistance to the member as necessary, and
- Obtaining an enrollment choice from the member and notifying the current Contractor.

4. Requested Contractor's Responsibilities

When a Program Contractor Change Request (DE-621) is received the requested Contractor is responsible for:

a. Approving or denying the change request by completing the DE-621, and

b. Transitioning the member when the change request is approved or the AHCCCS Medical Director directs the change.

5. AHCCCS Medical Director's Responsibilities

The AHCCCS Medical Director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current Contractor requests review by the AHCCCS Medical Director.

If approved, a written decision is issued to the current Contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current Contractor, the receiving/requested Contractor and the member.

6. AHCCCS Central Office Field Operations Responsibilities

The AHCCCS Central Office Field Operations is responsible for:

a. Processing enrollment and county of fiscal responsibility changes, and

b. Sending the ALTCS local office a copy of the DE-621.

F. Enrollment Change Process

The following steps are involved in the enrollment change process:

Step	Action
1	The member moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county.
2	When advised of the move the ALTCS office: • notifies the current Contractor, • advises the member to contact the current Contractor, and • warns the member about limitations on services received from out-of-network providers.
3	When the move has been verified, the ALTCS local office changes only the member's address/living arrangement, not the county of fiscal responsibility.
4	When the move is to a choice county: • The current Contractor asks the ALTCS local office to complete the Enrollment Choice Process. • The ALTCS local office obtains an enrollment choice and informs the current Contractor.
5	The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county this will be the requested Contractor. If the Contractor serving the new county of residence denies the request, the current Contractor may forward to the AHCCCS Medical Director for a final decision.
6	When the Contractors or the AHCCCS Medical Director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current Contractor will forward medical records and other materials to the receiving Contractor.

Step	Action
7	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors. When the change is denied, the current Contractor continues to provide services to the member.
8	The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

G. The Contractor's Responsibilities

1. Provide Contractor change policy

Contractors are responsible for providing information on the Contractor change policy in:

a. The Member Handbook for new and existing members, and

b. The Provider Manual for providers

2. Address members' concerns

The current Contractor is responsible for promptly addressing members' concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:

a. Quality of care

b. Case management responsiveness

c. Transportation service availability

d. Institutional care issues

e. Physician or provider office hours

f. Office waiting time, and

g. Network limitations and restrictions.

3. Refer unresolved issues

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:

a. The current Contractor's Quality Management Department and/or

b. The AHCCCS Medical Director

4. Transitioning Between Contractors

The current Contractor is responsible for:

a. Reporting the member's address and living arrangement changes to AHCCCS

b. Encouraging members to report anticipated moves to another county or geographic service area to them (current Contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.

c. Advising members to contact the ALTCS local office to request an enrollment change between Contractors serving a choice county if a valid reason other than medical continuity of care is claimed.

d. Accepting a member's request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the member's case manager.

e. Forwarding medical records and other materials to the receiving Contractor

Both the current Contractor and the receiving Contractor are responsible for assuring a safe transition for the member when an enrollment change occurs. The Contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.

5. Process Members' Enrollment Change Requests

The Contractor will process enrollment change requests from members as follows:

When the member requests a Contractor change	Then the current Contractor
Within a choice county and the member claims a valid condition exists	Refers the issue to the ALTCS local office for review using the ALTCS Member Change Report (DE-701).
That requires the approval of both the current and the receiving Contractors	Notifies the ALTCS local office if the member lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process. Negotiates the change with the requested Contractor. Completes a DE-621 and forwards it to the requested Contractor. Notifies the member if the change is approved. May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change. Notifies the member in writing if the enrollment change is denied at the Contractor level. The denial notice must include • the AHCCCS Program Contractor Grievance Policy, and • timeframes for filing a grievance.

6. Notify hospitals of certain enrollment changes

When an enrollment change occurs while the member is hospitalized, the current Contractor must notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor.

If the current Contractor fails to provide such notice to the hospital, the current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

7. Process Grievances

When an enrollment change requested by the member is denied by the Contractor (not the AHCCCS Medical Director), the current Contractor is responsible for processing any resulting grievances.

H. AHCCCS Administration's Responsibilities

1. Enrollment change requests received from members

Except for valid changes within a choice county or a change due to the member moving to his or her own home, the AHCCCS Administration or the ALTCS local office will refer a member's request for an enrollment change to the current Contractor.

2. Process enrollment change requests

The AHCCCSA will process enrollment change requests within 5 days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.

3. Issue decisions

The AHCCCSA will notify Contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the member.

AHCCCSA will send notification to both the current and receiving Contractors and the member when an enrollment change is denied by the AHCCCS Medical Director. When approved by the AHCCCS Medical Director, notification will be sent to the current Contractor.

4. Process Grievances

When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting member grievance.

The Division of Health Care Management, ALTCS Unit sends the member a denial notice, which explains the Grievance System under 9 A.A.C. 34.

5. Monitor policy compliance

The AHCCCS Division of Health Care Management (DHCM) will monitor Contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult members to another Contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

IV. References

- Arizona Administrative Code R9-28, Article 7
- ALTCS Contract, Section D
- AHCCCS Medical Policy Manual Chapter 500

404 – MEMBER INFORMATION

Effective Date: 06/01/12, 08/17/12, 11/01/12, 03/01/13
Revision Date: 06/09/09, 01/28/10, 08/12/10, 08/11/11, 05/18/12, 6/28/12, 10/24/12, 11/16/12, 02/07/13

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP), and ALTCS Division of Developmental Disabilities (DDD) Contractors. This policy establishes guidelines for AHCCCS Contractors regarding member information requirements and the approval process for member information materials developed by or used by the Contractor. This policy pertains to oral communication to members and written materials, including outreach materials that are disseminated to a Contractor's own members. It also pertains to the content of a Contractor's website. It does NOT pertain to marketing outreach or incentive materials, which are disseminated to potential members, as described in ACOM Policy 101, unless the materials meet the description in III.A.2 below. The exception is the written and oral information specifically mentioned in this policy.

All member information materials developed by the Contractor that may also be disseminated to non-members must also meet the requirements of ACOM Policy 101 and shall specify: "Contract services are funded in part under contract with the State of Arizona."

II. Definitions

Member/Recipient Information Materials	Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, 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.

III. Policy

A. Oral Information

1. The Contractor must make oral interpretation services available to its members free of charge. Services for all non-English languages and the hearing impaired must be available.

2. The Contractor must make oral interpretation services available to potential members, free of charge, when oral information is requested for use in choosing among Contractors. Services for all non-English languages and the hearing impaired must be available.

B. Printed Information

1. Materials Requiring Approval by the Administration

   All member/recipient information materials developed by the Contractor and disseminated to its own members must be submitted to AHCCCS for approval, prior to dissemination, unless otherwise specified in contract. All materials must be labeled with the Contractors name and/or logo; this includes member material that is located on the Contractor's website, e-mail messages and voice recorded phone messages delivered to a member's phone. Once member materials are approved by AHCCCS, the Contractor must ensure that the information contained within the material item is updated regularly and appropriately based on such changes as benefit, contractual, policy or other relevant updates.

2. Materials Not Requiring Approval by the Administration

   Customized letters for individual members need not be submitted for approval. Health related brochures developed by a nationally recognized organization (see Attachment A) do not require submission to AHCCCS for approval. Attachment A is not an all-inclusive list. Contractors may submit names of other organizations to AHCCCS to determine if they should be added to the list. Contractors will receive an updated copy of this Attachment, as necessary.

   The Contractor will be held accountable for the content of materials developed by the organizations listed in Attachment A. AHCCCS suggests that the Contractor review the materials to ensure that: 1) the services are covered under the AHCCCS program; 2) the information is accurate; and 3) the information is culturally sensitive.

   It is important to note that in all instances where the Contractor is required by its contract with AHCCCS to educate its members, brochures developed by outside entities must be supplemented with informational materials developed by the Contractor which are customized for the Medicaid population.

3. Reading Level and Language Requirements

   All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have limited English proficiency (LEP) in that language.

   All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denials, reductions, suspensions or terminations of services, consent forms, communications requiring a response from the member, detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, informed consent and all grievance and request for hearing information as described in the "Enrollee Grievance System Standards" section of the applicable contract.

   All written notices informing members of their right to interpretation and translation services in a language, shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

   The Contractor is not required to submit to AHCCCS the member material translated into a language other than English, however, it is the Contractor's sole responsibility to ensure the translation is accurate and culturally appropriate.

   The Contractor shall make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The reading level and methodology used to measure it should be included with the submission.

   The materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

4. Review of Materials

   All proposed Contractor member materials will be reviewed by the Division of Health Care Management. Information shall be submitted via electronic mail (unless the material is not available in an electronic format). Proposed materials shall be submitted to:

   Operations and Compliance Officer (or her/his designee)
   AHCCCS, Division of Health Care Management
   701 E. Jefferson, Mail Drop 6100
   Phoenix, AZ 85034

Unless otherwise indicated, proposed materials must be submitted 30 days before the intended publication date. AHCCCS will notify the Contractor in writing within fifteen (15) working days of receipt of the complete materials packet whether or not the materials have been approved, denied or require modification.

5. New Member Information

All Contractor(s) shall produce and provide the following information to each member/representative or household within twelve (12) business days of receipt of notification of the enrollment date. Contractors have the option of providing the Member Handbook and Network Description/Provider Directory with the new member packet, or providing written notification that the information is available on the Contractor's website, by electronic mail or by postal mailing. Should the Contractor elect to provide notification that the information available using the latter approach refer to the requirements listed under subsections A and B.

ALTCS EPD and DDD Contractors must continue to provide a printed copy of the Member Handbook and Network Description/Provider Directory. ALTCS Case Managers must also review the Handbook with the member annually.

C. Member Handbook

The Acute, ALTCS EPD, DDD, BHS, CMDP and CRS member handbooks shall contain the information provided in Attachment C.

Contractors who elect to provide notification that the information is available on their website, by electronic mail or by postal mailing, must submit the request along with a comprehensive list of all changes to the Member Handbook to AHCCCS for review and approval a minimum of sixty (60) days in advance of the effective date of the changes. The Contractor must also ensure that:

1. The Handbook is available electronically and may be printed from the Contractor's website, if the enrollee elects to do so;

2. The enrollee is provided the option of obtaining a printed version of the Handbook upon request;

3. Enrollees receive written notice of changes, considered to be significant by AHCCCS (see 42 C.F.R. 438.10), at least thirty (30) days in advance of the intended effective date and annually thereafter. Examples include but are not limited to:

    a. Contractor service hours and availability
    b. Changes to the Provider network
    c. Benefit changes

D. Network Description/Provider Directory

Acute, CMDP, ALTCS EPD and DDD Network Description

The description shall, at a minimum, contain information about primary care providers, specialists, hospitals and pharmacies. ALTCS Contractors shall also include skilled nursing facilities and alternative residential settings. The description will include:

a. Provider name
b. Provider address
c. Provider telephone number
d. Non-English languages spoken
e. Whether or not the provider is accepting new patients

The information will also include any restrictions on the member's freedom of choice among network providers. This information must be current and can be in the same form as typical correspondence to members.

Contractors who elect to provide notification that the information is available for the Network Description/Provider Directory information on their website, by electronic mail or by postal mailing must follow the same submission requirements as delineated for the Member Handbook under subsection A.

CRS Network Description

The description shall, at a minimum, contain information about CRS providers, specialists, hospitals and pharmacies. The description will include:

a. Specialty Provider and Clinic names
b. Specialty Clinic address
c. Specialty Clinic telephone number
d. Clinic Provider telephone number
e. Non-English languages spoken by clinic providers
f. Whether or not the specialty provider is accepting new patients

The information will also include any restrictions or an explanation of the recipient's freedom of choice among clinic providers. The materials can be in the same form as typical correspondence to members.

BHS Network Description

ADHS shall provide a description of the provider network ensuring the following information is provided to all behavioral health recipients:

a. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the behavioral health recipient's service area, including identification of providers that are not accepting new referrals.

b. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
c. The fact that the behavioral health recipient has a right to use any hospital or other setting for emergency care.
d. The names and locations of the pharmacies to be used for filling prescriptions for psychotropic medications.

E. Website Content

Acute, CMDP, CRS, ALTCS EPD, DDD, and BHS

The Contractor must include the following member related information on its website. All of the information must be located on the Contractor's website in a manner that members can easily find and navigate (e.g. "Consumer Page" from the Contractor's home page).

a. A current member handbook.
b. The current and past three member newsletters.
c. AHCCCS member and provider survey results via link to AHCCCS website.
d. Performance measure results via link to AHCCCS website.
e. Contractor member and provider survey results, as available.
f. Formulary, which must be updated within 30 days of a change being made. The following shall be available in a user friendly format:
    - A medication formulary listing by the Brand name and/or Generic name of the medication, including notations for all medications that require a prior authorization.
    - A medication formulary listing by drug class.
    - A specific (individual) drug look-up capability.

g. Tobacco Cessation Information, as described in the member handbook. A link to the Tobacco Education and Prevention Program (TEPP) website should be included.
h. A user friendly, searchable provider directory. The directory must include the following search functions and be updated at least monthly, if necessary:
    - Name
    - Specialty/Service
    - Languages spoken by Practitioner
    - Office Locations (e.g. county, city or zip code)
i. Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start and AzEIP. ALTCS resources may include Area Agency on Aging and the Alzheimer's Association. The following links should be provided: www.MyAHCCCS.com and www.azlinks.gov.

j. Services for which prior authorization is required and prior authorization criteria.
k. Best practice guidelines.

In addition, any information that is not listed above, that is directly related to members or potential members must be prior approved by the Division of Heath Care Management.

The Contractor will submit annually forty-five (45) days after the beginning of the contract year the Contractor's Annual Website Certification form (see Attachment B) verifying that all required information is available and current on the Contractor's website.

The Division of Health Care Management will review the content of the Contractor's website to ensure the Contractor is in compliance with this policy and the AHCCCS contract.

BHS and its subcontractors must have a website with links to the following information:

- Formulary
- Provider manual
- Member handbook
- Provider listing

ADHS must ensure that its subcontractors' websites have a fully operational claims inquiry function.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438
- Arizona Administrative Code R9-22, Article 5
- Acute Care contract, Section D
- CRS contract, Attachment J
- ALTCS EPD contract, Section D
- ADHS/DBHS contract, Section D
- ALTCS DDD contract, Section D
- CMDP contract, Section D
- ACOM Policy 101

Attachment A

NATIONAL ORGANIZATIONS RECOGNIZED BY AHCCCS

Ambulatory Pediatric Association
American Academy of Allergy, Asthma, and Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Ophthalmology
American Academy of Pediatrics
American Association of Cancer Education
American Association of Poison Control Centers
American Association of Psychiatric Services for Children
American Association of Public Health Physicians
American College of Allergy & Immunology
American College of Cardiology
American College of Emergency Physicians
American College Health Association
American College Medical Quality
American College of Nutrition
American College Obstetricians and Gynecologists
American College of Physicians
American College of Preventative Medicine
American Dental Association
American Diabetes Association
American Dietetic Association
American Gynecological and Obstetrical Society
American Heart Association
American Hospital Association
American Institute of Ultrasound in Medicine
American In Vitro Allergy/Immunology Society
American Lung Association
American Medical Association
American Medical Directors Association
American Medical Women's Association
American Pediatric Society
American Public Health Association
American Red Cross
American Society for Adolescent Psychiatry
American Society of Anesthesiologists
American for Clinical Nutrition
American Society for Reproductive Medicine
American Venereal Disease Association
Arizona Department of Health Services
Bright Futures
Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Centers for Disease Control and Prevention
Channing Bete Company
Environmental Protection Agency (EPA)
Health Wise
La Leche League USA
March of Dimes
Maricopa County Department of Health Services
National Domestic Violence Hotline
National Perinatal Association
Nemour's Kids Health
Pima County Department of Health Services
Produce for Better Health Foundation
Susan G. Komen for the Cure
The Arizona Partnership for Immunization (TAPI)
U.S. Department of Agriculture (USDA)
U.S. Department of Health & Human Services
U.S. State Health Departments World Medical Association

Attachment B

CONTRACTOR ANNUAL WEBSITE CERTIFICATION

Contractor:_____ Date Submitted:_____

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM Policy 404				
	A Program member specific link from the Contractor's home page			
A	A current member handbook			
B	Current and past 3 member newsletters			
C-1	AHCCCS member survey results via link to AHCCCS website			
C-2	AHCCCS Provider survey results via link to AHCCCS website			
D	Performance measure results via link to AHCCCS member website.			
E-1	Contractor member survey results, as available.			
E-2	Contractor provider survey results, as available.			

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM Policy 404, continued				
F	Formulary, which must be updated within 30 days of a change being made. The following shall be available in a user friendly format: • A medication formulary listing by the Brand name and/or Generic name of the medication, including notations for all medications that require a prior Authorization. • A medication formulary listing by drug class • A specific (individual) drug look-up capability			
G	Tobacco Cessation Information, as described in the member handbook. A link to the Tobacco Education and Prevention Program (TEPP) website should be included			
H	A user friendly, searchable provider directory (including specialists for referrals). The directory must include the following search functions and be updated at least monthly, if necessary: • Name • Specialty/Service • Languages spoken by Practitioner • Office Locations (e.g. county, city)			

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
MEMBER INFORMATION – ACOM Policy 404, continued				
I	Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start, AzEIP. ALTCS resources may include Area Agency on Aging, Alzheimer's Association. The following links should be provided: ❑ www.MyAHCCCS.com ❑ www.azlinks.gov			
J	Services for which prior authorization is required and prior authorization criteria.			
K	Best Practice Guideline			
L	(**BHS ONLY**) BHS and its subcontractors must have a website with links to the following information: • Formulary • Provider manual • Member handbook • Provider listing			

Additional Member Information that Has been Approved by AHCCCS

#	Requirement	URL of Page Where Information Is Found	Contractor Notes/Comments	AHCCCS Comments
PROVIDER INFORMATION – ACOM POLICY 416				
A	**Formulary (both Searchable and Comprehensive Listings**			
B	**Provider Manual**			
C	**Provider Directory (including specialists for referral)**			
D-1	**Performance measure results -Contractor Specific**			
D-2	**Performance measure results via link to AHCCCS member website (AHCCCS Program)**			
E	**Medical Determination Criteria and Practice Guidelines**			
F	**Contractor provider survey results, as available.**			
The following functionality is available to providers (Indicate compliance by typing "Yes" under Contractor notes/comments column)				
A	**Enrollment Verification**			
B	**Claims Inquiry (adjustments requests; information on denial reasons)**			
C	**Accept HIPAA compliant electronic claims transactions**			
D	**Display Reimbursement Information**			

- ❑ **Explain (describe) what actions have been taken to determine that members who access your website can easily find and navigate the required member website content.**

Contact Person:_____ Phone #: _____ E-mail Address:_____

Approved By:_____ Title:_____ Phone #:_____

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
Table of Contents	X	X	X	X
A general description about how managed care works, particularly in regards to member responsibilities, appropriate utilization of services and the PCP's roll as gatekeeper of services.	X	X	X	
A description of all available covered services and an explanation of any service limitations or exclusions from coverage. The description should include a brief explanation of the Contractor's approval and denial process.	X	X	X	X
How to obtain and change a PCP.	X	X		
The handbook revision date.	X	X	X	X
How to make, change and cancel appointments with a PCP/Provider.	X	X		X
How to make, change and cancel appointments with a CRS Clinic Provider/Provider.			X	
List of applicable co-payments, what to do if a member is billed, and under what circumstances a member may be billed for non-covered services.	X	X	X	X
Dual eligibility (Medicare and Medicaid) services received in and out of the Contractor's network and coinsurance and deductibles. See Section D, "Medicare Services and Cost Sharing" in the contract.	X	X	X	X
Inform Dual eligible members that AHCCCS does NOT pay for any drugs paid by Medicare, or for the cost sharing (coinsurance, deductibles, and copayments) for these drugs.	X	X	X	X
The process of referral and self-referral to specialists and other providers, including access to behavioral health services.	X	X	X	
How to file a complaint with the Contractor. This must include the	X	X	X	X

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
member's right to file a complaint to the Contractor regarding the adequacy of Contractor's Notice of Action letters. Further, it must include the member's right to contact AHCCCS if the Contractor does not resolve the member's concern of adequacy with the Notice of Action letter.				
What to do in case of an emergency and instructions for receiving advice on getting care in case of an emergency. In a life-threatening situation, the member handbook should instruct members to use the emergency medical services (EMS) available and /or activate EMS by dialing 9-1-1. The handbook should contain information on proper emergency service utilization. It must also state that a member has a right to obtain emergency services at any hospital or other emergency room facility (in or out of network).	X	X	X	X
How to obtain emergency transportation and medically necessary transportation.	X	X	X	X
The handbook must state the following verbatim: Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is 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 problems 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 listed in federal law 42 USC 1396d(a) to correct or ameliorate	X	X		

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
defects and physical and mental 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. A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules. Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) 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." This means that EPSDT covered services include services that 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. Services covered under EPSDT include all 28 categories of services in the federal law 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. EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services,				

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.				
Maternity and family planning services. This must include information on the importance of making, keeping, and the availability of postpartum services, and an explanation regarding choosing a Primary Care Obstetrician. The ability to change Contractors for Continuity of Care reasons should be included (This is not applicable if there is only one Contractor in a GSA).	X	X		
Description of all covered behavioral health services and how to access these services.	X	X		X
Out of Country/out of state/out of geographic service area moves.	X	X		X
All grievance and request for hearing information included in the Contractor's Enrollee Grievance System Policy as described in the "Grievance System" section of the contract.	X	X	X	X
Contributions the member can make towards his/her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor. This shall include a statement that the member is responsible for protecting his or her ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action. A sentence shall be included that stresses the importance of members keeping, not discarding, the ID card.	X	X	X	X
Advance Directives.	X	X	X	X

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
Use of other sources of insurance. See Section D, "Coordination of Benefits/Third Party Liability" in the contract.	X	X	X	X
A description of fraud and abuse, including instructions on how to report suspected fraud or abuse.	X	X	X	X
A statement that informs the member of their right to request information on whether or not the Contractor has physician incentive plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with PIP regulation.	X	X	X	X
The right to be treated fairly regardless of race, religion, gender, age, ability to pay.	X	X	X	X
Instructions for obtaining culturally competent materials and/or services, including translated member materials.	X	X	X	X
The availability of printed materials in alternative formats and how to access such materials.	X	X	X	X
The availability interpretation services for oral information at no cost to the member and how to obtain these services.	X	X	X	X
Information regarding prenatal HIV testing counseling services.	X	X	X	
The right to know about providers who speak languages other than English.	X	X	X	X
How to obtain, at no charge, a directory of providers.	X	X	X	
The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand the information.	X	X	X	X
Preventative services include, but are not limited to, screening services such as cervical cancer screening including pap smear,	X	X		

Member Handbook Requirements	ACUTE & CMDP	ALTCS EPD &DDD	CRS	BHS
mammograms, colorectal cancer, and screening for sexually transmitted infections.				
Female members, 21 years of age and over, have direct access to a gynecologist within the Contractor's network without a referral from a primary care provider. Preventive services such as cervical cancer screening or referral for a mammogram are covered. A well woman exam is not a covered benefit.	X	X		
Female members under the age of 21 years have direct access to preventive and well care services from a gynecologist within the Contractor's network without a referral from a primary care provider.	X	X		
The right to a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to the enrollee.	X	X	X	X
The right to request a copy of his/her medical record and /or inspect medical records at no cost.	X	X	X	X
The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.	X	X	X	X
The right to participate in decisions regarding his or her health care, including the right to refuse treatment.	X	X	X	X
Tobacco Cessation information. This should include, but is not limited to, information regarding the availability/accessibility of community support groups, information regarding the Arizona Smokers Helpline, and how members can seek tobacco cessation treatment, care and services.	X	X		

Information on community resources that is applicable to the Contractor's population and geographic service area. Examples of acute care resources are WIC, Head Start and AzEIP. ALTCS resources may include Area Agency on Aging and the Alzheimer's Association. The following link must be provided: www.MyAHCCCS.com	X	X	X	
Information on what to do when family size or other demographic information change.	X			
How to contact Member Services and a description of its function.	X		X	X
Description of all covered dental services and how to access these services, including the process form making dental appointments.	X			
How to access afterhours care (urgent care).	X	X		X
How to change Contractors.	X	X		
Information on where no cost/low cost family planning benefit and primary care coverage for members losing AHCCCS/Family Planning Services eligibility are available.	X			

ALTCS				
How to contact the case manager, including information on why and how to contact the Case Manager in between visitations.		X		
Member's share of cost.		X		
Explanation of the Transition Program and services available.		X		
Detailed descriptions of all current residential placement options.		X		
Explanation of when Program Contractor changes may occur.		X		
Information about advocates and advocacy systems and how to access those supports. Include at a minimum the following advocates/advocacy systems: -Centers for Independent Living -Arizona Center for Disability Law -Long Term Care Ombudsman -Legal Aid		X		
CRS				
How to contact the CRS Contractor.			X	
A description of CRS/Parent Advisory Council.			X	
Advocacy Information.			X	
A description of each clinic's specialties.			X	
Information to facilitate family members as decision-makers in the treatment planning process.			X	
Information regarding the unique needs of children with CRS Conditions and the CRS program for public/private health care insurers, health care insurers, health care providers, and students, regional and national health organizations, community groups and organizations and public health and school personnel.			X	

BHS				
Confidentiality and confidentiality limitations.				X
Information that coordination of care with schools and state agencies may occur, within the limits of applicable regulations. [42 CFR 438.10(e)(2)(i)(c)]				X
Statement of the Arizona Vision and information regarding the J.K. Principles.				X
A statement that TXIX and Title XXI covered services are funded under contract with AHCCCS.				X
Member's right to request information on the structure and operation of ADHS or subcontractors. [42 CFR 438.10 (g)(3)(i)]				X

405 - CULTURAL COMPETENCY AND FAMILY/PATIENT CENTERED CARE

Original Date: 03/02/00
Effective Date: 03/02/00, 10/01/12
Revision Date: 11/16/10, 01/01/11, 10/02/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, Arizona Long Term Care System (ALTCS), Children's Rehabilitative Services (CRS), Behavioral Health Services (BHS), and Division of Developmental Disabilities (DDD) Contractors. This policy describes the requirement that Contractors offer accessible and high quality services in a culturally competent manner.

II. Definitions

CLAS Standards	The collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services.
Competent	Properly or well qualified and capable.
Cultural Competency	An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.
Culture	The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
Limited English proficiency (LEP):	Not being able to speak, read, or write or understand the English language at a level that permits one to interact effectively with health care providers or the Contractor.
Member	A person eligible for AHCCCS, who is enrolled with a Contractor.

Provider	A person or entity who is registered with AHCCCS and/or subcontracts with an AHCCCS Contractor to provide AHCCCS covered services to members.
Subcontractor	A person, agency or organization to which a Contractor has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leased of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.

III. Policy

A. Cultural Competency Plan

Each Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner.

The Contractor must identify a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the Division of Health Care Management (DHCM).

The CCP must contain a description of:

1. Education and Training

    a. The training program consists of the methods the Contractor will use to train its staff so that services are provided effectively to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.

    b. The education program consists of methods the Contractor will use for providers and other subcontractors with direct member contact. The education program will be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. The contactor must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.

2. Culturally Competent Services and Translation/Interpretation Services

The Contractor describes the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the Contractor evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It must also describe the provision and coordination needed for linguistic and disability-related services. The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation service. A Contractor, at the point of contact, must make members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s).

The Contractor must provide translations in the following manner:

a. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have limited English proficiency (LEP) in that language.

b. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, vital information from the member handbook and consent forms.

c. All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

B. Evaluation and Assessment of CCP

The Contractor must evaluate the CCP for effectiveness. Evaluations are to be made on an annual basis and a copy of the evaluation sent to DHCM. The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or Contractor employee surveys. If issues are identified, they should be tracked and trended, and actions should be taken to resolve the issue(s).

C. CRS Family Centered and Culturally Competent Care

The CRS Contractor will provide family-centered care in all aspects of the service delivery system. The responsibilities of the CRS Contractors in support of family-centered care include:

1. Recognizing the family as the primary source of support for the recipients' health care decision-making process. Service systems and personnel should be made available to support the family's role as decision makers.
2. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:

    a. Care of the member;
    b. Development, implementation, and evaluation of programs; and
    c. Policy development.

3. Promoting a complete exchange of unbiased information between recipients, 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 recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
6. Participating in Family-Centered Cultural Competence 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 wellbeing and are crucial allies for quality within the service delivery system.
10. Appreciate and recognize the unique nature of each recipient and their family.

Culturally and Linguistically Appropriate Services CLAS

The CRS Contractor is expected to incorporate CLAS standards into its care model at all levels.

IV. Web Addresses

http://www.ahrq.gov/research/minorix.htm - Minority Health
http://www.ahrq.gov/populations/cultcomp.htm - Oral, Linguistic, and Culturally Competent Services Guides for Managed Care Plans
www.ahrq.gov/consumer/espanoix.htm - Has information in both Spanish and English
http://www.diversityrx.org/topic-areas/cultural-competence -101- Diversity Rx
http://minorityhealth.hhs.gov/ - Office of Minority Health, Choose the Cultural Competency tab
http://nccc.georgetown.edu/ - National Center for Cultural Competence
www.ahrq.gov/data/hcup/factbk3/factbk3.htm - Agency for Healthcare Research and Quality
www.lep.gov - Federal Governmental Web Address
http://www.lep.gov/guidance/guidance_DOJ_Guidance.html - LEP Page
www.languageline.com - Translation Service
www.cyracom.net - Translation Service
www.xculture.org - Cross Cultural Health Care Program (CCHCP)
http://minorityhealth.hhs.gov/ - From the home page choose Cultural Competency then choose About the Center for Linguistics and Cultural Competence in Health Care (CLCCHC)
www.mentalhealth.org/publications/allpubs/Ca-0015/default.asp - Substance Abuse and Mental Health Services Administration (Children's Issues)
http://www.ama-assn.org/ - Search "Cultural Competency to link to Cultural Competency Issues
www.cdcnpin.org/scripts/population/culture.asp - Centers for Disease Control
http://cecp.air.org/cultural/default.htm - Center for Effective Collaboration and Practice
http://www.childrensnational.org/emsc/ - Emergency Medical Services for Children, Search "Cultural Competency" from the home page

V. References

- Americans with Disabilities Act: 42 U.S.C., Chapter 126
- Balanced Budget Act of 1997 (BBA)
- BBA Regulations: Title 42 of the Code of Federal Regulations and (42 CFR) 438.206(c)(2)]
- National Standards of Culturally and Linguistically Appropriate Health Care, Volume 65 of the Federal Register (65 Fed. Reg.) 80865-80897 (December 22, 2000)
- Title VI of the Civil Rights Act: Title 42 of the United States Code (42 U.S.C.) 2000d (see 45 C.F.R. 80, app. A (1994)
- Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 68 Fed. Reg. 47311, (August 8, 2003)

406 – RESERVED

407 – RESERVED

408 - SANCTIONS

Effective Date: 10/01/03, 10/01/12, 11/01/12
Revision Date: 09/26/12, 10/09/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy specifies the sanctions which may be imposed by the AHCCCS Division of Health Care Management (DHCM) in accordance with Federal and State laws, regulations and the AHCCCS contract. This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors.

II. Definitions

Act	The Social Security Act
Contractor	*For the purpose of this policy*, Contractor means, a Managed Care Organization providing health care services to acute or long term care members and / or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and/or CRS related services to eligible acute or long term care members.
Medicaid Managed Care Regulations	The Federal law mandating, in part, that States ensure the delivery of quality health care by their managed care Contractors. CMS finalized the Medicaid regulations which implement the corresponding provisions of the BBA June 14, 2002. Included in these regulations is 42 CFR 438.700 et seq. regarding sanctions.
Sanction	A penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility.

III. Policy

A. General

AHCCCS may impose sanctions, including, but not limited to, temporary management of the Contractor, monetary penalties, suspension of enrollment, withholding of payments, suspension, refusal to renew, or termination of the contract or any related subcontracts in accordance with applicable Federal and States laws and regulations, and the AHCCCS contract. Prior to the imposition of a sanction, AHCCCS may provide a written cure notice to the Contractor regarding the details of the non-compliance. The cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCS will take no further action. If, however, the Contractor has not complied with the cure notice requirements, AHCCCS will proceed with the imposition of sanctions.

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld, when applicable. The Contractor may appeal the decision to impose a sanction in accordance with Arizona Administrative Code (A.A.C.) R9-34-401 et seq.

B. Basis for Imposition of Sanctions

AHCCCS may impose sanctions for any of the following:

1. Substantial failure to provide medically necessary services that the Contractor is required to provide under law or the terms of its contract to its enrolled members

2. Discrimination among enrollees on the basis of their health status or need for health care services

3. Misrepresentation or falsification of information furnished to CMS or AHCCCS

4. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

5. Imposition of premiums or charges in excess of the 1115 Waiver

6. Failure to comply with the requirements for physician incentive plan

7. Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCS or that contain false or materially misleading information

8. Failure to meet AHCCCS Financial Viability Standards

9. Material deficiencies in the Contractor's provider network

10. Failure to meet quality of care and quality management requirements

11. Failure to meet AHCCCS encounter standards

12. Failure to fund accumulated deficit in a timely manner

13. Failure to increase the Performance Bond in a timely manner

14. Failure to comply with any provisions contained in the contract, and/or

15. Failure to comply with applicable State or Federal laws or regulations.

C. Types of Sanctions

AHCCCS may impose the following types of intermediate sanctions:

1. **Monetary Penalties:** The amount of the monetary penalty may vary depending on the nature of the Contractor's action or failure to act. Examples are as follows:

   a. The maximum of $25,000 may be imposed per occurrence for the following actions:

      1) Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members

      2) Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider

      3) Failure to comply with physician incentive plan requirements, and

      4) Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCS or that contain false or materially misleading information.

   b. The maximum of $100,000 may be imposed per occurrence for the following types of actions:

      1) Discrimination among enrollees on the basis of their health status or need for health care services, and

      2) Misrepresentation or falsification of information furnished to CMS or AHCCCS.

2. **Member Enrollment Related Sanctions**: AHCCCS may sanction a Contractor by:

   a. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll (If another Contractor is available);

   b. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction (If another Contractor is available); and

   c. Suspending payment for members enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

3. **Additional Sanctions**: AHCCCS may impose additional sanctions as provided under State Laws, regulations, or contract to address areas of non-compliance.

D. General Notification of Sanction to Contractor

1. *Written Notification*: AHCCCS will notify the Contractor by certified letter of the specific basis for the sanction and applicable sanction as follows:

   a. If the Contactor continues non-compliance, the notification will include the type and amount (if applicable) of the sanction.

   b. If the sanction involves a monetary penalty, the notification will state the amount which will be deducted from the Contractor's next monthly capitation payment.

   c. The notification will include timelines for the imposition of the sanction.

   d. If the sanction involves termination, the notification will include the information in E2 below.

E. Termination of the Contract

1. *Cause for Termination*: AHCCCS retains the right to terminate a contract when a Contractor fails to:

   a. Carry out the substantive terms of its contract, or

   b. Meet applicable requirements in Sections 1932, 1903(m**),** or 1905(t) of the Social Security Act.

2. *Termination of Contract*: AHCCCS will:

   a. Send the Contractor the pre-termination notice by certified mail. The notice will specify AHCCCS' intent to terminate the contract, the reason for termination, and the time and place of the pre-termination hearing.

b. After the hearing, AHCCCS will give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract. If the decision affirms the proposed termination, the effective date of the termination will be provided.

c. In cases where termination is upheld as a result of the hearing, AHCCCS will notify the affected members of the Contractor's termination and provide them with information regarding available Contractors in their Geographic Service Area.

F. Temporary Management: Temporary management is necessary to insure the health of its members while:

1. The Contractor corrects the non-compliance or

2. The Contractor reorganizes, or

3. AHCCCS completes termination of the contract, or

4. The Contractor has violated a term of its contract, and temporary management is authorized by contract.

Appointment of temporary management for a Contractor may be optional or required.

1. **Optional Imposition:** Optional imposition of temporary management may occur when AHCCCS determines that:

   a. There is continued egregious behavior by the Contractor, including but not limited to the bases described in III(B) or behavior which is contrary to any requirements in Sections 1903 (m) and 1932 of the Social Security Act

   b. There is substantial risk to enrollees' health due to non-compliance of the Contractor

2. **Required Imposition:** Required imposition of temporary management will occur when AHCCCS determines that a Contractor has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act or 42 CFR 438.700 et seq. AHCCCS will:

   a. Allow the Contractor's members the option to disenroll from the Contractor without cause in the event another Contractor is available, and

b. Notify the affected members of their right to disenrollment:

1) *Hearing*. For temporary management imposed pursuant to the BBA provisions, AHCCCS may not delay the imposition of temporary management to provide a hearing before imposing the sanction. For temporary management imposed pursuant to State Law, AHCCCS will provide an opportunity for hearing prior to imposing this sanction unless public health, safety, or welfare requires emergency action .

3) *Duration*. AHCCCS will not terminate the temporary management until it determines that the Contractor can ensure that the sanctioned behavior will not recur.

G. Notification to CMS

For sanctions imposed or lifted pursuant to Medicaid Managed Care Regulations (42 CFR 438.700 et seq.), AHCCCS will provide CMS with written notice:

1. Whenever it imposes or lifts a sanction for any of the sanctionable items listed in III.B.

a. The notice will specify the Contractor, the type of sanction, and the reason for the imposition or lifting of the sanction; and

b. The notice will be given no later than 30 days after it imposes or lifts a sanction.

IV. References

- 42 USC 1396 u-2 (e) [Section 1932(e) of the Social Security Act]
- AAC R9-34-401 et seq.
- AAC R-9-22, Article 6
- AHCCCS Contract
- Arizona Revised Statutes (A.R.S.) 36-2903M
- Medicaid Managed Care Regulations
- Title 42 of the Code of Federal Regulations (42 CFR) 438.700 et seq.
- Title 42 of the United States Code (42 USC) 1396b(m) [Section 1903 (m) of the Social Security Act]

409 – Intra-Agency Care Coordination for Services

Original Date: 04/01/05
Effective Date: 04/01/05
Revision Date: 05/01/06; 03/01/10; 6/01/10, 1/1/11

Staff responsible for policy: DHCM Administration

I. Purpose

This policy applies to all Acute Care Contractors, Arizona Long Term Care System (ALTCS) Contractors, and the CRS Contractor. This policy provides guidance to the Contractors about the procedures to follow when a request for service potentially covered by another Medicaid (AHCCCS) payer is received by a Contractor who is not responsible for the service. This includes the care coordination responsibilities between Acute Care / ALTCS Contractors and CRS.

II. Definitions

Continuity of Care: The coordination of care received by a patient over time and across multiple healthcare providers.

Contractor: Acute Care Contractors, ALTCS Contractors, and/or the CRS Contractor.

CRS: CRS refers to the AHCCCS CRS subcontractor.

CRS Coverage Criteria: For a service to be considered covered by CRS, the service must be medically necessary and related to the member's CRS condition.

Days: Means a calendar day unless otherwise specified.

Filed: Means the date that the Contractor or AHCCCS, whichever is applicable, receives the request as established by a date stamp on the request or other record of receipt.

Materials for Forwarding: Materials will include a cover letter with the original date the service request was received and a copy of the NOE if applicable.

Receipt Date: The date of receipt is the date the request is filed with the original AHCCCS Contractor.

Recipient Status Check: The process utilized by a Contractor to determine whether an AHCCCS enrolled member has been previously accepted into the CRS program for a condition which can be covered under Arizona Administrative Code (AAC) R9-7.

Recipient Status Review: The process, outlined in ACOM Policy 426, Eligibility Review for CRS Applicants and Referrals, utilized by CRS and/or its subcontractor to determine whether an applicant has a condition that can be covered under AAC R9-7.

Working Days: Shall be a "Working Day" as defined in AAC 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 a Contractor is closed for business the prior Friday or following Monday.

III. Policy

To ensure the AHCCCS member receives medically necessary covered services in a timely coordinated manner. When any Contractor refers a member to another Contractor for eligibility determination or for services, the sending Contractor shall assist or direct the member in making initial contact with the receiving Contractor.

A. Service requests received by an Acute/ALTCS Contractor from a provider for a potentially CRS covered service:

1. EXPEDITED REQUEST
   a. The Contractor will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, the Contractor will proceed to A.1.b.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   b. The Contractor will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, the Contractor will proceed to A.1.c.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   c. The Contractor will perform a CRS recipient status check.
      i. If confirmed, the Contractor will prepare materials for forwarding to CRS (within 1 Working Day of receipt date).
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date); and the Contractor will assist in the completion of an application for CRS. (CRS will process the application under the normal application review process.) The Contractor cannot deny the service for being CRS covered under Policy 414 in this circumstance.

2. STANDARD REQUEST
   a. The Contractor will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, the Contractor will proceed to A.2.b.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   b. The Contractor will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, the Contractor will proceed to A.2.c.
      ii. If not confirmed, the Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   c. The Contractor will perform a CRS recipient status check.
      i. If confirmed, the Contractor will prepare materials for forwarding to CRS (within 3 Days of receipt date).
      ii. If not confirmed, the Contractor will assist in the completion of an application for CRS and prepare materials for forwarding to CRS (within 5 Days of receipt date if information is available to complete an application). If the Contractor does not have enough information for a complete application, it will follow ACOM 414 (within 14 Days of receipt date).

B. Service requests received by an Acute/ALTCS Contractor from CRS:

1. EXPEDITED REQUEST
   a. The Contractor will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   b. In the event the Contractor disagrees with the CRS coverage determination, the Contractor will follow ACOM Policy 414, and the Contractor shall follow the process identified in Section III.G of this policy.

2. STANDARD REQUEST
   a. The Contractor will follow ACOM Policy 414 (within 14 Days of receipt date).
   b. In the event the Contractor disagrees with the CRS coverage determination, the Contractor will follow ACOM Policy 414, and the Contractor shall follow the process identified in Section III.G of this policy.

C. Service requests received by CRS from a provider for a potentially CRS covered service:

1. EXPEDITED REQUEST
   a. CRS will review the service request to determine if the service is an AHCCCS covered service.
      i. If confirmed, CRS will proceed to C.1.b.

ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

b. CRS will determine whether the service requested is potentially covered by CRS.
   i. If confirmed, CRS will proceed to C.1.c.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

c. CRS will perform a CRS recipient status check.
   i. If confirmed, CRS will follow ACOM Policy 414 (within 3 Working Days of receipt date).
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor as an Expedited request (within 1 Working Day of receipt date).

2. STANDARD REQUEST

a. CRS will review the service request to determine if the service is an AHCCCS covered service.
   i. If confirmed, CRS will proceed to C.2.b.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor (within 3 Days of receipt date).

b. CRS will determine whether the service requested is potentially covered by CRS.
   i. If confirmed, CRS will proceed to C.2.c.
   ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor (within 3 Days of receipt date).

c. CRS will perform a CRS recipient status check.
   i. If confirmed, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
   ii. If not confirmed CRS will perform a recipient status review.
      a) If enrolled as a recipient, CRS will proceed to C.2.d.
      b) If not enrolled as a recipient, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

d. CRS will perform a service coverage review.
   i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt).
   ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that

indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

D. Service requests received by CRS from an Acute/ALTCS Contractor for a potentially CRS covered service for a CRS recipient:

1. EXPEDITED REQUEST
   a. CRS will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, CRS will proceed to D.1.b.
      ii. If not confirmed, CRS will initiate CRS Medical Director to AHCCCS Contractor Medical Director Contact. (within 2 Working Days of receipt date).
   b. CRS will perform a coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414.
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 3 Working Days of receipt date).

2. STANDARD REQUEST
   a. CRS will determine whether the service requested is potentially covered by CRS.
      i. If confirmed, CRS will proceed to D.2.b.
      ii. If not confirmed, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of the receipt date).
   b. CRS will perform a coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of the receipt date).

E. Service requests received by CRS from an Acute/ALTCS Contractor for a potentially CRS covered service for a non CRS recipient:

1. EXPEDITED REQUEST
   a. CRS Medical Director to AHCCCS Contractor Medical Director contact reminding the Acute/ALTCS Contractor of its responsibility to act on these requests under A(1).

2. STANDARD REQUEST
   a. CRS will perform a CRS recipient status check.
      i. If confirmed, CRS will follow ACOM Policy 414 (within 14 Days of receipt date).
      ii. If not confirmed CRS will perform a recipient status review.
         a) If enrolled as a recipient, CRS will proceed to E.2.b.
         b) If not enrolled as a recipient, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).
   b. CRS will perform a service coverage review.
      i. If service meets CRS coverage criteria, CRS will follow ACOM Policy 414 (within 14 Days of receipt).
      ii. If service does not meet CRS coverage criteria, CRS will prepare materials for forwarding to the Acute/ALTCS Contractor and issue a Notice of Extension (using a form letter developed by AHCCCS that indicates the name of the Acute/ALTCS Contractor performing the review [see Exhibit A]) to the member, provider and other AHCCCS Contractor (within 14 Days of receipt date).

F. Inpatient Care Coordination for ALTCS/Acute and CRS members and recipients:

1. For members who are also CRS recipients, CRS will be responsible for:
   a. Coverage and payment of all inpatient stays that are initiated by CRS and strictly related to the CRS condition being treated.
   b. Documenting the notification of the facility, the treating physician and the Acute/ALTCS Contractor if CRS determines that the inpatient stay no longer meets CRS coverage criteria and the date that CRS will no longer cover the inpatient stay.
   c. Providing care coordination in the concurrent review process with the Acute/ALTCS Contractor.

G. Request for Review Process (dispute):

1. If the Acute/ALTCS Contractor disagrees with a CRS coverage decision, the Contractor shall provide the medically necessary service and initiate a "Request for Review" to the CRS Contractor or designee. The following shall be the process for resolving the Request for Review:
   a. The Contractor shall submit the service request and all accompanying/relevant documentation to the CRS Chief Medical Officer or designee with a request for secondary review and determination if the coverage decision was appropriate; within 30 Days of the receipt of the CRS coverage decision.
   b. The CRS Chief Medical Officer or designee shall issue a written decision to the Contractor no later than ten (10) Working Days from the date of the receipt of the Request for Review.
   c. All CRS decisions shall advise the Contractor that the Contractor may file a request for review with the Office of Administrative Legal Services (OALS) at AHCCCS within thirty (30) Days of receipt of the CRS decision in the event that the Contractor continues to disagree with the CRS decision.
   d. If AHCCCS determines that the service should have been provided by CRS, the CRS Contractor shall be financially responsible for the costs incurred by the Contractor in providing the service.

IV. References

- 42 CFR §438.210
- 42 CFR Part 438 Subpart F, Grievance System
- AAC R9-7-201 et seq.
- AHCCCS Contracts

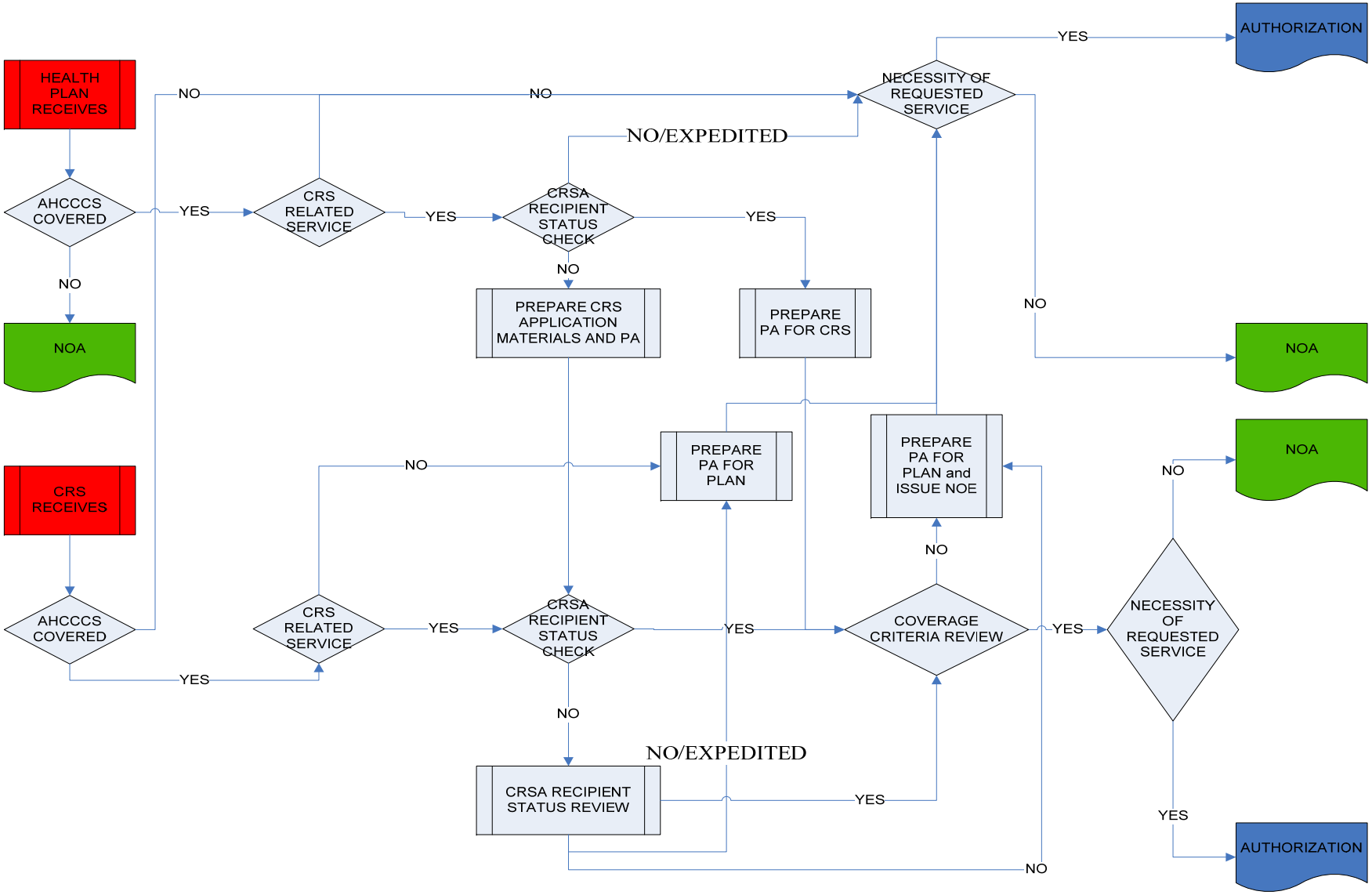

HEALTH PLAN RECEIVES
AHCCCS COVERED
NO
NOA
YES
CRS RELATED SERVICE
YES
CRSA RECIPIENT STATUS CHECK
NO
PREPARE CRS APPLICATION MATERIALS AND PA
YES
PREPARE PA FOR CRS
NO/EXPEDITED
NECESSITY OF REQUESTED SERVICE
YES
AUTHORIZATION
NO
NOA
CRS RECEIVES
AHCCCS COVERED
YES
CRS RELATED SERVICE
YES
CRSA RECIPIENT STATUS CHECK
NO
PREPARE PA FOR PLAN
NO
PREPARE PA FOR PLAN and ISSUE NOE
NO
COVERAGE CRITERIA REVIEW
YES
NECESSITY OF REQUESTED SERVICE
NO
NOA
YES
AUTHORIZATION
NO/EXPEDITED
CRSA RECIPIENT STATUS REVIEW
YES
NO

Exhibit A ACOM Policy # 409, Revised / Approved 10/1/09

Insert CRSA Logo

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX o (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF EXTENSION

TO: Date

FROM:

(Your doctor OR name of provider- as appropriate) have asked that Children's Rehabilitative Services (CRS) pay for your child's (*describe services requested and the reason for the services in easily understood language*).

The information sent by your (*doctor OR name of provider- as appropriate)* shows that you would not be able to get services from Children's Rehabilitative Services (CRS) at this time for this problem. AHCCCS requires children with special health problems to get their services for that health problem from CRS. We are sending the request to your health plan, *(insert the name of the AHCCCS Contractor the request is being forwarded to)* so they can decide if they will pay for *(insert what the service request is)*.

(*Insert the name of the AHCCCS Contractor the request is being forwarded to)* may take fourteen (14) more days to make a decision. (*Insert the name of the AHCCCS Contractor the request is being forwarded to)* will make this decision by *(insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the standard request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date on the letter which represents the mail date).*

If *(Insert name of AHCCCS Contractor)* cannot make a decision because they need more medical information that they do not get from (*requesting provider)* then they will have to deny this request.

If you do not agree with us taking this extra time to make a decision you can file a grievance (complaint). You can do this by contacting *(insert grievance phone number and insert the address for grievances for CRS).*

Sincerely,

Children's Rehabilitative Services

410 – RESERVED

411 - PRE-PAID MEDICAL MANAGEMENT INFORMATION SYSTEMS (PMMIS) INTERFACE

Effective Date: 05/01/05; 05/01/2012
Revision Date: 05/01/2012

Staff responsible for policy: DHCM/ALTCS Unit/Case Management

I. Purpose

This policy applies to Arizona Long Term Care System (ALTCS) Contractors. This policy provides a tutorial on access to and data entry into the Client Assessment and Tracking System (CATS) sub-system of the AHCCCS mainframe computer system, Pre-Paid Medical Management Information Systems (PMMIS).

II. Overview/General Information

PMMIS is made up of several sub-systems, each with a distinct function. The sub-systems however are interrelated and share common data and many rules of processing.

ALTCS eligibility information is recorded in a separate system from PMMIS, called AHCCCS Customer Eligibility (ACE). ACE transmits eligibility and enrollment data to PMMIS via an interface.

ALTCS Program and Tribal contractors have primary access to the CATS sub-system in PMMIS for purposes of recording and storing case management related data about ALTCS members.

Contractors are required to either directly input data or transmit the information via electronic interface. Comments must be directly entered on the CATS comment screens; they can not be transmitted electronically. If the contractor does not do direct data input, they are not required to enter comments in CATS. Tribal contractors are required to do direct data input, including comments.

III. UserID and Security Access Requests

All individuals needing access to PMMIS must complete and submit the following 2 forms to AHCCCS in order to obtain a UserID#:

- User Access Request Form
- User Affirmation Statement

These forms are available on the AHCCCS website in the "AHCCCS Data Access Forms" section at: http://www.azahcccs.gov/commercial/ISD/DataAccessForms.aspx. The completed forms for ALTCS case management staff should be faxed to the AHCCCS Division of Health Care Management (DHCM) ALTCS Unit at (602) 417 – 4855.

AHCCCS will provide each approved user with a permanent 7 digit UserID and a temporary password following completion of these forms. The first time the user signs on, s/he will be prompted to change the password before continuing with the sign-on. Passwords must be 6-8 digits and contain a combination of alpha and numeric characters, ending with a number. Passwords must then be changed approximately every 30 days thereafter. Users are prompted when the password needs to be changed.

Even if ALTCS case managers will not be directly accessing PMMIS for data entry, they will need a 6-digit Case Manager ID# for use in assigning members to their caseloads. This process requires the case manager to be affiliated, in PMMIS, to an ALTCS Contractor. The instructions for Case Manager Affiliation can be found in Appendix A at the end of this policy.

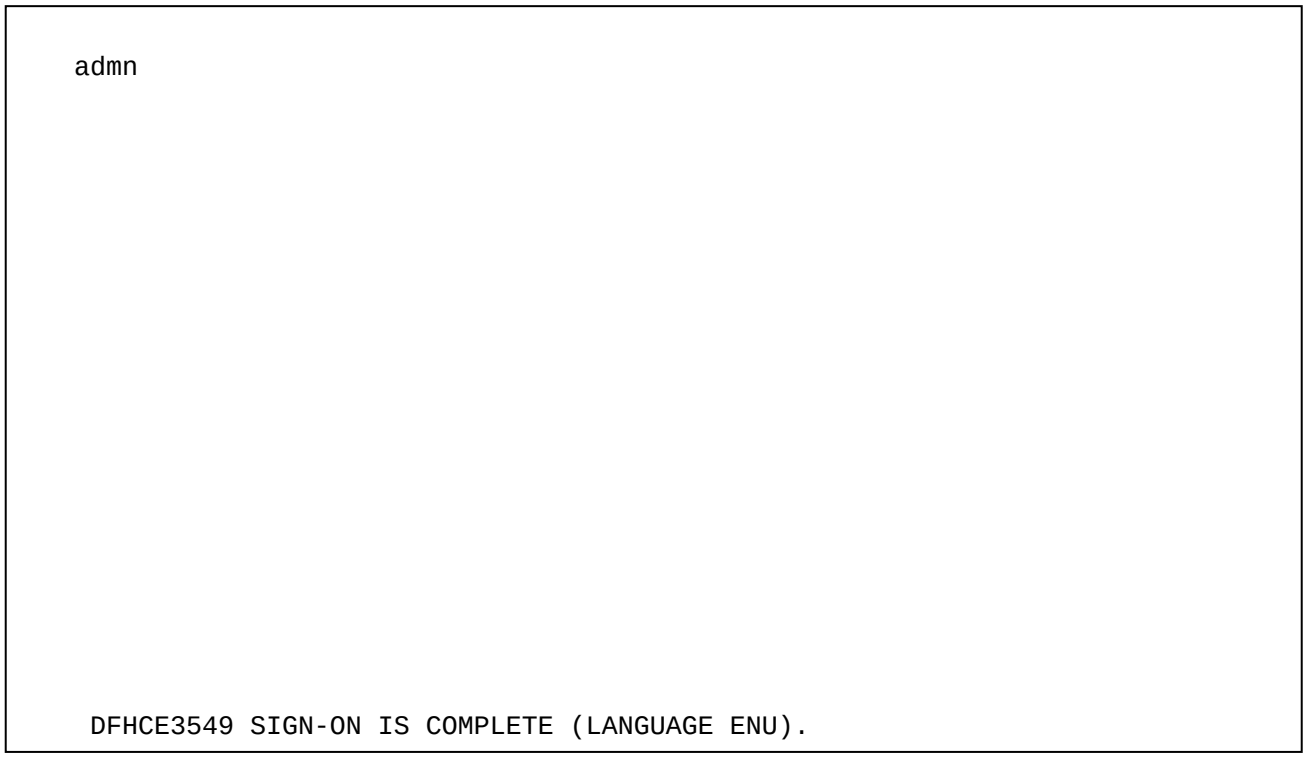
IV. Signing-on/off

```
                        A D O A   D A T A   C E N T E R
                        INFORMATION  SERVICES  DIVISION
*************************************************************************
*                                WARNING NOTICE                         *
* THIS SYSTEM IS RESTRICTED SOLELY TO STATE OF ARIZONA AUTHORIZED USERS FOR *
* LEGITIMATE STATE BUSINESS PURPOSES ONLY.  STATE OF ARIZONA STRICTLY     *
* PROHIBITS THE ACTUAL OR ATTEMPTED UNAUTHORIZED ACCESS, USE OR MODIFICATION*
* OF THIS SYSTEM.  UNAUTHORIZED USAGE AND/OR USERS ARE SUBJECT TO         *
* DISCIPLINARY PROCEEDINGS AND/OR CRIMINAL AND CIVIL PENALTIES UNDER STATE, *
* FEDERAL, OR OTHER APPLICABLE DOMESTIC AND FOREIGN LAWS.  THE USE OF THIS  *
* SYSTEM MAY BE MONITORED AND RECORDED FOR ADMINISTRATIVE AND SECURITY     *
* REASONS.  ANYONE ACCESSING THIS SYSTEM EXPRESSLY CONSENTS TO SUCH        *
* MONITORING AND IS ADVISED THAT IF MONITORING REVEALS POSSIBLE EVIDENCE OF *
* CRIMINAL ACTIVITY, STATE OF ARIZONA MAY PROVIDE THE EVIDENCE OF SUCH     *
* ACTIVITY TO LAW ENFORCEMENT OFFICIALS.  ALL USERS MUST COMPLY WITH STATE  *
* OF ARIZONA SECURITY POLICIES REGARDING THE PROTECTION OF STATE OF ARIZONA *
* INFORMATION ASSETS.                                                     *
*************************************************************************
PLEASE ENTER APPLICATION REQUEST: cicsacp

               IP ADDRESS = 170.68.17.115   - IP PORT = 01839
               ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
                     DATE = 05/19/06 - TIME = 10:53:53
                     THE HELP DESK TEL. (602) 364-4444
```

On the ADOA Data Center screen shown above, the user must type "**cicsacp**" in the Application Request field and press <Enter>. The screen pictured below will then be displayed.

```
                              Signon to CICS                          APPLID
CICSACPR

 WELCOME TO CICS/TS


 Type your userid and password, then press ENTER:

          Userid . . . . abcde12
          Password . . . *******
          Language . . .

      New Password . . .



 DFHCE3520 PLEASE TYPE YOUR USERID.
 F3=Exit
```

On the screen shown above, the user must type the 7 digit UserID and their Password and then press <Enter> to proceed with the sign-on. The screen shown on the next page will be displayed.



The user must then type “admn” on the screen shown above and press <Enter> to complete the sign-on process. The PMMIS Main Menu (shown on next page) will be displayed.

Signing-off
Users sign-off PMMIS by pressing the F12 key until the ADOA Data Center screen shown on page 411-3 of this policy is displayed again.

V. PMMIS Main Menu

```
TR: AH000                      AHCCCS - PMMIS                          05/19/06
NTR: _____________________        MAIN MENU                            09:13:07
                                                                       AH00M000

       1. CASE MANAGEMENT                  11. ALTCS MEDICAL ELIGIBILITY(CATS)
       2. ENCOUNTERS                       12. ALTCS FINANCIAL ELIGIBILITY(LEDS)
       3. SYSTEM SERVICE REQUEST           13. ALTCS GENERAL INQUIRY/MAINTENANCE
       4. HEALTH PLAN                      14. ELIGIBILITY QUALITY CONTROL/FRAUD
       5. INFORMATION MANAGEMENT           15. REINSURANCE
       6. PROVIDER                         16. (AVAILABLE)
       7. RECIPIENT                        17. FINANCE
       8. REFERENCES                       18. CLAIMS
       9. UR/QA                            19. SVES - WTPY REQUEST/RESPONSE
      10. SECURITY                         20. KIDS CARE (KEDS)



                          ENTER SELECTION: 11


PF: 1=HLP       3=CLR 4=MSG                                          12=ESC
```

Pictured above is the first screen users will see after completing the sign-on procedure for the AHCCCS system. From this screen users may access a variety of subsystems, including the Client Assessment and Tracking System (CATS) which is the focus of this policy.

Users may either enter "11" in the Selection field as shown above, or type the screen name of the specific screen the user wishes to access, in the NTR field at the top right of the screen and press Enter. Entering "11" will take the user to the CATS main menu which is shown in the next section.

VI. Client Assessment and Tracking System (CATS) Screens

Each of the screens described in this section share common features for access and movement within them. The following provides information about some of those common features:

The top of all PMMIS screens will look similar to this:

```
TR: SCREEN # HERE              AHCCCS - LONG TERM CARE                DATE HERE
 NTR: _____ I _______________    SCREEN NAME HERE                      TIME HERE
```

- "**TR**" – this field displays the 2-digit Alpha and 3-digit Numeric "name" of the screen or "Transaction" the user is currently accessing. For example: CA160.
- "**NTR**" – the 2-digit Alpha and 3-digit Numeric "name" of the screen that the user wishes to access next may be entered in the 1st position of this field as the "Next Transaction".
  The user may access any of the screens described in this section directly by entering the screen name here or s/he may use the Transaction Keys described below to "transaction travel" through them in sequential order.
- **Function Codes**: these single digit codes, entered in the 2nd position of the "NTR" field, indicate the action the user will take on the screen.

  - **I** - Used to inquire into a record, no changes will be made to the data
  - **C** - Used to change a record. Users may not have "Change" security access to all the screens described in this section.

See the Cost Effectiveness Study (CA160) section of this policy for information regarding 2 additional Function Codes that apply to that screen only.

- **AHCCCS ID#**: Most of the member data screens described in this policy are accessed by entering the member's 9-digit AHCCCS ID# in the 3rd position of the "NTR" field, to the right of the Function Code described above.

- **Transaction Keys**: these keys (described on the next page) allow the user to maneuver between the screens and within the system. As the user "transaction travels" with these keys, the data for the member whose AHCCCS ID# was last entered will be displayed until the user changes the AHCCCS ID# in the NTR field as noted above.

Transaction Keys

F2	From any CATS screen described in this chapter, returns the user to the CATS main menu (CA000) OR from a Comments screen, returns the user to the CATS screen from which they entered the Comments screen.
F3	Takes the user to a Comments screen from those CATS screens that have a Comments feature.
F5	Takes the user to the screen that immediately **precedes** the current one (for example, F5 from CA161 will take the user to CA160).
F6	Takes the user to the screen that immediately **follows** the current one (for example, F6 from CA160 will take the user to CA161).
F7	Takes the user backward, on the same screen, to information from previous dates (e.g., prior CES dates)
F8	Takes the user forward, on the same screen, to information from later dates (e.g., more CES dates)
F9	Scrolls the user back to lines of data (e.g., more placement lines on CA161) or Comments that precede those which are visible on the current screen.
F10	Scrolls the user forward to additional lines of data or comments on the current screen.
F11	Clears data entry errors so the user may proceed without having to resolve the edits first. Changes will not be saved until the edits are resolved.
F12	From any screen except Comments, begins to back the user out of PMMIS by either first returning to the sub-system main menu or going directly to the PMMIS main menu. Pressing F12 from the PMMIS main menu returns the user to the ADOA Data Center sign-on screen.

There are some exceptions to the above Transaction Keys. The user should note the directional information specific to each screen listed at the bottom of each screen.

The following screens that the contractors have access to for inquiry and/or direct data input of member information will be covered in this policy:

A. CATS Main Menu (CA000)
B. Case Management Name Search (CA105)
C. Cost Effectiveness (CA160)
D. Placement History (CA161)
E. Case Management Service Plan (CA165)
F. ACE Critical Data (CA166)
G. Member Income (CA167)
H. Case Management Review Tracking List (CA225)
I. Inquire Part D Drug Plan (RP214)
J. Inquire FYI Data (RP215)

K. Inquire Eligibility and Enrollment (RP285)

All contractors will use this system to record the Cost Effectiveness Study and Placement History for all enrolled members. Tribal Contractors must also enter service plan authorization data for ALTCS Fee for Service members. The remaining screens in this policy provide inquiry access to other member or case management related data.

A. CATS MAIN MENU (CA000)

```
 TR: CA000                  AHCCCS - LONG TERM CARE                    05/19/06
NTR: _____ _ _______________ MEDICAL ELIGIBILITY MENU                  09:16:59
ASSESS DATE: ___________                          WORKER ID: 605636  LT03L820


 A  PAS ADD SCREEN           (CA005)     L  PAS ASSIGNMENT TRACKING  (CA220)
 B  PAS INTAKE SCREEN        (CA010)     M  CASE MGMT NAME SEARCH    (CA105)
 C  OLD PAS MENU             (CA100)     N  COST EFFECTIVENESS STUDY (CA160)
 D  EPD PAS MENU             (CA500)     O  PLACEMENT MAINTENACE     (CA161)
 E  DD PAS MENU              (CA700)     P  SERVICE PLAN             (CA165)
 F  ASSESSMENT SUMMARY       (CA070)     Q  ACE CRITICAL DATA        (CA166)
 G  PAS REOPEN/DELETE        (CA075)
 H  TRANSITIONAL PGM MAINT.  (CA080)     R  SHARE OF COST            (CA175)
 I  PAS SIMULATED SCORE MENU (CA600)     S  CASE MANAGER REVIEW      (CA225)

 J  PAS REFERRAL TRACKING    (CA210)     T  AMADC ERROR MESSAGES     (CA230)
 K  REASSESSMENT TRACKING    (CA215)


                    SELECT LETTER:  _  AND PRESS ENTER


             ENTER=PROCESS       1=HELP       12=SECURITY DRIVER
```

To access the CATS screens used by ALTCS case managers (bolded above), users may either enter the letter code indicated for the screen (M, N, O, P, Q or S) in the space at the middle bottom of this screen (Select Letter) or type the screen name of the specific screen the user wishes to access in the NTR field at the top right of the screen and press Enter.

CA167/Member Income can not be accessed directly from this menu because the user needs to have designated the AHCCCS ID# of the desired member prior to entering CA167. See detailed instructions about CA167 beginning on page 411-38 of this policy for more information.

An example and description of each of the bolded screens follows in this section.

B. CASE MANAGEMENT NAME SEARCH (CA105)

```
TR: CA105                      AHCCCS - LONG TERM CARE                  01/10/03
 NTR: _____ I _______________    CASE MGMT NAME SEARCH                    09:13:24
 WORKER ID: 605636                                                       LT02L105

 NAME: CAMPBELL              __________   DOB: __________   SEX: _

 SEL                NAME                 AHCCCS ID   CASE ID   BIRTHDATE   SEX
 ---  ---------------------------------  ---------  ---------  ----------  ---
  S   CAMPBELL              ED           A12345678  100043562  01/01/1949   M
  _   CAMPBELL              SUE          A98765432  110430905  02/01/1925   F




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN 9=CNF               12=ESC
```

This screen allows the user to search for an ALTCS member by name and/or date of birth.

When searching by name, the system will seek to match the exact spelling of the last name, so the user must either enter the last name in its entirety or an asterisk after as many letters as the user is sure of. For example, if the user entered "CAMPB*", the system would bring up all names beginning with "CAMPB" but if the user had just entered "CAMP", the name CAMPBELL would not have appeared.

Both a name or date of birth search may be narrowed by entering an "M" or "F" to indicate the sex of the member sought.

From the list of names provided in the search, the user may enter an "S" to the left of the name and press **F9** to bring up the same demographic screen as shown on page **411- 31 of this policy**.

C. COST EFFECTIVENESS STUDY (CA160)

The purpose of the Cost Effectiveness Study (CES) is to compare the cost of Home and Community Based Services (HCBS) to the cost of institutionalization for each ALTCS member. AHCCCS considers HCBS to be cost effective if the cost is at or below 100% of the cost of institutionalization. The CES must be completed prior to the initiation of HCBS services in order to determine if those services will be cost effective and can be provided.

The CES is a projection of HCBS costs so it should be completed based on the services and amounts that the member **needs**, including any services which are expected to be authorized but may not be authorized currently. In order to determine the ongoing cost effectiveness of services the member needs, the units in each of the 3 months should reflect the units the member would receive for the entire month, not just the amount from the CES date until the end of the month.

```
TR: CA160                        AHCCCS - LONG TERM CARE                  09/01/04
NTR: _____ 1 ___2_________ CMP - COST-EFFECTIVENESS STUDY                15:28:25
                                                                          LT02L110

CES DATE:____3______  ASSESS DATE: ___________
NAME: _____________________ ___________ _     AHCCCS ID: __________
WORKER ID: 605636    CURR CSMGR: _______    LATEST ACN: _________

 LOC: A INST GRS COST: $ ____4______ SOC: $ ___B______ NET COST: $ ____C______
        HCBS GRS COST: $ ____D______ SOC: $ __E_______ NET COST: $ _____F_____
SERVICE    UNIT          MONTH 1        MONTH 2        MONTH 3      AVG COST
 CODE MOD  COST    UNITS  COST    UNITS  COST    UNITS  COST       PER MONTH
__5__ _6 __7______ _8__ __G______ __9_ __G_____ _10__ ___G_____    ___H_____
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________
______ __ _________ ____ _________ ____ _________ ____ ___________ ___________

                      COMMENTS: I  CUR PLACEMENT: _ DATE: ___J______ REASON: __
HCBS PRCNT : __K___   SSI PRCNT: ____

                                                      Z037 NO APPLICATION FOUND
1=HLP 2=CA000 3=COM 4=EDSUM 5=CA070 6=CA161 7=SBK 8=SFD 9=SUP 10=SDN 11=CLR/ADD
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **A** - used to add a new CES date. This function code is unique to CA160.
- **C** - used to change an existing CES. All data except the date can be changed.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.
- **D** - used to delete an entire CES record, including the date. This function code is unique to CA160.

Hint: If a CES already exists for a member and the case manager wants to create a new one, with a new date, s/he can either:

1. Change the function code to an **"A"**, add a new CES date and type over the existing service/cost data with the desired changes OR
2. Press F11 which will bring up a blank CES screen for the member and automatically change the function code to an **"A"** so that a new CES date can then be added

Do **NOT** use a function code **"C"** if a new CES needs to be created. An **"A"** function must be used to add a new CES date. The Change function should be used to make changes to an existing CES only. If the user uses a **"C"** and types over the existing data with current information, all the historical CES data will be lost. This is not the appropriate method for making a new CES.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose CES information the user wishes to access. CES information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be available for each member.

(3) CES DATE - the date of the most recent CES will appear, if one already exists for the member. If there is no previously established CES, the message "NO CES RECORDS EXIST" will appear at the bottom right of the screen.

If there are prior CES dates, press F7 to scroll backward to view these. Press F8 to scroll forward again.

Enter the date in this field, along with an "A" Function code to add a new CES. The format is MM/DD/YYYY.

(4) INST GRS COST - the anticipated monthly institutional gross cost should be entered here.

(5) SERVICE CODE - enter the appropriate 5 character service codes for the services that the member needs. If more services will be entered than there are lines on the screen, pressing F10 (after the 1st screen is entered) will provide additional lines. F9 will return the user to the 1st screen after additional line data is entered or viewed.

The word "NONE" may be typed on the 1st service line under the following circumstances:

- members residing in a Nursing Facility who have no potential for HCBS placement
- members who are receiving only Hospice services
- members residing in a Nursing Facility because HCBS would not be cost effective
- members with Acute Care Only status

(6) MOD - enter the 2 character modifier for the service, as needed. A list of all available modifiers can be found on RF114 and the valid modifiers for a specific procedure code can be found via RF122. The following are the most common modifiers:

- U2 – used to designate Attendant Care provided as Self-Directed Attendant Care
- U3 - used to designate Attendant Care provided by the member's spouse
- U4 – used to designate Attendant Care provided by a family member who does NOT live with the member
- U5 - used to designate Attendant Care provided by a family member who DOES live with the member
- U6 – used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver

(7) UNIT COST - enter the cost per unit of the service. This is entered as dollars and cents, with a maximum of 6 digits ($9999.99).

(8) (9) and (10) UNITS - enter the units of service that are needed per month for each of the 3 months. The units should reflect the units the member would receive for a whole month, not just the amount from the CES date until the end of the month. The units may vary from month to month if the member's service needs are expected to change over time. The number entered in this field can not exceed 4 digits (9999). **A zero must be entered in the field if no units of service are expected for one or more months.**

Below is an explanation of the **Lettered, information-only** fields:

(A) LOC – this field will generally be blank but it may show a Level of Care code from the last PAS. Since no LOC is assessed from the PAS process anymore, this information might be very old and most likely will be irrelevant to the member's current status. If a code does appear, the following explains the codes used:

CODE	DESCRIPTION
I	Class 1
P	Class 2
S	Class 3
T	ALTCS Transitional

(B) SOC - the member's anticipated monthly Share of Cost, if s/he were to be placed in a Nursing Facility, will be displayed here, based on the date of the CES. The member's monthly SOC history may be found via the CA166 screen (see information on this screen beginning on page 411-28 of this chapter). The SOC amount will change over time with the member's income and deductions. If the member is not currently known, by ALTCS eligibility staff, to be in a NF, the amount shown in the "CES SOC AMT" field on CA166 is the SOC amount that the member would be expected to pay if s/he were in a NF.

(C) NET COST - the system will display the net institutional cost (gross cost minus SOC) after the CES is entered by the user.

(D) HCBS GRS COST - the system will display the total average cost of the HCB services. This is the sum of the 3 month average for each service entered on the CES.

(E) HCBS SOC – if the member will have a Share of Cost in an HCBS setting (usually due to an Income-Only Trust), the amount, based on the date of the CES, will be displayed here. The SOC amount will change over time with the member's income and deductions.

(F) NET COST - the system will display the net HCBS cost (gross cost minus SOC) after the CES is entered by the user.

(G) COST - the system will display the total monthly cost (unit cost X units) for each service.

(H) AVG COST - the system will calculate and display the average monthly cost of each service (total cost divided by 3).

(I) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA160 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA160 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA160 screen.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the **Shift key and F10** together will immediately bring up the end of the file so new comments can be added.

(J) CUR PLACEMENT/DATE/REASON - this information is read from the most recent line on CA161/Placement Maintenance.

(K) HCBS PRCNT - the system calculates the HCBS percentage based on the services entered above compared to the cost of an institutional placement. The figure is the HCBS net cost (F) divided by the institutional net cost (C).

NOTE – the "SSI PRCNT" field is no longer used and no data/information will appear in this field.

NOTE - Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without having to resolve the errors created first.

D. PLACEMENT MAINTENANCE (CA161)

```
TR: CA161                    AHCCCS - LONG TERM CARE                      10/14/03
NTR: _____ 1 ___2_______      PLACEMENT MAINTENANCE                        11:29:47
                                                          WORKER ID:        LT02L115
NAME: _____________________ __________ _                AHCCCS ID: _________
LAST CES DATE: ___A_______  CURR CSMGR: ___3___   LATEST ACN: _________
LAST REVIEW DATE:  ____4_____  NEXT REVIEW DATE:  ____B_____
LATEST PC: __C___          ENROLL DATE: ___D_______  DISENROLL DATE: ____E____
CTRT TYPE:  F                                      BEHAVIORAL HEALTH CODE:  5
 PLACEMENT   RES    PLACEMENT     PLACEMENT      PLACEMENT     WORKER     DATE LAST
    CDE      CDE     REASON       BEG DATE       END DATE       ID       MODIFIED
     6        7        8          ___9_____     ___10_____    __G___     ____H_____
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________
     _        _        __         __________    __________    ______     __________

                                  COMMENTS: I

                                                        Z037 NO APPLICATION FOUND
 1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **C** - used to change placement information, including adding new placement data.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose placement history the user wishes to access. Placement information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) CURR CSMGR - enter the 6-digit ID# of the Case Manager currently assigned to the case. This field **must** be changed when a new case manager is assigned to a case. It is this field that is read by the system as the current case manager for all reports generated by AHCCCS. This field is also used by the system to generate the information on CA225/CM Review Tracking List.

(4) LAST REVIEW DATE – the date of the last on-site service review with the member should be entered here.

(5) BEHAVIORAL HEALTH CODE – the Behavioral Health code that describes the member's current BH status should be entered here. The code entered must correspond to the member's current Placement and Residence code (see matrix of appropriate combinations shown on the next page). This field must be reviewed and updated, as needed, at the time of each service review to ensure it reflects the member's current BH status, even if the member's Placement has not changed. **This field may not be left blank.**

The following provides a description of the Behavioral Health codes to be used:

CODE	DESCRIPTION
A	**Psychotropic Medications only.** Includes only medications used to modify behavioral health symptoms. Does not include Sedative-Hypnotics when used to treat insomnia or on a PRN basis prior to a procedure, Anti-anxiety medications used for muscle spasms or Anticonvulsants used to treat a seizure disorder. Medication monitoring by the prescribing physician is not considered a separate service so if the member receives no other BH "services", s/he would be included in this category.
B	**Behavioral Health services only**. This category would apply to members who receive any Behavioral Health services but who take no psychotropic medications. Does not include members who have only received a Behavioral Health evaluation but do not receive on-going BH services.
C	**Behavioral Health services and Psychotropic medications**. See A and B above. Includes members receiving psychotropic medication monitoring by a nurse.
D	**Behavioral Health Placement without Psychotropic medications**. Includes RTC, Level II or III Behavioral Health facilities and Alternative Residential Settings that specialize in Behavioral Health. Also includes Behavioral Health units within nursing facilities but excludes Wandering/Dementia units in nursing facilities.
E	**Behavioral Health Placement with Psychotropic medications**. See A and D above.
F	**No Behavioral Health Needs**.

The table below shows appropriate combinations of Placement, Residence and Behavioral health codes. Descriptions of the available Placement and Residence codes can be found following this table.

PLACEMENT	RESIDENCE	BEHAVIORAL HEALTH
H	8, F, K, L, R	D or E
H	5, 6, 9, B, E, G	A – F
H	1, P	A – C, F
Q	2, 4	A – F
Q	W	A – C, F
Q	7, C, J	D or E
D	1, 2	A – C, F
Z	1	F

(6) PLACEMENT CODE - enter the code for the placement that corresponds to services authorized by the Case Manager. These codes are shown below.

CODE	DESCRIPTION	
Z	Not Placed – a member must not remain in this placement for more than 30 consecutive days following ALTCS enrollment. No active services can be approved on the service plan during any "not placed" period.	
H	HCBS – members residing in their own home or an approved alternative residential setting. Members residing in their own home must receive at least one of the following LTC services to qualify for an HCBS placement:	
	• Adult Day Health • Attendant Care • Behavior Management • Emergency Alert System • Habilitation • Home Delivered Meals • Home Health Services	• Homemaker • Home Modifications • Partial Care • Personal Care • Psychosocial Rehabilitation • Respite
Q	Institutionalized – members residing in an AHCCCS registered Nursing Facility, ICF-MR, Institution for Mental Disease (IMD) or inpatient psychiatric facilities for individuals under age 21 (RTCs).	
D	Acute Care Only - members who reside in their own homes but receive no LTC services, members who reside in an uncertified facility, members who reside in alternative residential settings not registered with AHCCCS and/or members who have been disqualified from LTC benefits due to an uncompensated transfer of resources. Acute care services include: physician services, medical equipment and supplies, prescription drugs, medically necessary transportation, rehabilitative therapies (physical, speech, occupational and/or respiratory) and behavioral health services.	

(7) RESIDENCE CODE – enter the code that best describes the type of placement setting the member resides in. The Residence code must correspond with both the current Placement and Behavioral Health codes (see matrix of appropriate combinations on preceding page). A new Placement line must be started if the Residence code changes, even if the Placement code has not changed. Residence codes are shown below.

CODE	DESCRIPTION
1	Home
2	Nursing Facility
4	ICF/MR
5	Adult Foster Care
6	Group home for DD
7	Residential Treatment Center
8	Traumatically Brain Injured
9	Assisted Living Centers
B	Assisted Living Home
C	Institute for Mental Disease
E	Adult Developmental Home
F	Adult Therapeutic Foster Home
G	Child Developmental Foster Home
J	Level I Behavioral Health Center
K	Level II Behavioral Health Center
L	Level III Behavioral Health Center
R	Rural Substance Abuse Transitional Center
W	Wandering Dementia Unit in NF

(8) PLACEMENT REASON - enter the 2-digit code for the reason the placement was authorized by the case manager. Reason codes are shown below – the most commonly used codes are bolded..

CODE	DESCRIPTION
01	HCBS not appropriate or cost effective
02	HCBS not available in member's community
03	**Member/rep desires nursing facility placement**
04	Member voluntarily withdraws/awaiting disenroll
05	**Member in NF with no discharge potential**
06	HCBS recommended, cost expected to decrease
07	HCBS - Ventilator Dependent
08	Member hospitalized prior to initial placement
10	**Hospice – used with HCBS and NF placement codes**
11	Other (**Comments required**)
12	**Acute Care only**
13	**HCBS is available and cost effective**

Placement Reason code "**23**" may be used to delete a placement line if entered in error. This code will remove the entire placement line from the screen.

Reason code "11" should only be used if none of the other reason codes adequately describes the member's circumstances. When Reason code "11" is used, comments to describe those special circumstances are required (there will be a system error if comments are not entered).

(9) PLACEMENT BEG DATE - enter the start date of the placement. Format is MM/DD/YYYY.

(10) PLACEMENT END DATE - enter the end date of the placement, if applicable. Format is MM/DD/YYYY. The end date will be left blank for the member's current placement. This field must be completed before a new placement can be entered. There can not be an overlap between the end date and a subsequent placement start date.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - the date of the most recent CES from CA160 is displayed.

(B) NEXT REVIEW DATE – The system will calculate the date the member's next on-site service review is due based on the "Last Review Date" entered and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(C) LATEST PC - the 6-digit ID# of the ALTCS Contractor the member was last, or is currently, enrolled with, is displayed here. A list of ALTCS Contractor IDs can be found in Appendix B at the end of this chapter.

(D) ENROLL DATE - the date the member was enrolled with the ALTCS Contractor shown in "Latest PC" field is displayed. The current Placement begin date can not precede this date.

(E) DISENROLL DATE - if the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. The last Placement End date must match this date.

(F) CTRT TYPE – The member's current Contract Type will be displayed here. The following shows the applicable Contract types for ALTCS Program and Tribal Contractors:

CODE	DESCRIPTION
Program Contractors	
J	LTC, Capitated
L	LTC, Capitated, Acute Care Only
M	LTC, Prior Period Coverage
O	LTC, Prior Period Coverage, Acute Care Only
Tribal Contractors	
P	LTC, Partially Capitated
T	LTC, Fee For Service, Acute Care Only

(G) WORKER ID# - the ID# of the worker who last updated the line is displayed.

(H) DATE LAST MODIFIED - the date the line was last updated is displayed.

(I) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA161 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA161 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA161 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the **Shift key and F10** together will immediately bring up the end of the file so new comments can be added.

NOTE - Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without having to resolve the errors created first.

CA161 Provider Search Instructions

On CA161/Placement Maintenance, users can do a "provider" search to determine who the "CURR CSMGR" (Field 3) or "WORKER ID" (Field G) indicated on this screen belong to. The user may place the curser in either Field 3 or Field G (bolded in the screen example below) and press F1.

```
TR: CA161                  AHCCCS - LONG TERM CARE                      07/17/06
NTR: _____ C _______________ PLACEMENT MAINTENANCE                       11:39:54
                                                  WORKER ID: 605636     LT02L115
NAME: SMITH                  RICHARD              AHCCCS ID: A12345678
LAST CES DATE: 01/26/2006  CURR CSMGR: 605636   LATEST ACN:
LAST REVIEW DATE:  04/27/2006  NEXT REVIEW DATE:  07/26/2006
LATEST PC: 999999          ENROLL DATE: 07/28/2003  DISENROLL DATE: __________
CTRT TYPE:  J                                    BEHAVIORAL HEALTH CODE:  F
PLACEMENT  RES   PLACEMENT    PLACEMENT     PLACEMENT    WORKER    DATE LAST
   CDE     CDE    REASON      BEG DATE      END DATE       ID       MODIFIED
    H       1       13       07/28/2003    __________    605636    07/17/2006
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________

                                COMMENTS: N

                            Z171 ACTIVE IN ACE        Z011 END OF FILE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA161.

```
  TR: CA161 ACT: C      AHCCCS - INFORMATION REFERENCING                 07/17/06
                              PROVIDER ID/NAME                          12:54:45
                                                                        AH05L012
 S  SORTED BY PROVIDER ID
 E
 L PR ID  NPI         PROVIDER NAME              -----PROVIDER TYPE-------------
   ______ __________ _________________________
 _ 605636             SANDERS, CAROL             98 CASE MANAGER
 _ 605644             SURBER/SANDRA              98 CASE MANAGER
 _ 605652             GONZALES DOLORES           98 CASE MANAGER
 _ 605660             SALM, JANICE               98 CASE MANAGER
 _ 605678             SULLIVAN MARIE             98 CASE MANAGER
 _ 605686             HUMPHRIES FRED             98 CASE MANAGER
 _ 605694             HEGLUND/MARILYN            98 CASE MANAGER
 _ 605701             HERREID SUSAN              98 CASE MANAGER
 _ 605719             LANGLEY SHEVA              98 CASE MANAGER
 _ 605727             NORRIS/SUSAN               98 CASE MANAGER
 _ 605735             PHILLIPS/WANDALEE          98 CASE MANAGER
 _ 605743             SKERTICH/OLIVE             98 CASE MANAGER
 _ 605751             WINOGRAD ROCHELLE          98 CASE MANAGER
 _ 605769             YANNO/RICHARD              98 CASE MANAGER
PF:       2=RTN                        7=UP  8=DWN       10=TOP 11=BOT
```

E. SERVICE PLAN (CA165) – Used by Tribal Contractors to authorize ALTCS services.

```
TR: CA165                  AHCCCS - LONG TERM CARE                    11/04/03
NTR: _____ 1 ___2_______      CMP - SERVICE PLAN                       14:57:18
KEY DATE: ____3______                                  WORKER ID:      LT02L120
NAME: ____________________ __________ _                AHCCCS ID: _________
LAST CES DATE: ___A_______  CURR CSMGR: ___B___   LATEST ACN: _________
LAST PC: ___C___ ENR DT: ____D_____ DISEN DT: ___E______ LST RVW DT: ____F____
CUR: LOC: G_   PLACEMENT: _H   DATE: __________   RSN __  NXT RVW DT: ___I____
PAS DIAG CDS:  ______ __J____ ______   DIAG 1:  ____________________________
DIAG 2: ____________________________ DIAG 3:  ____________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
4 __5__ 6_ _ ____7_____ ____8_____ __9__ __10_ __ ___K_____ ___L____ _11___ 12
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __
_ _____ __ _ __________ __________ _____ ________ _________ ________ ______ __

                                COMMENTS: M

1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA175 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - enter the appropriate function code from the options below:

- **C** - used to change service information, including adding service authorizations.
- **I** - used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – this unlabeled line is where the user enters the AHCCCS ID# of the member whose service plan history the user wishes to access. Service authorizations are saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) KEY DATE – This **optional** field may be used to quickly display previous service plan entries beginning with a specific date by entering that date in this field. Format is MM/DD/YYYY. Services with that begin date or later will be displayed. This avoids having to scroll through screens of entries to find a specific service or time period. This field may be left blank if the user does not wish to review previous entries.

HINT: Usually, the end of the file (last authorized services) is brought up when you first go to this screen. F9 will scroll backward to previous authorizations and F10 scrolls forward again.

Pressing the **Shift key and F9** together will immediately bring up the beginning of the file (first screen of authorized services) and the **Shift key and F10** together will immediately bring up the end of the file.

(4) ACT - enter the appropriate action code from the options below:

- **I** - used to initiate a new service authorization
- **C** - used to make changes to an existing service authorization
- **T** - used to terminate an existing service authorization that has unclaimed units. This Action code requires a Reason code at the end of the service line (see table of Termination Reason codes beginning on the next page).

(5) SERV - enter the appropriate procedure 5-digit HCPCS or 4-digit Revenue code for the service being authorized.

(6) MOD - enter the 2 character modifier for applicable services. Durable Medical Equipment and medical supplies must have a modifier to be authorized. Fee-For-Service (FFS) Transportation intended as "Rural" will need a modifier entered in order for AHCCCS to pay the rural rate. The following are the most common modifiers:

- U2 – used to designate Attendant Care provided as Self-Directed Attendant Care
- U3 - used to designate Attendant Care provided by the member's spouse
- U4 – used to designate Attendant Care provided by a family member who does NOT live with the member
- U5 - used to designate Attendant Care provided by a family member who DOES live with the member
- U6 – used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver
- NU - used for a DME or medical supply purchase
- RR - used for a DME rental
- RA - Replacement of a DME item.
- RB - Replacement of a part of DME furnished as part of a repair.
- TN – used for rural transportation

All valid modifiers for a specific procedure code may be found in the PMMIS Reference subsystem, on RF122.

(7) EFF DT - enter the start date for the service authorization. Format is DD/MM/YYYY.

(8) END DT - enter the end date for the service authorization. The end date of an authorization must not exceed 90 days for an HCBS service or 180 days for an institutional service.

Service authorization begin and end dates must not overlap Placement begin and end dates on CA161/Placement Maintenance.

(9) UNITS - enter the number of units being authorized for the dates of service indicated. Information about maximum units allowed for a specific procedure code can be found in the PMMIS Reference subsystem, on RF113.

(10) UNIT COST - enter the unit cost of the service being authorized. The system will not allow this cost to exceed the AHCCCS FFS rate (if one has been set) for ALTCS FFS members. The maximum allowable charge for a specific procedure code can be found in the PMMIS Reference subsystem, on RF112.

(11) PROV - enter the 6-digit ID# of the Provider authorized to render the service. The provider must be eligible to provide the specific type of service authorized. Refer to PR035, in the PMMIS Provider subsystem, for the Categories of Service a specific provider is registered to provide.

NOTE: The following "dummy" Provider codes should be used to show that ALTCS covered services are provided but they are <u>not</u> paid for with AHCCCS funds:

<u>029108</u> - Signifies any service paid completely by another payer source, for example Tribal or private pay. In these cases, the appropriate service code would be used (for example, G0154 for Home Health Nursing), however, 029108 would be used as the provider number and the unit cost would be $0.00 to indicate the service will not be paid by AHCCCS.

<u>042490</u> - Signifies services provided in an uncertified facility.

(12) RSN – when a service line is being <u>terminated</u>, a Reason Code must be entered in this field. The termination of a service authorization should be rare. Changes in service code, begin or end dates, units and unit cost should be made using the (C)hange action code instead and no Reason Code is needed for these types of changes. Terminations Reason Codes are listed below.

Code	Description
01	Member does not meet medical/functional PAS criteria of AHCCCS
02	Member becomes financially ineligible
03	Member becomes financially and medically ineligible
04	Member's needs have been met and service is no longer required
05	Member's request for suspension or termination of service
06	Member moved out of provider's service area
07	Member died
08	Member moved out of state
09	Contact with member has been lost
10	Provider has been changed
11	No service is available

12	Another source is available
13	Member's caregiver/family is able to take over care
14	Member discharged to home
15	Member left against medical advice
16	Member discharged to other
17	Member needs a higher level of care
18	Member needs a lower level of care
19	Hospitalization
20	Covered by Medicare
21	Member refused services
22	Assessment only – completed
23	Delete - This code may be used to delete a service line if entered in error. The entire service line will be removed from the screen as long as AHCCCS has not paid any claims from that authorization.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - the most recent CES date from CA160 will be displayed here.

(B) CURR CSMGR - the 6-digit ID# of the case manager currently assigned to the case on CA161 will be displayed here.

(C) LAST PC - the 6-digit ID# of the Contractor the member was last or is currently enrolled with is displayed. A list of ALTCS Contractor IDs can be found in Appendix B at the end of this chapter.

(D) ENR DAT - the date the member was enrolled with the Contractor shown in "LAST PC" field is displayed.

(E) DISEN DAT - if the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. **If a date appears in this field, the member is not currently enrolled and no service can be authorized beyond the date shown.**

(F) LST RVW DT - the last date the case manager has entered in "LAST REVIEW DATE" field on CA161/Placement Maintenance will be displayed here. The field will be blank if no reviews or placement data has been entered.

(G) LOC – this field is currently not used. It used to show either the member's Level of Care from the most recent PAS or the Level of Care, for members in a nursing facility, based on the Nursing Facility service/revenue code authorized by the case manager on this screen.

(H) PLACEMENT/DATE/RSN - the Placement/Reason codes and begin date from the current placement on CA161 will be displayed here.

(I) NXT RVW DT - the date the next service review is due, as calculated based on the date entered in the "LAST REVIEW DATE" field on CA161/Placment Maintenance, is displayed here. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(J) PAS DIAG CDS - up to 3 diagnostic (ICD-9) codes from the last PAS will be displayed. The three lines next to and below this, labeled "DIAG 1/2/3", will display the definition of those codes.

(K) TOTL COST - the total cost of the service authorized on the line (units X unit cost).

(L) TOT USED - The total number of units AHCCCS has paid to the provider to date will be displayed. The number in this field will not exceed the number of units authorized but may be less.

(M) COMMENTS - a "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA165. The user must be in a "C" (Change) function on CA165 prior to moving to the Comments screen in order to be able to enter comments on that screen. The oldest comments saved for the member are displayed when the screen is first accessed. F9 will scroll backward to prior comments and F10 will scroll forward. Pressing the **Shift key and F9** together will take you immediately to the beginning of the comments and the **Shift key and F10** together will take you immediately to the end of the comments. F2 will return the user to the CA165 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

CA165 Provider Search Instructions

On CA165/Service Plan, users can do a provider search to determine who the Provider ID# on any service authorization line and/or who the Case Manager ID# on this screen belong to. The user may place the curser on either the Provider ID# (one at a time) or the Current Case Manager ID# (examples shown bolded in the screen example below) and press F1.

```
TR: CA165                  AHCCCS - LONG TERM CARE                    05/30/06
NTR: _____ I _______________  CMP - SERVICE PLAN                       07:41:43
KEY DATE: __________                                WORKER ID: 605636    LT02L120
NAME: BROWN                 SAMUEL                  AHCCCS ID: A23456789
LAST CES DATE: 04/13/2006  CURR CSMGR: 124412   LATEST ACN:
LAST PC: 999999 ENR DT: 11/01/2005 DISEN DT:            LST RVW DT: 05/16/2006
CUR: LOC: _   PLACEMENT: H   DATE: 11/01/2005   RSN 13  NXT RVW DT: 08/14/2006
PAS DIAG CDS:  3449                    DIAG 1:  PARALYSIS, UNSPECIFIED
DIAG 2: _____________________          DIAG 3:  ____________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
_ 97113 __ _ 04/20/2006 06/22/2006    28    31.74    888.72     0.00 020876 __
_ 97535 __ _ 04/20/2006 06/22/2006    28    29.87    836.36     0.00 020876 __
_ S5125 __ _ 05/08/2006 06/30/2006   960     3.88   3724.80   312.00 076433 __

                                  COMMENTS: Y

                           Z171 ACTIVE IN ACE        Z022 MORE DATA AVAILABLE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA166 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA165.

F. AHCCCS Customer Eligibility (ACE) Critical Data (CA166)

Information available about a member through the ACE Critical Data screen is accessed in the same way as the previously described CATS screens, via member AHCCCS ID# entered in the field labeled **(A)** below. This screen is inquiry only; no information can be changed on this screen.

1. Main screen:

```
TR: CA166                  AHCCCS - LONG TERM CARE                    09/07/04
NTR: _____ I ___A_________  ACE CRITICAL DATA                         07:54:48
WORKER ID: 605636                                                      LT02L130
NAME: CAMPBELL                    ED        STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A12345678  ACE ID: 900000000 TRIBE CD: 07  RES CD: 07  NET TEST: F
CASE MANAGER: 123456 MANAGER, CASEY                   OFFICE: 12A  PAS LOC: I
FIN REDE DUE DATE: 07/13/2005    MED REASS DUE DATE: NONE        DD STATUS: 4

LIVING ARRANGEMENT(LAR): HS   LAR PROVIDER: ______   LAR BEG DATE: 07/23/2004
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: 12/01/1999   END DATE: 05/31/2001
 MAJOR DIAG 1: 03B(7169 )  MAJOR DIAG 2: 06G(3109 )  MAJOR DIAG 3: 12C(     )

  AUTH REP: CAMPBELL             MARY        _          RELATION: SP
         STREET ADDRESS: 1234 E NORTHVIEW AVE          _________________________
     CITY: PHOENIX             ST: AZ  ZIP: 85034 ____  RES PHO: 602 555 5555
                                                        BUS PHO: ___ ___ ____
 LEGAL REP: _____________________ __________ _          RELATION: __
         STREET ADDRESS: _____________________          _________________________
     CITY: ____________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                                        BUS PHO: ___ ___ ____
                          Z171 ACTIVE IN ACE        Z008 RECORD FOUND
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA225 (7=DEM 8=SOC 9=VER 10=MHS) 11=CLEAR
```

The following tables provide information regarding codes that appear on the CA166:

ALTCS Eligibility Site Codes	
12	Valley ALTCS
15	Freedom to Work
21	Tucson
22	Sierra Vista
31	Flagstaff
32	Prescott
33	Show Low
34	Chinle
35	Cottonwood
41	Yuma
42	Lake Havasu City
43	Kingman
51	Casa Grande
52	Globe

DD Status Codes	
1	Potential DD member
2	DD member In ICF/MR or Home/Group Home
3	DD member in Nursing Facility
4	EPD member

Status Codes	
A	Active enrollment
I	Inactive enrollment

Tribe/Reservation Codes					
01	Ak Chin	**08**	Havasupai	**15**	Salt River Pima-Maricopa
02	Camp Verde Yavapai	**09**	Hopi	**16**	San Carlos Apache
03	Cocopah	**10**	Hualapai	**17**	Yavapai-Apache
04	Colorado River	**11**	Kaibab Paiute	**18**	Fort Mohave
05	White Mountain Apache	**12**	Navajo	**19**	Quechan
06	Fort McDowell	**13**	Tohono O'Odham	**20**	Pascua Yaqui
07	Gila River	**14**	Tonto Apache	**21**	San Juan Southern Paiute

More Codes from CA166 Main Screen

Living Arrangement Codes	
AH	CLIENT IS IN ACUTE HOSPITAL BED
HA	CLIENT IS IN AN ASSISTED LIVING HOME
HB	MH LEVEL I OR II BEHAVIORAL HEALTH CTR
HC	DD CHILD IN DD CHILD DEVELOPMENT FOSTER HOME
HD	MH LEVEL III BEHAVIORAL HEALTH CTR
HF	LIVES IN AN ADULT FOSTER HOME
HG	LIVES IN A GROUP HOME
HI	LIVES AT HOME AND INTENDS TO RECEIVE SERVICES
HL	CLIENT IS IN AN ASSISTED LIVING CENTER
HN	LIVES AT HOME AND DOESN'T RECEIVE IN-HOME SERVICES
HO	QMB-ONLY LIVING ARRANGEMENT (SERVICES N/A)
HR	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY
HS	LIVES AT HOME AND RECEIVES IN-HOME SERVICES
HT	LIVES IN A THERAPEUTIC ADULT FOSTER HOME
HZ	ALZHEIMER ASSISTED LIVING FACILITIES
LH	A/R IN LTC HOSPITAL BED OR ACUTE PSYCHIATRIC HOSPI
LT	CLIENT IS IN LTC FACILITY OR RTC
OS	CLIENT IN OUT-OF-STATE FACILITY (HOSPITAL OR LTC)
RH	CLIENT REFUSING LTC SERVICES
SC	ALTERNATE ACUTE LIVING ARRANGEMENT

Relationship Codes (for authorized and/or legal representative)			
AU	AUNT	**NB**	NEIGHBOR
BR	BROTHER	**NO**	NONE
CH	CHILD	**NR**	NOT RELATED
CO	COUSIN	**OT**	OTHER
DA	DAUGHTER	**PA**	PARENT
FA	FATHER	**PO**	PARENT OF ADULT
FF	FOSTER FATHER	**PS**	STEP PARENT
FM	FOSTER MOTHER	**NO**	NONE
GD	GRANDDAUGHTER	**SI**	SISTER
GF	GRANDFATHER	**SO**	SON
GM	GRANDMOTHER	**SP**	SPOUSE
GS	GRANDSON	**UN**	UNCLE
MO	MOTHER		

2. Pressing **F7** will bring up the Demographic screen shown below. **F2** will return the user to CA166.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    10/27/11
                              DEMOGRAPHIC INQUIRE                   15:19:32
                                                                    RP01L035
A12345678 CAMPBELL ED                     SEX F DOB 12/04/1966 DOD

      HOME ADDRESS           RES CTY: MARICOPA             HEAD OF HOUSE?: N
SOUTH MOUNTAIN CARE          FIS CTY: MARICOPA           ON RESERVATION?: N
6420 S. 22ND ST                   SSN: 555-55-5555
PHOENIX                      CASE ID: 555555555              OTHER RECORDS?
AZ 85040                        RACE: CAUCASIAN/WHITE         SPECIAL PGMS:
                            TRIBE ID:                             MEDICARE: Y
     MAILING ADDRESS         MAR STA: SINGLE                THIRD PTY CHG: Y
SOUTH MOUNTAIN CARE          LANG: ENGLISH                   ALTERNATE ID: Y
6420 S. 22ND ST               LANG SRC: ON-LINE, DMS
PHOENIX                      CITIZEN: US US CITIZEN           MEDICAL COND:
AZ 85040                CITIZEN SRC: AZ                    CORRESPONDENCE: Y
                            CARE LVL:
                            FACILITY:                                CO-PAY: N
HOME PH: (602) 555-0000  ATTN:
 EMG PH: (   )    -        EMAIL SRC: WB
E-MAIL: MYNAME@NETZERO.NET
PF: 1=HLP 2=RTN                  6=NXT                              12=ESC
          14=MDC 15=TPL 16=ALT       18=COR
```

NOTE - The F14, F15 and F16 options above will only appear on the screen if there is data to report (i.e. F14 will not appear on this screen if the member does not have Medicare).

3. If "F14=MDC" is shown as an option on the demographic screen (#2), pressing **Shift and F2** will bring up the Medicare Coverage screen shown below. **F2** will return the user to the demographic screen.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    05/19/06
                          INQUIRE MEDICARE COVERAGE                  13:21:30
                                                                     RP01L050
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________

      MEDICARE   PAYER  BEGIN      END          CHG    DATE       LAST MOD
PART  CLAIM NO.   ID    DATE       DATE      SRC RSN  REC ADDED  DATE      USR
 A  123456789A   FREE 05/01/1995             AS      01/13/1995 09/07/2005 BAT
 B  123456789A   030  05/01/1995             SI      01/13/1995 01/12/2001 BAT
 C  123456789A        07/01/2005             AS      06/14/2005 06/14/2005 BAT
 D  123456789A        01/01/2006             MS      12/15/2005 12/15/2005 BAT


PF: 1=HLP 2=RTN                          7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

If this screen indicates the member has "Part C" as shown in the example above, this means the member is eligible for the Qualified Medicare Beneficiaries (QMB) program.

If the screen indicates that the member has "Part D' as shown in the example on the preceding page, refer to the RP214 screen (instructions on page 411-42 of this chapter) to determine which Part D drug plan the member is enrolled with.

4. If "F15=TPL" is shown as an option on the demographic screen (#2), pressing **Shift and F3** will bring up the Third Party Coverage Summary screen shown below. **F2** will return the user to the demographic screen.

```
 TR: CA166 ACT: I                AHCCCS - RECIPIENT   USER-ID: 57N  01/13/03
                           INQUIRE THIRD PARTY COVERAGE SUMMARY      10:48:56
                                                                     RP01L055
A12345678 CAMPBELL ED                      SEX M DOB 01/01/1949 DOD __________

       CARRIER                                                       COV CHG
  SRC NUM   NAME                 POLICY NUMBER  BEGIN DATE  END DATE TYP RSN
 S OA       BCBS                 1234-5678      07/10/2002

 PF: 1=HLP 2=RTN                        7=UP  8=DWN                   12=ESC
```

For more information on any TPL listed in the screen above, put an **"S"** in the selection field to the left of the policy and press Enter. The Third Party Coverage Detail screen shown in #5 below will be displayed.

5. Pressing **F2** from this Third Party Coverage Detail screen will return the user to the TPL screen shown in #4.

```
TR: RP155 ACT: I                  AHCCCS - RECIPIENT  USER-ID: 57N   01/13/03
                             INQUIRE THIRD PARTY COVERAGE DETAIL       10:49:17
                                                                       RP02L055
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________
            SOURCE: OA
      CARRIER NUMBER:           CARRIER NAME: BCBS
    STREET ADDRESS-1: 123.W EAST ST
    STREET ADDRESS-2:
              CITY: PHX                  STATE: AZ    ZIP: 85223
       CARRIER PHONE: (     )     -
        GROUP NUMBER:
       POLICY NUMBER: 1234-5678            COVERAGE TYPE:
   POLICY BEGIN DATE: 07/10/2002           DATE VERIFIED:
     POLICY END DATE:
       CHANGE REASON:
POLICY HOLDER'S NAME: CAMPBELL ED
 POLICY HOLDER'S SSN: 555-55-5555
            EMPLOYER:
RELATIONSHIP OF POLICY HOLDER TO RECIPIENT: SELF
DATE RECORD ADDED: 07/10/2002  LAST MOD. DATE: 07/10/2002 LAST MOD. USER: 067

PF: 1=HLP 2=RTN                                                      12=ESC
```

6. If "F16=ALT" is shown as an option on the demographic screen (#2), pressing **Shift and F4** will bring up the Alternate ID screen shown below. **F2** will return the user to the demographic screen.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
NTR: _____________________  INQUIRE ALTERNATE ID                       10:49:51
                                                                       RP01L085
A12345678 CAMPBELL ED                        SEX M DOB 01/01/1949 DOD __________

    ALTERNATE ID  ID   ID DESCRIPTION   BEGIN         LAST MOD       DAT REC
                 TYPE                    DATE   SRC  DATE      USR   ADDED

  90014760        AC APPLICATION CONT 06/19/2002 OA 06/19/2002 0A1 06/19/2002
  100555555       AS ACE SYSTEM ID NU 07/23/2002 OA 07/23/2002 0A1 07/23/2002
  123456780A      MC MEDICARE CLAIM I 01/01/2002 OA 07/10/2002 067 07/10/2002
  555-55-5555     SN UNVERIFIED SSN/P 06/19/2002 OA 06/19/2002 0A1 06/19/2002



PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN                    12=ESC
```

7. From CA166 (#1), pressing **F8** will bring up the Share of Cost screen shown below. **F2** will return the user to CA166. The "CES SOC AMT" field indicates the SOC amount an HCBS member would have to pay if s/he were admitted to an institutional placement.

```
TR: CA166 ACT: I          AHCCCS - RECIPIENT          USER-ID: 57N   04/23/04
NTR: _____________________  INQUIRE SHARE OF COST                      09:42:15
                                                                       RP03L075
A12345678 CAMPBELL ED                      SEX   DOB 19490101   DOD

                                                          T  ORIGINAL    DATE    USER
    SOC       SOC         SOC        SOC        CES      Y  POSTING     LAST    LAST
    DATE     AMOUNT     ADJ AMT    USED AMT   SOC AMT    P    DATE       MOD     MOD

  04/2004        .00                   .00     963.69    I 03/29/2004 03/29/2004 BAT
  03/2004        .00                   .00     963.69    I 02/27/2004 02/27/2004 BAT
  02/2004        .00                   .00     963.69    I 01/26/2004 01/26/2004 LC*
  01/2004        .00                   .00     946.49    I 12/26/2003 12/26/2003 LC*
  12/2003        .00                   .00     946.53    I 11/28/2003 11/28/2003 BAT
  11/2003        .00                   .00     946.53    I 10/29/2003 10/29/2003 BAT
  10/2003        .00                   .00     946.53    I 09/28/2003 09/28/2003 BAT
  09/2003        .00                   .00     946.53    I 08/29/2003 08/29/2003 BAT
  08/2003        .00                   .00     946.53    I 07/29/2003 07/29/2003 BAT
  07/2003        .00                   .00     946.53    I 06/28/2003 06/28/2003 BAT
  06/2003        .00                   .00     946.53    I 05/29/2003 05/29/2003 BAT
  05/2003        .00                   .00     946.53    I 04/28/2003 04/28/2003 BAT

PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                      12=ESC
```

8. From CA166 (#1), pressing **F9** will bring up the Verification screen shown below. The user must enter a date in "DOS FROM DATE" field in order for eligibility/enrollment data to appear. This date can be the specific date for which eligibility or enrollment information is sought or the current date.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
 NTR:                             VERIFICATION                         11:38:29
                                                                       RP07L050
 A12345678 CAMPBELL ED                       SEX M DOB 01/01/1949 DOD

 AS OF DATE 01/13/2003 DOS FROM DATE __________ DOS THRU DATE __________ FYI
 THE RECIPIENT'S ELIGIBILITY IS:                                    ADDED ON
                           BEGIN ON:            ENDED ON
                           BEGIN ON:            ENDED ON

 THE RECIPIENT'S  ENROLLMENT IS:        BEGIN      END      RATE
      HEALTH PLAN          CTRT TYP     DATE       DATE     CODE CSA  ADDED ON

 PART A BEGINS:            AND ENDS:            MEDICARE CLAIM #:
 PART B BEGINS:            AND ENDS:
 THE RECIPIENT HAS THIRD PARTY COVERAGE WITH:
 THE POLICY NO IS                BEGINNING ON            ENDING ON

 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                    12=ESC
```

9. Entering a "DOS FROM DATE" brings up information as shown below. **F2** will return the user to CA166.

```
TR: CA166 ACT: I             AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
 NTR:                             VERIFICATION                         10:39:17
                                                                       RP07L050
 A12345678 CAMPBELL ED                       SEX M DOB 01/01/1949 DOD

 AS OF DATE 01/13/2003 DOS FROM DATE 11/01/2002 DOS THRU DATE __________ FYI N
 THE RECIPIENT'S ELIGIBILITY IS:                                    ADDED ON
 L SD MAO                  BEGIN ON: 11/01/2000 ENDED ON            06/19/2002
                           BEGIN ON:            ENDED ON

 THE RECIPIENT'S  ENROLLMENT IS:        BEGIN      END      RATE
      HEALTH PLAN          CTRT TYP     DATE       DATE     CODE CSA  ADDED ON
 ANY LTC PLAN            LTC/CAP      08/01/2002              2200 13 07/24/2002
 ANY LTC PLAN            LTC/CAP      06/19/2002 07/31/2002 2210 13 06/19/2002
 ANY LTC PLAN            LTC/PPC      10/01/2000 06/18/2002 221Z 13 06/19/2002

 PART A BEGINS: 01/01/2002 AND ENDS:            MEDICARE CLAIM #: 555555555A
 PART B BEGINS:            AND ENDS:
 THE RECIPIENT HAS THIRD PARTY COVERAGE WITH: BCBS
 THE POLICY NO IS 1234-5678       BEGINNING ON 07/10/2002 ENDING ON

 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN                    12=ESC
               15=TPL
```

10. From CA166 (#1), pressing **F10** will bring up the BHS/FYI Data screen shown below. Pressing **F2** from this screen will generate an error. **F12 must be used to return the user to CA166 from the BHS/FYI Data screen.**

```
  TR: CA166 ACT: I                AHCCCS - RECIPIENT    USER-ID: 57N    06/04/04
 NTR: _____________________     INQUIRE BHS/FYI DATA                    07:36:10
                                                                        RP04L016
A12345678 CAMPBELL              ED       SEX  M  DOB 19490101   DOD __________

             BHMIS ID: XXXXXXXXXX
     TYPE                                  CHG                              LAST MOD
      ID    BEGIN DATE END DATE    STA    RSN SITE CAT    DATE ADDED    DATE     USER

    079999 09/01/1994 06/20/2002   A     CH    23    S     09/24/2003 09/24/2003 CNV
    079999 06/01/1994 07/31/1994   A     RO    23    S     09/24/2003 09/24/2003 CNV
    079999 04/19/1994 04/30/1994   A     RO    23    S     09/24/2003 09/24/2003 CNV



 PF: 1=HLP 2=RTN 3=CLR 4=MSG        6=DSP 7=UP   8=DWN        10=TOP 11=BOT 12=ESC
```

"BHMIS ID" is an identification number assigned by ADHS/BHS for their tracking purposes only.
"TYPE ID" should be 079999 which indicates enrollment with ADHS/BHS.
"CHG RSN" (Change Reason) codes may be found on RF525 in PMMIS.

SITE CODES	
02	CENPATICO 2
03	YUMA BEHAVIORAL HEALTH SERVICE
05	COMCARE
07	MAGELLAN
08	VALUE OPTIONS
11	GILA RIVER INDIAN TRIBE
14	NAVAJO NATION
15	NORTHERN AZ REG BEHAVIORAL SER
17	SALT RIVER PIMA-MARICOPA IND
18	SOUTHEAST AZ BEHAVIORAL SERV
22	CENPATICO 4
23	PINAL/GILA BEHAVIORAL SERVICES
24	AZ CENTER FOR CLINICAL MGMT
25	PASCUA YAQUI TRIBE
26	COMM PARTNER SO AZ SVC AREA 5
27	COMM PARTNER SO AZ SVC AREA 3
MENTAL HEALTH CATEGORIES	
C	CHILDREN SERVICES
D	SUBSTANCE/ALCOHOL ABUSE MENTAL HEALTH SERVICES
G	GENERAL MENTAL HEALTH SERVICES
S	SMI
Z	SED CHILDREN

CA166 Provider Search Instructions

On CA166/ACE Critical Data, users can do a provider search to determine who the Provider ID# in the "LAR Provider" (Living Arrangement) field belongs to, if applicable. The Provider ID# that appears in this field will reflect only the Nursing Facility or Assisted Living Facility provider that AHCCCS eligibility has recorded as the member's current living arrangement in ACE.

```
TR: CA166                  AHCCCS - LONG TERM CARE                      05/30/06
NTR: _____ I _______________  ACE CRITICAL DATA                          07:53:31
WORKER ID: 605636                                                        LT02L130
NAME: JONES                ALICE           STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A87654321  ACE ID: 100000000 TRIBE CD: 15  RES CD: __  NET TEST: P
CASE MANAGER: 123456 MANAGER, CASEY                   OFFICE: 13A  PAS LOC: I
FIN REDE DUE DATE: 10/31/2006    MED REASS DUE DATE: NONE        DD STATUS: 4

LIVING ARRANGEMENT(LAR): LT   LAR PROVIDER: 355752   LAR BEG DATE: 07/22/2000
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: __________   END DATE: __________
 MAJOR DIAG 1: 3109        MAJOR DIAG 2: 582         MAJOR DIAG 3: __________

  AUTH REP: JONES                PHYLLIS    _          RELATION: OT
         STREET ADDRESS: 12345 E THOMAS
     CITY: ANYWHERE            ST: AZ  ZIP: 85256 ____  RES PHO: ___ ___ ____
                                                        BUS PHO: 555 555 5555
 LEGAL REP: _____________________ __________ _          RELATION: __
         STREET ADDRESS: _____________________    ____________________
     CITY: ____________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                                        BUS PHO: ___ ___ ____

                                                   Z026 RETURN FROM HELP
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA167 (7=DEM 8=SOC 9=VER 10=MHS) 11=CLEAR
```

The user should place the curser on the Provider ID# in the LAR Provider field (bolded in the screen example above) and press F1. A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA166.

```
TR: CA166 ACT: I      AHCCCS - INFORMATION REFERENCING                  05/30/06
                               PROVIDER ID/NAME                         07:54:14
                                                                        AH05L012
S  SORTED BY PROVIDER ID
E
L PR ID  NPI        PROVIDER NAME               -----PROVIDER TYPE------------
  ______ __________ _________________________
_ 355752             PLAZA HEALTHCARE           22 NURSING HOME
_ 355760             DUNKIN/MARTHA(BETH)        50 ADULT FOSTER CARE
_ 355778             JOHNSON/LEONILA(MILA)      50 ADULT FOSTER CARE
_ 355786             WHITE MNTN REG MED CENTER  22 NURSING HOME
_ 355794             LEAR/LISA A.               07 DENTIST
_ 355801             CARDOZA/MARTY              50 ADULT FOSTER CARE
_ 355819             THE WILLOWS                50 ADULT FOSTER CARE

PF:       2=RTN                          7=UP  8=DWN       10=TOP 11=BOT
```

G. MEMBER INCOME (CA167)

Monthly income data for a member is displayed on this screen. Data is available by the Budget Months recorded in the AHCCCS Customer Eligibility (ACE) system, not necessarily for every calendar month. This data is made available to case managers for purposes of determining Room & Board charges if/when the member is admitted to an Assisted Living Facility.

Users may not designate or switch between members on the CA167 screen. Users can only access CA167 from any of the other member data screens (CA160, CA161, CA165 or CA166) as long as the member's AHCCCS ID# has already been entered on that previous screen. For example, if the user is viewing John Smith's CA160/CES, s/he may type "CA167" in the NTR field and bring up CA167 for John Smith but could not travel to CA167 from John Smith's CA160 and plan to view Mary Jones' Income data. To switch between members for income data, the user may press F5 to return to CA166, enter another member's AHCCCS ID and then return to CA167 for that member's income data by either pressing F6 or by typing "CA167" in the NTR field.

Upon entering CA167 for a specific member, the current month will appear in the Budget Month field (e.g. March 2006 = Budget Month 200603) but the user must press the Enter key in order for any income data available for that month to be displayed. As eligibility does not record income data for every month, if the member's income has not changed since it was last recorded, income data may not appear for the current month. The F7 key will scroll the user backward, month by month, to view data for prior months. If there is no data recorded for a particular month, the message "NOT FOUND IN ACE" will appear at the top of the screen. Users may continue to scroll until income data is displayed or a specific Budget Month can be entered to bring the user directly to that month.

```
2519 NOT FOUND IN ACE
TR: CA167                    AHCCCS - LONG TERM CARE                  04/12/06
NTR:       I                      MEMBER INCOME                       09:38:21
BUDGET MONTH: 200604                                                  LT02L135

NAME: BUNNY               BUGS             ACN:          AHCCCS ID: A12345678

 TYPE OF INCOME            SOURCE OF INCOME            REPORTED AMOUNT




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

In the example below, the last Budget Month for which income was recorded in ACE is March 2006. All Earned and Unearned income for the member will be displayed, including the Type, Source and Amount. Up to 14 income types/sources may be displayed for a member as applicable.

```
TR: CA167                      AHCCCS - LONG TERM CARE                    03/09/06
NTR:       I                        MEMBER INCOME                         08:41:32
BUDGET MONTH: 200603                                                      LT02L135

NAME: BUNNY                 BUGS            ACN:          AHCCCS ID: A12345678

 TYPE OF INCOME             SOURCE OF INCOME            REPORTED AMOUNT
 SOCIAL SECURITY            SOCIAL SECURITY ADMINISTR       227.00
 NO EARNED INCOME                                             0.00




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

H. CASE MANAGER REVIEWS TRACKING LIST (CA225)

```
TR: CA225                  AHCCCS - LONG TERM CARE                      10/01/03
 NTR: _____ I _____________ CASE MANAGER REVIEWS TRACKING LIST          08:01:59
                  FROM MONTH: ____1____ THRU MONTH: ____2_____          LT02L170
 CASE MANAGER: ___3__   ____________________________________   WORKER ID: 605636
                                                      CURRENT
  DUE DATE                  CLIENT NAME       AHCCCS ID PLC LOC   FACILITY
 ____A_____ ___________B________ _____ _____ _____C__  D_ E ___F__ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________
 __________ ____________________ _____ _____ __________  __ _ _______ _____________


  ENT=PROCESS   1=HELP   2=CA000   6=CA165   9=SUP  10=SDN  11=CLEAR  12=CA000
```

This screen is designed to provide the user with a list of member service assessment/review due dates within a specified time period for a specific case manager. This information is obtained from the "CURR CSMGR" (current case manager) and "Next Review Date" fields on CA161. This screen is one of only 2 CATS screens that is not accessed with a member's AHCCCS ID# (CA105 is the other).

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) FROM MONTH - this field will contain the current month/year when the user enters this screen. If the user wants to view an earlier time period, that month/year should be entered (for example if, in April 2006, the user wants to see if there are any overdue cases back to January 2006, 01/2006 would be entered in this field). The format is MM/YYYY.

(2) THRU MONTH - this field will contain the current month/year when the user enters this screen. If the user wants to view a later time period, that month/year should be entered. The format is MM/YYYY.

(3) CASE MANAGER - enter the 6-digit ID# of the case manager for whom case review information is sought. Only review information about enrolled members who are currently assigned to this case manager on CA161 will appear when this ID# is entered.

Below is an explanation of the **Lettered, information-only** fields:

(A) DUE DATE - the date from the "NEXT REVIEW DATE" field on CA161 will be displayed here. The system calculates the date the member's next on-site service review is due based on the

"Last Review Date" entered on CA161 and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(B) CLIENT NAME - the member's name (last, first) will be displayed here.

(C) AHCCCS ID - the member's AHCCCS ID# will be displayed here.

(D) CURRENT PLC - the member's current placement code will be displayed here. This information is read from CA161.

(E) CURRENT LOC - the information in this field is inconsistent and should not be relied on. This field used to display the Level of Care from either the most recent PAS or as updated by the case manager on CA165.

(F) FACILITY - the provider ID# and name of the nursing facility the member resides in, if applicable, will be displayed here. This information is read from CA165/Service Plan. If there is no open service authorization for the facility on CA165, this field will be blank.

I. INQUIRE PART D DRUG PLAN (RP214)

```
 TR: RP214 ACT: I              AHCCCS - RECIPIENT    USER-ID: MA3    10/25/10
NTR: _____________________  INQUIRE PART D DRUG PLAN                 16:35:40
   (A)          (B)                      (C)         (D)    (E)     RP01L014
A12345678  BEET VICTORY H                SEX F DOB 01/01/1900  DOD
     (F)
ALTERNATE DOB:
  (F)                                                      (L)
  S  (G)   (H)          (I)             (J)     (K)      DATE         (M)
  T EN   DRUG                          BEGIN    END      REC       LAST MOD
  A TP   PLAN ID     PLAN NAME         DATE     DATE     ADDED     DATE   USER

  A EC   S5678001  HEALTH NE/HEALTH N 01/01/09          12/27/08 12/27/08 BAT
  A EC   S5884086  HUMANA IN/HUMANA S 01/01/07 12/31/08 11/27/07 12/27/08 BAT
  A AA   S5960028  UNICARE L/MEDICARE 01/01/06 12/31/06 03/24/06 09/25/08 CV*









PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

The RP214/Inquire Part D Drug Plan screen may be used to determine which Medicare Part D drug plan the member is enrolled with and whether this was an enrollment choice or an auto-assignment by CMS. This information may be used by Contractors to determine if the member has Medicare Part D coverage so that this can be coordinated with the member's other AHCCCS benefits. AHCCCS does not cover prescriptions or the copayments when a member has Medicare Part D drug coverage.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the enrollment segment was totally inactivated.

(G) This is the enrollment type. "EC" is enrollment choice by the member. "AA" is auto-assignment to the plan by CMS (Centers for Medicare and Medicaid Services).

(H) This is the drug plan ID# for the Medicare Part D plan the member is assigned to. RF568 provides a reference table of plan IDs . This reference table will show you the full name of the Part D plan and the effective dates of the plan availability.

(I) This is the abbreviated name of the Medicare Part D drug plan.

(J) This is the begin date of the member's coverage with the specific Medicare Part D drug plan. In the example on the screen, you can see the begin and end dates of three different Medicare Part D drug plans.

(K) This is the end date of the member's coverage with the specific Medicare Part D drug plan.

(L) This is the date the record was added to the system.

(M) This is the date the particular record was last modified and how it was modified. If there is a "*CV", this record is a result of conversion. If there is a "BAT", this is record is a result of the batch process.

J. INQUIRE FYI DATA (RP215)

```
 TR: RP215 ACT: I              AHCCCS - RECIPIENT    USER-ID: MA3    10/26/10
NTR: _____________________      INQUIRE FYI DATA                     16:52:29
(PRIMARY)                                                            RP02L015
   (A)        (B)                              (C)        (D)            (E)
A12345678 BALDMAN GERM                      SEX M DOB 06/01/1982 DOD

           CRS CLIENT ID:   (F)                  TSC CLIENT ID:  (G)
         AZEIP CLIENT ID:    (H)
     (I)      (J)         (K)    (L)  (M)              (N)           (O)
    TYPE                            CHG                          LAST MOD
     ID   BEGIN DATE  END DATE   STA RSN SITE CAT  DATE ADDED     DATE    USR

   H7352  03/01/2008              A                 06/09/2010  06/09/2010 BAT
   999222 01/01/2008              A                 01/04/2008  10/03/2010 BAT
   999222 07/01/1999 12/31/2007   A                 12/22/2004  12/03/2007 BAT
```

The RP215/Inquire FYI Data screen is used to show special enrollments.. This information is used by Contractors to determine if the member is enrolled with a Medicare HMO, Children's Rehabilitative Services (CRS), AzEIP (Arizona Early Intervention Program) or TSC (Targeted Support Coordination).

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the member's Children's Rehabilitative Services client ID number, if applicable.

(G) This field was created to display the member's Targeted Support Coordination client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(H) This is the member's Arizona Early Intervention Program (AzEIP) client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(I) The type ID will show the member's special enrollment as follows.

Medicare HMO enrollment show a Type ID starting with an "H". The reference table to look up the Medicare HMO plan names is RF517.

999111 = CRS

999555 = AzEIP

999222 = TSC

(J) This is the begin date of the member's special enrollment.

(K) This is the end date of the member's special enrollment. If there is no end date, the member's enrollment in that special category continues. Members can have more than one special enrollment active at one time. In the example on the screen, the member has a Medicare HMO enrollment and TSC enrollment active.

(L) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the special enrollment segment was totally inactivated.

(M) If there is a change to the Medicare HMO enrollment, there will be a change reason in this field. Refer to RF525 for a list of change reasons.

The "Site" and "CAT" fields on this screen are no longer used.

(N) This is the date the record was added to the system.

(O) This is the date the particular record was last modified and how it was modified. This information is updated by daily/monthly electronic matches between DES and PMMIS so this field will usually show "BAT". This means that the record was updated in that the batch process.

K. INQUIRE ELIGIBILTIY AND ENROLLMENT (RP285)

```
TR: RP285 ACT: I                    AHCCCS - RECIPIENT  USER-ID: MA3 11/12/10
 NTR: _____________________  INQUIRE ELIGIBILITY AND ENROLLMENT       15:12:58
                                                                      RP02L085
 A12345678 JOHNS WILBUR                    SEX M DOB 07/18/1929 DOD
                     (A)
                    ELG          COMB BEG          COMB END
                    KEY            DATE              DATE
                    140         02/01/2009
                    587         07/01/2008        01/31/2009
                    587         10/01/2005        08/31/2007




       (B)  (C)                                        (E)      (F)
      HEALTH PLAN/     ENROLLMENT    ENROLLMENT      RATE     ENRL
      CSA/CTRT TYP (D) BEGIN DATE      END DATE      CODE     TYP     STA
      110015 19 J      10/28/2010                     2210      MA      A
      110306 13 J      07/01/2010    10/27/2010       2210      EC      A
      110088 13 J      03/16/2009    06/30/2010       2210      EC      A
      110088 13 M      03/01/2009    03/15/2009       221Z      RA      A
      010497 05 A      12/11/2008    02/28/2009       3618      RE      A
 PF: 1=HLP 2=RTN 3=CLR 4=MSG              7=UP  8=DWN       10=UP  11=DWN 12=ESC
```

The Inquire Eligibility and Enrollment (RP-285) screen is used to review the combined eligibility and enrollment history for a specific member. The top half of the screen contains eligibility data and the bottom half of the screen contains enrollment information. This screen is useful to quickly reference which AHCCCS program a member is eligible for, the dates of that enrollment and their health plan.

The only entry field on this screen is the member's AHCCCS ID number. Enter the number for the member you wish to inquire about and press ENTER. The member's information will appear on the screen.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) Eligibility Key: Use RF534 to determine what each eligibility key code means. Enter the code you are looking for on RF534 and press ENTER. A full description of the code will be displayed.

(B) Health Plan: The following table lists current AHCCCS Health Plans and ALTCS Contractors:

Code	Name		Code	Name
Acute AHCCCS Health Plans			**ALTCS Contractors**	
010088	Bridgeway Health Solutions		110007	DES/Division of Developmental Disabilities
010158	AP/IPA		110049	Evercare Select
010166	DES CMDP		110088	Bridgeway Health Solutions
010254	Care 1st		110306	Mercy Care Plan LTC
010299	PHP/Community Connection		190000	Native American Community Health
010306	Mercy Care Plan		190009	White Mountain Apache Tribe
010314	University Family Care		190017	Navajo Nation
010383	Maricopa Health Plan		190025	Gila River Indian Community
010497	Health Choice Arizona		190033	Tohono O'Odham Nation
999998	American Indian Health Plan		190075	Pasqua Yaqui Tribe
000850	Federal Emergency Services		190083	San Carlos Apache Tribe
002220	AHCCCS Non-Pay		190091	Hopi Tribe
003335	FFS Regular			
008040	SLMB - Part B Buy-In Only			
008050	QI1 - Part B Buy-In Only			
008690	FFS Temporary			
008715	AHCCCS QMB Only			
888886	FFS LTC (Residual)			

(C) County: Use the following table for Arizona County codes:

CODE	COUNTY
01	APACHE
03	COCHISE
05	COCONINO
07	GILA
09	GRAHAM
11	GREENLEE
13	MARICOPA
15	MOHAVE
17	NAVAJO
19	PIMA
21	PINAL
23	SANTA CRUZ
25	YAVAPAI
27	YUMA
29	LA PAZ

(D) Contract Type: RF410 displays a list of contract types. The most common contract types for Long Term Care are:

J	Long Term Care Capitated
L	Long Term Capitated Acute Care Only
P	Long Term Care Partially Capitated (for FFS members)
T	Long Term Care FFS Acute Care Only

(E) Rate Code: RF401 displays a list of rate codes.

(F) Enrollment Type: RF513 displays a list of enrollment types.

V. References

- AHCCCS Medical Policy Manual, Chapter 1200
- AHCCCS Medical Policy Manual, Chapter 1600

Appendix A
ALTCS CONTRACTOR
CASE MANAGER AFFILIATION

Purpose: The purpose of the following information is to provide the procedures to follow regarding the affiliation of case managers with ALTCS Contractors. These procedures are necessary to assign case managers their 6-digit Case Manager ID#.

- Procedure One includes the steps to follow to affiliate a case manager who has never before been affiliated with an ALTCS Contractor.
- Procedure Two includes the steps to follow to affiliate a case manager who was affiliated previously with another Contractor and that affiliation is still active. The prior affiliation must be terminated before a new one can be initiated.
- Procedure Three includes the steps to follow to affiliate a case manager who was affiliated previously with a Contractor and that affiliation has been terminated.
- Procedure Four includes the steps to follow to terminate a case manager's affiliation when s/he no longer works for the Contractor.
- Procedure Five includes the steps to follow to change a case manager's name.

Procedure One
New Case Manager, Never Affiliated

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                    05/17/11
 NTR: _____________________   CASE MANAGER SEARCH                    07:54:18
                                                                     PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: _____________________________          SSN: ____________
     PROVIDER TYPE:

 SEL             NAME                          ID    STATUS     SSN       PR TYPE









 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. Search for the case manager by last name.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
NTR: ____________________  CASE MANAGER SEARCH                        07:54:18
                                                                      PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: doe_____________________           SSN: ___________
    PROVIDER TYPE:

SEL             NAME                          ID    STATUS     SSN       PR TYPE









PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

```
7338 NO MATCH FOUND FOR SEARCH CRITERIA
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
NTR: ____________________  CASE MANAGER SEARCH                        07:58:48
                                                                      PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: _____________________           SSN: 234-23-2345
    PROVIDER TYPE:

SEL             NAME                          ID    STATUS     SSN       PR TYPE









PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. If the above name search does not result in a listing for the case manager and with the SSN number displayed, press the <F6> key to go to the PR800A AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________   CASE MANAGER DEMOGRAPHICS                  08:00:10
                                                                        PR01L193
      CASE MANAGER  ID:         NAME: _______________________________ SSN: 234-23-2345



 ENROLLMENT BEGIN DATE: ___________


CORRESPONDENCE ADDRESS:
         STREET LINE 1: _____________________________
         STREET LINE 2: _____________________________
        CITY/STATE/ZIP: _____________________________ __ _____
           COUNTY CODE: __                    COUNTRY CODE: __
        BUSINESS PHONE:( ___ ) ___ - ____ EMERGENCY PHONE:( ___ ) ___ - ____
          ATTENTION TO: _____________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                       12=ESC
```

5. The case manager's Social Security Number will be transferred from the previous screen. Complete the screen as follows. For "Name", enter the case manager's last name (comma) (space) case manager's first name. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is located. For City/State/Zip, enter the program contractor office information. For County Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________   CASE MANAGER DEMOGRAPHICS                  14:37:44
                                                                        PR01L193
      CASE MANAGER  ID:         NAME: doe, john____________________ SSN: 234-23-2345


 ENROLLMENT BEGIN DATE: 03/01/2008


CORRESPONDENCE ADDRESS:
         STREET LINE 1: any program contractor_
         STREET LINE 2: 1111 w. elm st___________
        CITY/STATE/ZIP: phoenix__________          az  85034
           COUNTY CODE: 13                  COUNTRY CODE: 01
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO: _____________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                       12=ESC
```

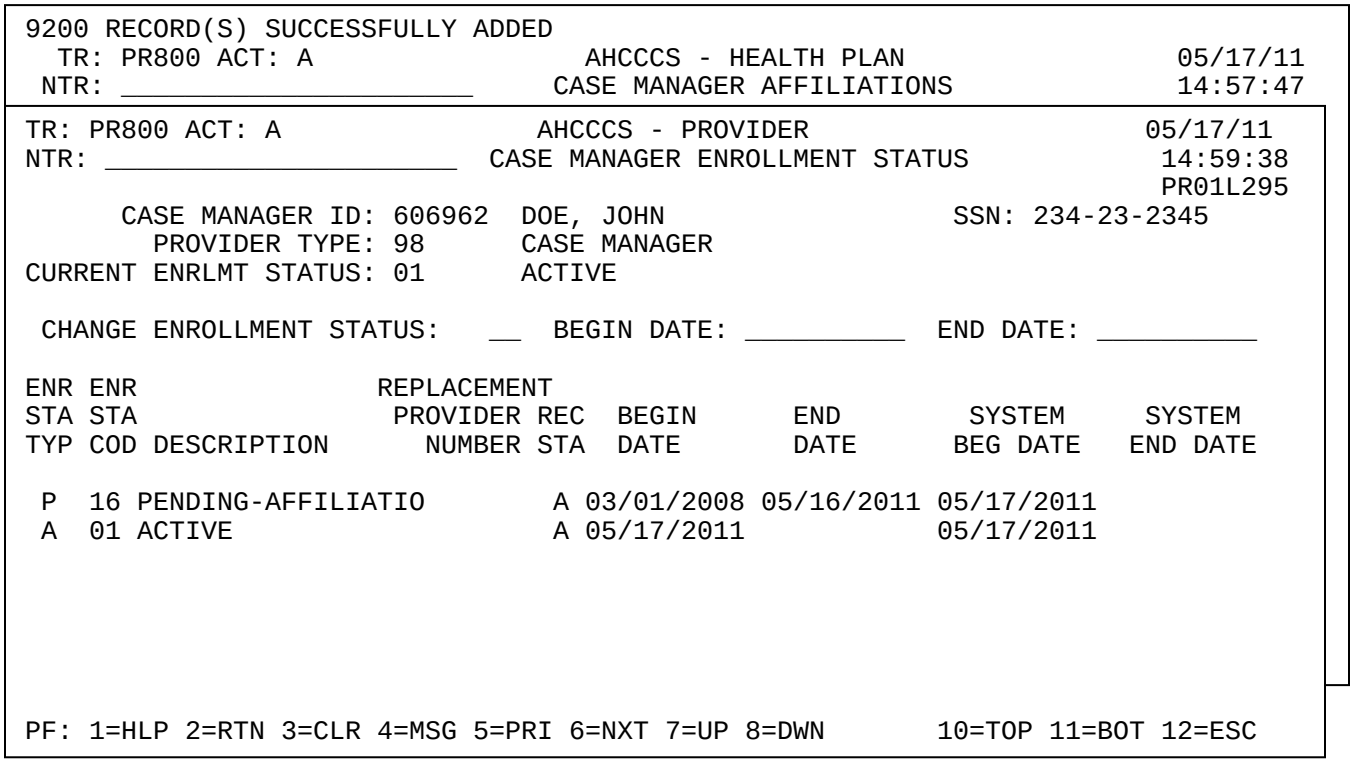
6. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED". The ID assigned to the case manager will be displayed on the screen.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR800 ACT: A               AHCCCS - PROVIDER                      05/17/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                  14:41:0
                                                                       PR01L19
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 16  PENDING-AFFILIATION MISSING


 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY PROGRAM CONTRACTOR
         STREET LINE 2: 1111 W. ELM ST
        CITY/STATE/ZIP: PHOENIX                   AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO:




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

7. Press the <F6> key to go to the PR800A AHCCCS - HEALTH PLAN CASE MANAGER AFFILIATIONS screen. For Program Contractor, enter the program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
TR: PR800 ACT: A                AHCCCS - HEALTH PLAN                  05/17/11
NTR: _____________________     CASE MANAGER AFFILIATIONS               14:56:21
                                                                       HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110007                            13                   03 01 08    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT       8=DWN                    12=ESC
```

8. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED".



9. Press the <F6> key to go to the PR800A AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

10. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

```
 TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             14:59:38
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE
```

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/1
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             15:06:3
                                                                       PR01L29
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE       BEG DATE   END DATE

 A  01 ACTIVE                    A 03/01/2008            05/17/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT 7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “A 01 ACTIVE” and for “Begin Date” the employment begin date.

12. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  05/17/11
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS           15:08:33
                                                                        HP07L190
```

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  05/17/11
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS           15:12:16
                                                                        HP07L190

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                      AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110007 LTC DD DES                 13 MARICOPA         03/01/2008




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

13. Enter the case manager ID and press the <ENTER> key. The screen will display the “Program Contractor”, “County” and “Affiliation Start Date”.

Procedure Two

Transferred Case Manager, Prior Affiliation still Active

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the above name search provides a listing for the case manager, place an “S” in the “SEL” field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
 TR: PR800 ACT: A              AHCCCS - PROVIDER                    05/23/11
NTR: _____________________  CASE MANAGER SEARCH                    15:29:15
                                                                   PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: DOE                                  SSN: ____________
    PROVIDER TYPE:

SEL             NAME                          ID     STATUS     SSN        PR TYPE

 S   DOE, JOHN                               606962    A 01   234-23-2345     98
 _   DOHANYOS, MEREDITH                      123456    A 01   000-00-0000     98
 _   DOHERTY TOM                             456789    T 30   111-22-3333     98
 _   DOLLEY, SYLVIE                          987654    T 30   222-33-4444     98
 _   DOLORES JOSSE                           654321    T 30   333-44-5555     98

PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C                AHCCCS - PROVIDER                      05/17/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                   15:29:06
                                                                        PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                SSN: 234-23-2345
      PROVIDER TYPE: 08  CASE MANAGER
```

```
TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/17/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             15:31:36
                                                                        HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: ___ __ ____
     CASE MANAGER'S NAME:
   CURRENT ENRLMT STATUS:

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                      AFFILIATION
CONTRACTOR                          COUNTY                START DATE   END DATE




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. If the PR810C screen displays a former program contractor with a current enrollment status of ***01 Active***, go to the HP014C AHCCCS - HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen.

5. Enter the case manager ID and press the <ENTER> key.

```
TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/17/1
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             15:32:4
                                                                        HP07L49
```

```
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                   05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS             14:37:40
                                                                        HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

 DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

 PROGRAM                                                     AFFILIATION
 CONTRACTOR                          COUNTY                START DATE   END DATE

 110007 LTC DD DES                   13 MARICOPA            03 01 08    04 30 11




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

6. Enter the Affiliation End Date one day prior to the employment begin date with the new program contractor.

7. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS            14:39:31
```

```
  TR: PR815 ACT: C                AHCCCS - PROVIDER                     05/23/11
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             14:40:44
                                                                       PR01L295
       CASE MANAGER ID: 606962                              SSN:
         PROVIDER TYPE:
 CURRENT ENRLMT STATUS:

  CHANGE ENROLLMENT STATUS:       BEGIN DATE:             END DATE:

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

8. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

9. For Current Enrollment Status, enter “30”. For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                     05/23/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             14:42:02
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING
```

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C                AHCCCS - PROVIDER                     05/23/11
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             14:44:00
                                                                       PR01L295
       CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                    A 03/01/2008 04/30/2011 05/17/2011
  T  30 TERMINATION-OTHER         A 05/01/2011            05/23/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Go to the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:10:50
                                                                         PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
```

```
TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:10:5
                                                                         PR01L29
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: new PROGRAM CONTRACTOR
         STREET LINE 2: 5555 E. oak ST
        CITY/STATE/ZIP: PHOENIX                  AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
          ATTENTION TO: _____________________________



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

12. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is located. For City/State/Zip, enter the program contractor office information. For County Code, enter the program contractor office county location (must agree with zip code). For Country Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR810 ACT: C               AHCCCS - PROVIDER                        05/23/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                    15:14:29
                                                                         PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: NEW PROGRAM CONTRACTOR
         STREET LINE 2: 5555 E. OAK ST
        CITY/STATE/ZIP: PHOENIX                  AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
          ATTENTION TO: _____________________________



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

14. Go to the HP014A AHCCCS - HEALTH PLAN ADD CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:16:20
                                                                      HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                          COUNTY          START DATE   END DATE

_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __
_______                             __               __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                  8=DWN                  12=ESC
```

15. For Program Contractor, enter the new program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:17:28
                                                                      HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21                   05 01 11       __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

16. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY ADDED”.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:20:11
                                                                      HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21 PINAL             05 01 11
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __
_______                           __                   __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

17. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                      05/23/1
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS              15:21:2
                                                                       PR01L29
```

```
 TR: PR815 ACT: C                AHCCCS - PROVIDER                      05/23/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS              15:21:21
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

 CHANGE ENROLLMENT STATUS:   01  BEGIN DATE: 05/01/2011  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 03/01/2008 04/30/2011 05/17/2011
 T  30 TERMINATION-OTHER         A 05/01/2011            05/23/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

18. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

19. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED". The screen will display "Enr Sta Type/Enr Sta Cod/Description" of "A 01 ACTIVE" and for "Begin Date" the employment begin date.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS            15:24:18
                                                                      PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                  SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
```

```
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                 05/23/1
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS          15:25:3
                                                                      HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                      AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21 PINAL            05/01/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

20. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key. The screen will display the "Program Contractor", "County" and "Affiliation Start Date".

Procedure Three

Reinstated Case Manager

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the above name search provides a listing for the case manager, place an “S” in the “SEL” field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                      08/22/11
 NTR: _____________________  CASE MANAGER SEARCH                      14:44:35
                                                                      PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                  SSN: ___________
     PROVIDER TYPE:

 SEL             NAME                          ID    STATUS     SSN       PR TYPE

 S   DOE, JOHN                               606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                     123456   A 01   000-00-0000    98
 _   DOHERTY TOM                            456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                         987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                          654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
  TR: PR810 ACT: C               AHCCCS - PROVIDER                     08/22/11
 NTR: _____________________  CASE MANAGER DEMOGRAPHICS                 14:43:12
                                                                       PR01L093
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN              SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 10/25/2006
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
           STREET LINE 1: EVERCARE SELECT
           STREET LINE 2: 3141 N. 3RD AVE STE100
          CITY/STATE/ZIP: PHOENIX                    AZ  85013
             COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
          BUSINESS PHONE:( 602 ) 331 - 5100 EMERGENCY PHONE:( 602 ) 745 - 7992
            ATTENTION TO:


 PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

4. If the PR810C screen displays a former program contractor with a current enrollment status of ***30 TERMINATION-OTHER***, do the following. For Enrollment Begin Date, enter the employment begin date with the new program contractor. For Street Line 1, enter the new program contractor name. For Street Line 2, enter the program contractor office address where the case manager is now located. For City/State/Zip, enter the program contractor office information. For County Code, enter the program contractor office county location (must agree with zip code). For Country Code, enter “01”. For Business Phone, enter the

case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

5. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR810 ACT: C              AHCCCS - PROVIDER                      08/22/11
 NTR: _____________________  CASE MANAGER DEMOGRAPHICS                 15:01:29
                                                                       PR01L293
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN               SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 10/01/2011
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
          STREET LINE 1: NEW PROGRAM CONTRACTOR
          STREET LINE 2: 5555 E. OAK ST.
         CITY/STATE/ZIP: PHOENIX                   AZ  85034
            COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
         BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
           ATTENTION TO: _____________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

6. Press the <F6> key to go to the HP014A AHCCCS - HEALTH PLAN CASE MANAGER AFFILIATIONS screen.

```
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 08/22/1
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:05:5
                                                                     HP07L69

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

7. For Program Contractor, enter the program contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

8. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY ADDED”.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 08/22/11
NTR: _____________________  ADD CASE MANAGER AFFILIATIONS             15:10:58
                                                                     HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

PROGRAM                                                  AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110044 NEW PROGRAM CONTRACTOR     13 MARICOPA          10 01 11     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __
_______                           __                  __ __ __     __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                 8=DWN                  12=ESC
```

9. Press the <F6> key to go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

10. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                      08/22/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             15:15:42
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                  SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR815 ACT: C                AHCCCS - PROVIDER                      08/22/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS             15:19:19
                                                                       PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                  SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 T  30 TERMINATION-OTHER         A 10/26/2007 09/30/2011 10/25/2007
 A  01 ACTIVE                    A 10/01/2011            08/22/2011









PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “A 01 ACTIVE” and for “Begin Date” the employment begin date.

12. To confirm case manager affiliation with the new program contractor, go to the HP014I AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

13. Enter the case manager ID and press the <ENTER> key. The screen will display the "Program Contractor", "County" and "Affiliation Start Date".

```
TR: HP014 ACT: I                  AHCCCS - HEALTH PLAN                  08/22/1
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS            15:25:1
                                                                        HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                      AFFILIATION
CONTRACTOR                          COUNTY              START DATE   END DATE

110044 NEW PROGRAM CONTRACTOR       13 MARICOPA         10/01/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

Procedure Four

Terminating a Case Manager

1. If the case manager's current CM ID is not known, go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen to search for the individual by last name. As shown below, the ID is displayed on this screen once the case manager is found.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                        08/22/11
 NTR: _____________________  CASE MANAGER SEARCH                        14:44:35
                                                                        PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                  SSN: ____________
     PROVIDER TYPE:

 SEL             NAME                          ID     STATUS     SSN       PR TYPE

 S   DOE, JOHN                                606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                      123456   A 01   000-00-0000    98
 _   DOHERTY TOM                             456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                          987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                           654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. If the case manager's CM ID is known, go to the HP014C AHCCCS - HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key.

```
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                  05/23/1
NTR: _____________________ INQUIRE CASE MANAGER AFFILIATIONS           15:25:3
                                                                       HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

PROGRAM                                                    AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC             21 PINAL            05 01 09




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Enter the Affiliation End Date as the day the individual's employment with the program contractor ended.

```
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  05/23/11
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS           12:22:03
                                                                      HP07L490
```

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                  09/06/1
NTR: _____________________ CHANGE CASE MANAGER AFFILIATIONS           12:30:1
                                                                      HP07L49

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

 DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

 PROGRAM                                                    AFFILIATION
 CONTRACTOR                        COUNTY                START DATE   END DATE

 110065 PINAL                      21 PINAL               05 01 09    08 31 11




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

5. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

6. For Current Enrollment Status, enter “30”. For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                       09/06/11
NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               12:33:48
                                                                        PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING

 CHANGE ENROLLMENT STATUS:   30  BEGIN DATE: 09/01/2011  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 12/13/1999 08/31/2011 12/22/1999
 P  16 PENDING-AFFILIATIO        A 09/01/2011            09/06/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

7. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta Type/Enr Sta Cod/Description” of “T 30 TERMINATION-OTHER” and for “Begin Date” the date previously entered.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C                AHCCCS - PROVIDER                       09/06/
 NTR: _____________________  CASE MANAGER ENROLLMENT STATUS               12:44:
                                                                        PR01L2
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30     TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                    A 12/13/1999 08/31/2011 12/22/1999
  T  30 TERMINATION-OTHER         A 09/01/2011            09/06/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

Procedure Five

Changing a Case Manager's Name

1. Go to the PR810C AHCCCS - PROVIDER CASE MANAGER DEMOGRAPHICS screen using the case manager's ID. Type over the existing name with the changed name.

```
TR: PR810 ACT: C                AHCCCS - PROVIDER                        10/14/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                     11:11:5
                                                                         PR01L29
      CASE MANAGER  ID: 123456 NAME: BROWN, MARY            SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                    AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY BROWN



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

2. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR810 ACT: C                AHCCCS - PROVIDER                       10/14/11
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                     11:02:15
                                                                         PR01L293
      CASE MANAGER  ID: 123456 NAME: SMITH, MARY            SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                    AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY SMITH



PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                              12=ESC
```

APPENDIX B
ALTCS Contractor ID Numbers

ID	Contractor Name
Program Contractors	
110007	DES/Division of Developmental Disabilities
110049	Evercare Select
110306	Mercy Care Plan
110088	Bridgeway Health Solutions
Tribal Contractors	
190000	Native American Community Health Center
190009	White Mountain Apache Tribe
190017	Navajo Nation
190025	Gila River Indian Community
190033	Tohono O'Odham Nation
190075	Pascua Yaqui Tribe
190083	San Carlos Apache Tribe
190091	Hopi Tribe

412 - Claims Reprocessing

Original Date: 1/12/2008
Effective Date: 10/01/2008
Revision Date: 09/01/09, 11/1/11, 07/01/2012

Staff responsible for policy: DHCM Operations

I. Purpose

This policy establishes requirements to be followed by all Acute, Arizona Long Term Care System (ALTCS), Children's Rehabilitative Services (CRS) and Behavioral Health Services (BHS) Contractors for recoupment, refund, and recovery activities.

II. Definitions

Day	Calendar day unless otherwise specified.
Provider	Any person or entity who submits a claim and receives payment for the provision of covered services to members pursuant to the provisions A.R.S. § 36-2901 et seq. or any subcontractor of a Provider delivering such services. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number utilized for claiming purposes.
Recoupment	An action initiated by the Contractor to recover all or part of a previously paid claim(s). Recoupments include Contractor initiated/requested repayments as well as overpayments identified by the Provider where the Contractor seeks to actively withdraw funds to correct the overpayment from the Provider. For purposes of this policy, a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days from the date of the recovery would be considered a recoupment. A recovery and subsequent repayment(s) of a claim with a differential greater than $50,000 that is completed within 30 days from the date of the recovery is not considered a recoupment. However, the Contractor must report such repayments to AHCCCS on a quarterly basis. The information must include the AHCCCS Member ID number, date of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

Refunds	An action initiated by a Provider to return an overpayment to a Contractor. In these instances the Provider writes a check or transfers money to the Contractor directly.
Retroactive Third Party Recovery	An action initiated by the Contractor to recover all or part of a previously paid claim resulting from the discovery of a liable party not known at the time of payment. Retroactive Third Party Recoveries only include overpayments identified by the Contractor where the Contractor seeks to actively recover funds from a liable party without the involvement of the provider.

III. Policy

A. Single Recoupments in Excess of $50,000

Prior to initiating any single recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Contractor must submit a written request for approval to the assigned AHCCCS Operations and Compliance Officer at least thirty (30) 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
    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. 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 a minimum:

    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 claim CRNs

The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment

The Contractor 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 AHCCCS. Retroactive Third Party Recoveries (as outlined in Section G) are not typically included in this section. Dependent on the size and/or volume of the recoupment request, AHCCCS reserves the right to follow the process defined in Section G.

To request approval from AHCCCS, the Contractor must submit a request in writing to the assigned AHCCCS Operations and Compliance Officer with all of the following information:

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. 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).

C. Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

Contractors must continuously track recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN have or are forecasted to cumulatively exceed $50,000 during a contract year (based on recoupment date), the Contractor must notify the assigned AHCCCS Operations and Compliance Officer at the time total recoupments are anticipated to exceed $50,000 with all of the following information:

1. A detailed letter of explanation that describes:

    a. How the need for recoupment was identified
    b. The process that will be utilized to recover the funds
    c. Methods to notify the affected Provider(s)
    d. Cumulative recoupment amount, total number of claims and range of dates for the claims being recouped

D. AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of the Agency.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating such factors as validity, accuracy, and efficiency of Contractor processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor. Any request to which no response is sent within the 30 day timeframe above will be deemed approved by DHCM.

E. Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Contractor shall have no more than 120 days to complete the project and submit the following to the assigned AHCCCS Operations and Compliance Officer:

1. Voided or replacement encounters (which must reach adjudicated status) and the appropriate associated information for all impacted encounters for recouped claims;

2. Upon completion of the recoupment project, an electronic file containing all of the following information for all recouped claims:

a. AHCCCS Member Identification number
b. Date of Service
c. Original AHCCCS CRN
d. New AHCCCS CRN
e. AHCCCS Allowed amount
f. Health Plan Allowed amount
g. Health Plan Paid amount
h. Provider Identification Number

The Contractor must submit the above information for each adjudicated encounter. Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in compliance action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of the adjudicated encounter data, AHCCCS may adjust related reinsurance payments, Title XIX or Prior Period Coverage reconciliation payments or any other amounts paid to the Contractor that are impacted by the recoupment.

F. Data Processes for Refunds

Upon receipt of refund from a Provider, the Contractor shall have 120 days from the date of the refund to void or replace related encounters. All voided or replaced encounters must reach an adjudicated status within the 120 days timeframe.

The Contractor must also be able to identify the following for all refunds received and provide this information to AHCCCS upon request:

a. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred
b. The corrective actions that will be implemented to avoid future occurrences, if applicable
c. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund
d. List of impacted claim CRNs

G. Retroactive Third Party Recovery

Contractors may engage in Retroactive Third Party Recoveries for members for which a claim was paid, *for dates of service in the current and/or prior contract years,* to determine if there are other payor sources that were not known at the time of payment. This recovery period is limited to three years after the date of service as defined in A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171). *The Contractor is prohibited from recouping related payments from providers, requiring providers to take action or requiring the involvement of providers in any way.*

Although all encounters related to these recoveries must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the Contractor may not request adjustments from, nor adjust related payment to, providers. Instead, the Contractor must submit an external replacement (adjustment) file (via an approved AHCCCS vendor with 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. The Contractor must contact the AHCCCS Encounter Unit at the completion of the recovery project for a list of approved AHCCCS vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Based upon the submitted replacement (adjustment) file data, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments if appropriate.

The Contractor must submit quarterly updates regarding retroactive third party recoveries as outlined in the Program Integrity Reporting Guide (Cost Avoidance/Recovery Report) to their assigned AHCCCS Financial Compliance Officer.

H. Attestation

All documentation and data submitted by the Contractor for purposes of recoupment and refund activities must be certified by the Contractor as specified in the Balanced Budget Act of 1997 42 CFR 438.600 et seq.. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Contractor failed to comply with any provision of this Policy, the Contractor may be subject to corrective action, up to and including sanction under the Acute Care contract, Paragraph 72 or the ALTCS contract, Paragraph 80.

IV. References

- Title 42 of the Code of Federal Regulations Part 438 Subpart H, 42 CFR 438.600 et seq.
- Title 9 of the Arizona Administrative Code, Chapter 22, Articles 6 and 7 (A.A.C. R9-22-601 et seq. and A.A.C. R9-22-701 et seq.)
- Title 9 of the Arizona Administrative Code, Chapter 28, Articles 6 and 7 (A.A.C. R9-28-601 et seq. and A.A.C. R9-28-701 et seq.)
- Acute Care contract Section D, ALTCS contract Section D, CMDP Intergovernmental Agreement Section D, BHS contract Section D.
- Arizona Revised Statute §36-2923
- Deficit Reduction Act of 2005 (Public Law 109-171)

413 - GAP-IN-SERVICES POLICY

Effective Date: April 1, 2007
Revision Date: July 1, 2010

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to all Arizona Long Term Care System (ALTCS) Contractors. This policy establishes guidelines, criteria and timeframes for the responding to and reporting of gaps in critical services for ALTCS Home and Community Based (HCBS) members. This policy is based in part by the Ball vs. Betlach (Biedess) Court decision made in Federal District Court.

II. Definitions

AHCCCSA: means the Arizona Health Care Cost Containment System Administration

Arizona Long Term Care System (ALTCS) Contractor is a contracted managed care organization, that provides long term care, acute care, behavioral health, and case management services to Title XIX eligible elderly, physically or developmentally disabled individuals who are determined to be at risk of an institutional level of care.

Ball vs. Betlach (Biedess) is a Federal class action lawsuit brought against the State of Arizona and AHCCCS in 2000 alleging violations of Federal laws. The Federal District Court has ordered that AHCCCS (via its Contractors) establish a network of contracted provider agencies adequate to ensure that critical services are provided without gaps. Furthermore, the order states that unforeseeable gaps in critical services be resolved within two hours of the gap being reported. This matter is currently under appeal by AHCCCS.

Contractor means a Managed Care Organization providing health care services to acute or long term care members and / or a Prepaid Inpatient Health Plan providing behavioral health services to eligible acute care members and / or CRS related services to eligible acute or long term care members.

Critical Services are Attendant Care, Personal Care, Homemaking and Respite care.

Contingency Plan or Back-up Plan includes information about actions that the member/representative should take to report any gaps in critical services.

Gap in Service is the difference between the number of hours of home care worker critical service scheduled in each individual's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the qualified individual.

Gap in Services Log is the form Contractors must complete on a monthly basis which records gaps in services.

Member Service Preference Level indicates how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available.

Non-Provision of Service is any time that the number of hours of home care worker critical services are not provided as scheduled**.**

Non-Provision of Service Log is the form contracted provider agencies must complete monthly on which all non provisions of services must be recorded.

Telephone Survey is a survey conducted by Contractors to all providers agencies contracted to provide services deemed as "Critical Services" verifying each contracted provider agency has availability after normal business hours, including weekends.

III. Policy

A. Non-Provision of Services Log

1. The Non Provision of Service Log (NPS Log) should be completed by the provider agency and/or Contractor:
    a) when the authorized services are not provided as scheduled
    b) when scheduled services are no longer available because a replacement caregiver cannot be found
    c) when a request for DDD nonscheduled respite is made and not met

2. Contractors will determine what fields should be completed by the provider agency and any additional instructions for the completion of the form. Contractors will need to complete any fields that the provider agency does not complete.

3. Reporting timelines will be set by the Contractor.

4. Contractors will review each NPS Log submitted by each provider agency to determine which non-provision of services meet the definition of gap in services as defined in AMPM, Chapter 1600, Case Management, Policy 1620.

5. Contractors will compile all NPS Logs submitted by each provider agency into one complete NPS Log. The complete NPS Log will be submitted to AHCCCS, ALTCS Operations by the 10th business day of the month.

6. See Attachment A for NPS Log Instructions and Form.

B. Gap In Services Log

1. Contractors must submit a completed Gap in Service Log (Gap Log) and Hours Authorized report to AHCCCS, ALTCS Operations for all gaps in critical services as defined by the AMPM Chapter 1600, Policy 1620.

2. Completed reports are to be submitted to ALTCS Operations by close-of-business on the 10th business day of the month following the reporting month – e.g., if report is for critical gaps in service for January, the report must be received by COB on the 10th business day of February.

3. See Attachment B for Gap In Service Log and Authorized Hours Log Instructions and Form.

C. Telephone Survey

1. Each Contractor must conduct Telephone Surveys verifying that each of their contracted provider agencies of critical services has availability after normal business hours, including weekends. A provider agency is determined to be available to address a member's potential gap in critical services if they immediately answer the phone call or return the phone call within 15 minutes.

2. Surveys must be conducted at a minimum of quarterly. A Contractor may request from AHCCCS to conduct Surveys a minimum of semi-annually if they can demonstrate 100% compliance for two consecutive quarters. AHCCCS may at anytime direct a Contractor to conduct Telephone Surveys more frequently than quarterly.

3. Completed Surveys are to be submitted to ALTCS Operations by close of business on the 10th business day of the month following the end of the quarter – e.g., for quarter ending March 31, 2010 Surveys would be due April 14, 2010.

4. See Attachment C for Telephone Survey form and instructions.

IV. References

- Ball vs. Biedess Court Order
- AHCCCS ALTCS Contract, ¶16, Case Management; ¶28, Network Development
- AMPM Chapter 1600, Case Management

I. INSTRUCTIONS FOR COMPLETING THE NPS LOG

The Non-Provision of Services (NPS) Log form should be completed by the Provider/Agency and/or Program Contractor. An NPS takes place anytime a service that has an open authorization does not occur at the time authorized and for the amount of hours authorized. Examples of NPS are

- when the authorized services are not provided at the time scheduled
- when scheduled services are no longer available because a replacement cannot be found
- when a request for DDD nonscheduled respite is made and not met
- When a member is not home due to a hospitalization

Note: Non-Provision of Services are not limited to the examples above.

Program Contractors will determine what fields should be completed by the Provider/Agency and any additional instructions for the completion of the form. Program Contractors will need to complete any fields that the Provider/Agency does not complete. Reporting timelines will be provided by the Program Contractors.

If you have any questions please call your respective ALTCS Program Contractor.

II. NPS

Column # Instruction/Explanation

0. **Program Contractor ID #** - Program Contractor fills in column with identification number 110306, 110049, etc.
1. **Provider Registration Number** - Provider's AHCCCS Identification numbers. Column to be filled in by Provider or Program Contractor. Please ensure that this Column is completed.
2. **Date Called In** - The date the Agency was notified of the NPS. Use the following format 02/01/05.
3. **Time Called In** - The time the Agency was notified. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
4. **NPS Date** - The date the NPS occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format 11/01/04.
5. **Time Service Scheduled to Begin** - Insert the time the service was regularly scheduled to begin. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
6. **County Code** - The County of **residence** code from the following chart:

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

7. **Member's Name** - List consumer's name, last name, first name and middle initial – Jones, Mary J.

8. **Member's Zip Code** - Member's Zip Code – this column can be filled in either by the Program Contractor or the Provider.

9. **Member's AHCCCS ID** - List consumer's AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** - Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service i.e., personal care and homemaker. Please list member's name twice and use a separate line to record the second service.

Service type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

11. **Member Service Preference Level at the time of notice** – Agencies shall obtain from the member/representative the Member Service Preference Level at time the Provider/Agency either receives a call from consumer advising of a NPS or the Provider/Agency contacts the member/representative. The Member Service Preference Level is a designation of how quickly the member chooses to have a service gap filled if the scheduled caregiver of that critical service is not available. The member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.

    Insert the Member Service Preference Level as indicated by the member/representative at the time the Provider/Agency makes contact with the member. Column to be filled in by Agency/Provider.

Member Service Preference Level	___
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

12. **Member Service Preference Level** at time of last Case Manager's visit - Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by Program Contractors.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

13. **Reason for the NPS** - List the reason the non-provision of services occurred. Use the corresponding numerical bullet only. Use #8, only when a non-scheduled respite service has been requested and the Agency does not have a caregiver available. Provide a brief explanation in Column 22, "Comments", if "Other" is used.

Reason for non-provision of service	
Caregiver Cancelled	1
Caregiver Did Not Show	2
Caregiver Left Early	3
Caregiver refuses to go or return to an unsafe or threatening environment at the member's residence	4
Caregiver quit	5
Member not available to receive services when caregiver arrives at the scheduled time	6
Replacement caregiver not available	7
Non scheduled respite service request	8
Member refuses services	9
Member called to cancel/reschedule services	10
Other	11

III. RESOLUTION

14. **Explain how NPS was resolved** - List how the NPS was met on the day of the NPS. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer's church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the Agency can get another caregiver to the home use "H".

Explain how NPS was resolved	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D
Unpaid Caregiver	E
Unpaid Community Organization	F
Other	G
Unpaid/Paid Caregivers	H

Note: 1) If an "E", "F" or "H" is recorded in Column 14, then Column 21 must be completed.
2) If "G" is used then an explanation must be included. Begin explanation(s) of "Other" in column 22, "Comments". A "G" should not be used to indicate that no services were provided. If no services are provided leave the column blank.

15. **Original Hours Authorized** - The amount of hours authorized by the Case Manager for the date of the NPS being reported.

16. **Hours provided to resolve NPS on the day of the NPS**- Number of hours provided by all entries in Column 14 above to meet member's needs. For example, Case Manager authorized 8 hours for attendant care services; Agency was able to get a replacement caregiver to provide 6 hours and Unpaid Caregiver

provided 2 hours until replacement arrived so a total of 8 hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services replaced** - Time to resolve NPS in service hours – i.e., the time between the Agency/Contractor notification and the delivery of service. Please record time to resolve NPS in hours– a half day as 12 hours; 1 day as 24 hours; the next once a week scheduled visit as 168 hours.

    For example:

    A. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was "1" – Within 2 hours. The Agency was able to get a substitute caregiver to the member's home by 9:30 AM. Column 17 should record the length of time to resolve the NPS as 1 hour.
    B. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM regularly scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The Agency is able to have a substitute caregiver there at 8:00 AM Wednesday morning. Column 17 should record the length of time to resolve the NPS as 23.5 hours.
    C. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM once a week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the NPS as 167.5 hours.

18. **Was Member Service Preference Level Timeline Met** - Place a Y (Yes) or N (No) to indicate if the NPS was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. **The clock on the NPS begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. NOTE: if an "N" is recorded in Column 18, then Column 19 must be filled out.**

19. **If Member Service Preference Level Timeline Not Met** - List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in column 22, "Comments".

If Member Service Preference Timelines not met explain why	
Reserved (Do Not Use)	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

20. **If total Authorized Hours not replaced explain why -** List the reason the total authorized units not replaced. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in column 22, "Comments".

If total hours were not replaced explain why	
Full replacement hours not needed	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of NPS	4
Other	5

21. If Unpaid Caregiver used, explain why – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an "E", "F" or "H" used in Column 14 then Column 21 must be completed. For example, the Agency is notified that the caregiver cancelled, the Agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if "Other" is used in column 22, "Comments".

If Unpaid Caregiver used, explain why	
Consumer Choice	1
No Agency Staff Available	2
Other	3

Attachment A-1 NON-PROVISION OF SERVICE GAP LOG (Revised 4/1/2007)

Provider Name:

Program Contractor:

														RESOLUTION								
										(10)	*(11)*	*(12)*	*(13)*	*(14)*					*(19)*	*(20)*	*(21)*	*(22)*
0		*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	Select from the following authorized service type	Member Service Preference Level at Time of Notice (Agency)	Member Service Preference Level (Program Contractor)	Reason for the NPS	Explain How NPS was Resolved	*(15)*	*(16)*	*(17)*	*(18)*	If Member Service Preference Timeline not met explain why:	If total Authorized Hours not replaced explain why:	If unpaid Caregiver used explain why:	To be completed when an explanation is required.
Program Contractor ID #	Provider Registration Number	Date Called In	Time Called In	NPS Date	Time Services Scheduled to Begin	County Code	Member's Name	Member's Zip Code	Member's AHCCCS ID	A. Attendant Care B. Homemaker C. Personal Care D. Respite	1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	1. Caregiver cancelled 2. Caregiver did not show 3. Caregiver left early 4. Caregiver refuses to go or return to an unsafe or threatening environment 5. Caregiver quit 6. Member not available to receive services when caregiver arrives at scheduled time 7 Replacement caregiver not available 8. Non-scheduled respite services not available 9. Member refuses service 10. Member called to cancel/reschedule services 11. Other	A. Attendant Care B. Homemaker C. Personal Care D. Respite E. Unpaid Caregiver F. Unpaid Community Organization G. Other (explain) H. Unpaid/Paid Caregivers	Original Hours Authorized	Hours Provided to Resolve NPS	Length of Time Before Services Provided	Was Member Service Preference Level Timeline Met - Y/N	1. Reserved 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of NPS 5. Other (explain)	1. Full replacement hours not needed 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of NPS 5. Other (explain)	1. Consumer Choice 2. No Agency staff available 3. Other	Comments

I. INSTRUCTIONS

Program Contractors must submit a completed Gap in Service Log (Gap Log) and Hours Authorized report to AHCCCS, ALTCS Operations for all gaps in critical services as defined by the AMPM Chapter 1600, Policy 1620. Completed reports are to be submitted to AHCCCS, ALTCS Operations by the 10th business day of the month following the reporting month.

II. GAP

Column # Instruction/Explanation

0. **Program Contractor ID #** - Program Contractor fills in column with identification number 110306, 110049, etc.
1. **Provider Registration Number** - Provider's AHCCCS Identification numbers. Column to be filled in by Provider or Program Contractor. Please ensure that this Column is completed.
2. **Date Called In** - The date the Agency was notified of the gap in service. Use the following format 02/01/05.
3. **Time Called In** - The time the Agency was notified. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
4. **Gap Date** - The date the gap in service occurs. This date may be the same as the date in column 1 or the consumer may have waited to call. Use the following format 11/01/04.
5. **Time Service Scheduled to Begin** - Insert the time the service was regularly scheduled to begin. **Use military time** i.e., 08:00, 13:30, etc. Please round to the nearest 15-minute increment.
6. **County Code** - The County of **residence** code from the following chart:

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

7. **Member's Name** - List consumer's name, last name, first name and middle initial – Jones, Mary J.

8. **Member's Zip Code** - Member's Zip Code – this column can be filled in either by the Program Contractor or the Provider.

9. **Member's AHCCCS ID** - List consumer's AHCCCS Identification Number – A12345678.

10. **Select from the following authorized service type** - Select what service the consumer was to receive and list the corresponding alphabetical bullet in Column 10. A consumer may be receiving more than one service i.e., personal care and homemaker. Please list member's name twice and use a separate line to record the second service.

Service type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

11. **Member Service Preference Level at the time of notice** - Insert the Member Service Preference Level as indicated by the member/representative at the time the Provider/Agency either receives a call from consumer advising of a gap in service or the Provider/Agency contacts the member/representative to discuss the member's current needs. Agencies shall obtain from the member/representative the Member Service Preference Level at time of service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now. Column to be filled in by Agency/Provider.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

12. **Member Service Preference Level** at time of last Case Manager's visit - Insert the Member Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by Program Contractors.

Member Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

13. **Reason for Service Gap** - List the reason the gap in service hours occurred. Use the corresponding numerical bullet only. **#4 should be used only when there is an ongoing NPS/gap in service**. Provide a brief explanation in Column 22 if "Other" is used.

Reason for service gap	
Caregiver Cancelled	1
Caregiver Did Not Show	2
Care Giver Left Early	3
Replacement Caregiver Not Available	4
Reserved	5
Other	6

III. RESOLUTION

14. **Explain how gap was resolved** - List how the gap was met on the day of the gap. If services are not provided on the day of the gap regardless of the reason (i.e., member chose next scheduled visit) the column will be blank. Use the corresponding alphabetical bullet only. Unpaid Community Organization could be the consumer's church or civic organization. Unpaid Caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the Agency can get another caregiver to the home use "H". See scenario #2.

Explain how gap was resolved	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D
Unpaid Caregiver	E
Unpaid Community Organization	F
Other	G
Unpaid/Paid Caregivers	H

Note: 1) If an "E", "F" or "H" is recorded in Column 14, then Column 21 must be completed.
2) If "G" is used then an explanation must be included. Provide an explanation of "Other" in Column 22. A "G" should not be used to indicate that no services were provided. **If no services are provided leave the column blank.**

15. **Original Hours Authorized** - The amount of hours authorized by the Case Manager for the date of the gap.

16. **Hours provided to resolve gap on the day of the gap** - Number of hours provided by all entries in Column 14 above to meet member's needs. For example, Case Manager authorized 8 hours for attendant care services; Agency was able to get a replacement caregiver to provide 6 hours and Unpaid Caregiver provided 2 hours until replacement arrived so a total of 8 hours should be recorded. Note: If Column 16 is less than the number of hours authorized in Column 15, then Column 20 must be completed.

17. **Length of time before services provided** - Time to resolve gap in service hours – i.e., the time between the Agency/Contractor notification and the delivery of service. Please record time to resolve gaps in hours – a half day as 12 hours; 1 day as 24 hours; next once a week scheduled visit as 168 hours.

For example:

A. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM scheduled service. The Member Service Preference Level indicated by the member/representative at the time of the call was 1 – Within 2 hours. The Agency was able to get a substitute caregiver to the member's home by 9:30 AM. Column 17 should record the length of time to resolve the gap in service as 1 hour.
B. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM regularly scheduled Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The Agency is able to have a substitute caregiver there at 8:00 AM Wednesday morning. Column 17 should record the length of time to resolve the gap in service as 23.5 hours.
C. the Agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM once a week Tuesday services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the gap in service as 167.5 hours.

18. Was Member Service Preference Level Timeline Met - Place a Y (Yes) or N (No) to indicate if the service gap was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11. **The clock on the service gap begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide services. NOTE: if an "N" is recorded in Column 18, then Column 19 must be filled out.**

19. If Member Service Preference Level Timeline Not Met - List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation in Column 22 if "Other" is used.

If Member Service Preference Timelines not met explain why	
Reserved	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of service gap	4
Other	5

20. If total Authorized Hours not replaced explain why - List the reason the total authorized units not replaced on the day of the gap. Use the corresponding numerical bullet. Provide a brief explanation if "Other" is used in Column 22.

If total hours were not replaced explain why	
Full replacement hours not needed	1
Consumer Choice	2
Unable to find replacement	3
Not alerted of service gap	4
Other	5

21. If Unpaid Caregiver used, explain why – Use corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an "E", "F" or "H" used in Column 14 then Column 21 must be completed. For example, the Agency is notified that the caregiver cancelled, the Agency calls the member/representative to determine the Member Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states they wish to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if "Other" is used in Column 22.

If Unpaid Caregiver used, explain why	
Consumer Choice	1
No Agency Staff Available	2
Other	3

22. **Explanation Column –** Complete this column when an explanation is required**.**

Authorized Hours Worksheet – (See tab at bottom of Excel page) The Program Contractor must report monthly the total hours of authorized services by service provided on the second sheet of the Service Gap Log. Please do not modify the worksheet as any modifications interfere with the analysis.

(a) Month	*(b) Program Contractor ID Number*	*(c) Attendant Care*	*(d) Personal Care*	*(e) Homemaking*	*(f) Respite*	*(g) TOTAL*
Insert Previous Month (Jan.)	123456	65,266	585	1,579	0	67,430
Insert Current Month (Feb.)	123456	67,422	531	1,804	0	69,757

(h) Month	*(i) # of HCBS In-Home Members as of the last day of the month*	*(j) # of Gap Hours Reported*	*(k) Hours Provided to Resolve Gap*	*(l) Average Gap Hours Per Member*	*(m) Total Authorized Hours*	*(n) % of Gap Hours to Authorized Hours*
Previous Month (Jan.)	500	125	87	25	67,430	.19%
Current Month (Feb.)	490	91	69	19	69,757	.13%
(o) % of Variance to Current	<2%>	< 37%>	<26%>	<32%>	3.34%	<46%>

(a) Previous Month: This row should contain the name of the previous month's data. i.e., January.
Current Month: This row should contain the name of the current month's data, i.e., February.

(b) Program Contractor ID Number: List Program Contractor identification number from Column 0 on the Gap in Service Log.

(c) Attendant Care: List the total number of attendant care hours authorized for the previous and current months.

(d) Personal Care: List the total number of personal care hours authorized for the previous and current months.

(e) Homemaker: List the total number of homemaker hours authorized for the previous and current months.

(f) Respite: List the total number of respite hours authorized for the previous and current months.

(g) Total: List the totals of Columns (c), (d), (e) and (f).

(h) Previous Month: This row should contain the name of the previous month's data. i.e., January.
Current Month: This row should contain the name of the current month's data, i.e., February.

(i) # of HCBS In-Home Members as of the Last Day of the Month: List the total number of in-home HCBS members for the month you are reporting on the appropriate line; i.e., January and February

(j) # of Gap Hours reported: List the total hours reported in column 15 (Original Hours Authorized) of the Gap in Service Log.

(k) Hours Provided to Resolve Gap: List the total of hours reported in column 16 (Hours Provided to Resolve Gap) of the Gap in Service Log.

(l) Average GAP Hours Per Member: The total number of gap hours (j) divided by the # of HCBS in-home members (i).

(m) Total Authorized Hours: List the totals from column g above.

(n) % of Gap Hours to Authorized Hours: The total of gap hours reported (j) divided by the total hours authorized (m).

(o) % of Variance to Current: The difference between the previous month's information and the current month's information divided by the current month's data. **Provide comments/explanations of variances that may need clarification at the bottom of the Excel sheet.**

NOTE: Please bracket all negative numbers as shown in the example.

Authorized Hours Worksheet - (See tab at bottom of Excel page) The Program Contractor must indicate on the line on the second page of the Service Gap Log that it has received from each contracted provider a report or acknowledgement that they have had no gaps in service for the reporting month. If no report or acknowledgement is received, the Program Contractor must send, under separate cover, an explanation of why no report or acknowledgement was received.

_____Yes/No - All Contracted Providers Reporting; If No, Provide Explanation Under Separate Documentation

Service Gap Scenarios **See Service Gap Tracking Log for recording of scenarios.**

Scenario 1:

History: J. Smith, with quadriplegia lives at home alone and requires services in the morning and evening. Consumer has limited to minimal informal support systems.

Assessment/
Authorized: Case Manager has assessed and authorized a total of 6 hours of attendant care to be split 3 hours in the morning and 3 hours at night, to begin at 8:00 AM and 7:00 PM, seven days a week. Member Service Preference Level indicated by the member/representative was a Level 1 and the Agency has been notified.

Situation: At 8:00 AM the caregiver calls the Consumer and then calls the Agency letting both know that they will be unable to work today. Agency calls Consumer to discuss situation and member indicates immediate priority needs. (Agencies shall obtain from the member/representative the Member Service Preference Level at time of service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now.)

Resolution: Agency is able to obtain another caregiver and has them at the Consumer's home at 10:00 AM and will provide 2 hours of personal care services. The replacement morning caregiver will also be able to cover the 3 hour evening shift therefore; a gap is not recorded for the evening shift because it was resolved before the scheduled time service was to begin.

Scenario 2:

History: T. Jones is an older person with dementia who tends to wander and cannot be left alone. Consumer lives with his son. The son works outside of the home.

Assessment/
Authorized: Case Manager has assessed and authorized a total of 9 hours of attendant care six days a week. Caregiver is scheduled to begin at 7:00 AM. Member Service Preference Level indicated by the member/representative was a Level 1 and the Agency has been notified.

Situation: At 7:30 AM the caregiver calls to say they will be unable to work today. The Agency calls the Consumer's son to discuss the situation and the son indicates immediate priority needs. The son is not part of the Contingency Plan due to his employment outside of the home.

Resolution: The Agency makes several calls to try and find another caregiver. At 8:30 the Primary Agency calls the Program Contractor and informs them they can not find a replacement caregiver. The Program Contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member's home at noon. The son then stays with his father until the replacement caregiver arrives. Total number of service hours received from both paid and unpaid are 9 (5 unpaid caregiver and 4 by paid caregiver) therefore, an "H" is recorded under column 14.

Scenario 3:

History: M. Brown is married and lives with his elderly spouse. The spouse is unable to assist with most personal care however is able to assist with simple meals and the urinal. The Browns are a Spanish speaking family who live 30 miles from town. The Browns would prefer Spanish speaking caregivers.

Assessment /Authorized: Case Manager has assessed and authorized 2 hours of personal care 7 days a week and 2 hours of homemaker services Monday, Wednesday and Friday. Personal care hours are to begin at 7:30 AM and homemaker hours at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 2 because of the Personal Care service. The spouse can get the member simple meals and is able to assist with the urinal. The member has indicated that when a Homemaker is not available the service can be delayed until the next scheduled visit.

Situation: Personal Care Worker called the Agency at 7:30 AM on Wednesday and lets the Agency know they won't be in to work. The Agency calls the Consumer to discuss the situation pertaining to Personal Care services and member confirms his Service Preference Level as a Level 2. The Homemaker calls the Agency at 11:00 AM on Wednesday to let the Agency know they wouldn't be in to work. The Agency calls the member and discusses the Homemaker needs. The Member Service Preference Level is indicated by the member to be a Level 4 – Next Scheduled Visit.

Resolution: The Agency only has a non-Spanish speaking Personal Care worker available. That worker is sent to the member's home at 10:30 AM for 2 hours of care. The family refuses the caregiver because of the language issue and calls the Primary Agency. The Agency calls the Program Contractor and informs them they can not find a Spanish speaking replacement caregiver. The Program Contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member's home at 1:00 PM. The time recorded in column 17 to resolve the gap in Personal Care services is 5.5 hours. On a separate line the hours recorded in Column 17 for the resolution of Homemaker services is 48 hours.

NOTE: **As no Homemaker services were provided until the next scheduled visit Column 14 is blank. Column 20 now shows a "2" as member chose not to receive Homemaker services until the next scheduled visit.**

Scenario 4:

History: S. White is married and lives with her elderly spouse. The spouse is unable to do housework, shopping, laundry, etc.

Assessment/ Authorized: Case Manager has assessed and authorized 2 hours of Homemaker services Monday, Wednesday and Friday beginning at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4 for Homemaker.

Situation: At 11:30 on Wednesday the member calls the Agency to report the homemaker has not shown up. While on the phone, the Agency and the Whites discuss the situation. The Whites explain that the homemaker always goes grocery shopping for them on Wednesdays and they can't wait until Friday for the service. The Member Service Preference Level is currently indicated as Level 2.

Resolution: The Agency is able to have a homemaker out to the Whites at 4:30 PM the same day. The time recorded in Column 17 is 5 hours.

Scenario #5:

Situation: The member is to receive attendant care services 3 times a week for 6 hours a day. Caregiver shows up at the regularly scheduled time and the member did not answer the door. The caregiver made a reasonable attempt to verify that the member was not home (i.e. looked in windows, checked with a neighbor, called the member's telephone number, etc.) The caregiver notified their agency who instructed them to wait 15 minutes before leaving.

Resolution: The provider agency records this on the Non-Provision of Service Log and would indicate 6 (Member not available to receive services when caregiver arrives at scheduled time) in column 13. Because this is not a gap in services, Program Contractors would not record this on the Gap In Service Log submitted to AHCCCS.

Scenario 6:

History: J. Johnson lives with her son who works outside the home. The son performs her morning and evening care. All the member requires is assistance with housekeeping.

Assessment/
Authorized: Case Manager has assessed and authorized 2 hours of homemaker services twice a week. Services are scheduled Tuesdays and Thursdays beginning at 10:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4.

Situation: At 10:15 AM on Tuesday the member calls the Agency and states that the homemaker did not show up. The Agency discusses the situation with the member who indicates the Member Service Preference Level is Level 4. The Agency calls the homemaker and finds out the homemaker has been in an accident and is no longer available and they do not have another homemaker available today or in the foreseeable future. The Agency calls the Program Contractor and advises them of the situation.

Resolution

The Program Contractor contacts other contracted providers in their network and is unable to find a replacement caregiver for today from any of them. All agencies will continue to look for a replacement caregiver for as soon as possible. On Friday, a provider agency (not the original agency) contacts the Program Contractor to report having found a replacement caregiver for this member to begin at 10:00 AM that day. This caregiver will only be available for one week while the member she usually takes care of is out of town. The Program Contractor contacts the original provider agency to advise them the non-provision of services has been temporarily resolved so this does not continue to be recorded on the log. At the end of the week when the replacement caregiver is no longer available for the member neither the original nor any of the Program Contractor's other provider agencies are able to find another replacement caregiver. One month later a replacement caregiver has still not been found. Program Contractor, Agencies continue to look for a caregiver. The Case Manager continues to discuss with the member alternative service/placement options to meet her needs. Member chooses to remain in her son's home. The Case Manager and the member develop a Managed Risk Agreement.

Scenario 7:

History: Ms. Brown is a 48 year old member with MS who lives alone but has friends in her home frequently. Member has had numerous caregivers and agencies providing her care over the last several months. The current agency is the last of the Program Contractor's contracted providers who is willing to serve this member.

Assessment/
Authorized: Case Manager has assessed and authorized 5 hours per day of Attendant Care, 7 days/week. Member Service Preference Level is 2

Situation: Member's current caregiver arrives at member's home at scheduled time and finds member and a few friends actively using illegal drugs. This is not the first time this has occurred. The caregiver does not feel the situation is safe for her so she advises the member that she can not stay to provide care. One of member's friends becomes verbally aggressive towards caregiver so she immediately leaves the home. She drives away from the home and calls her employer agency to inform them of the situation. The provider contacts the Program Contractor to inform them that they are no longer willing to send a caregiver into this unsafe setting.

Resolution: The case manager contacts the member to inform her that as a result of the drug activity in her home, they are unable to find a caregiver for the member today and it is not known when another caregiver will be found. The next day the case manager and her supervisor visit the member in her home to update her Managed Risk Agreement which outlines what the barriers to care are and the potential consequences if the member's behaviors/choices continue. This is recorded on the Non-provision of service log until a replacement caregiver is found. It is not a gap in service and therefore not recorded on the Gap In Service Log.

Attachment B-1 SERVICE GAP LOG (Revised 02/12/2007)

Provider Name:

Program Contractor:

0	*(1)*	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*	*(13)*	*(14)*	*(15)*	*(16)*	*(17)*	*(18)*	*(19)*	*(20)*	*(21)*	*(22)*
														RESOLUTION								
Program Contractor ID #	Provider Registration Number	Date Called In	Time Called In	Gap Date	Time Services Scheduled to Begin	County Code	Member's Name	Member's Zip Code	Member's AHCCCS ID	Select from the following A. Attendant Care B. Homemaker C. Personal Care D. Respite	Member Service Preference Level at 1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	Member Service Preference Level 1 - Within 2 hrs 2 - Services today 3 - Within 48 hrs 4. Next scheduled visit	Reason for Service Gap 1. Caregiver cancelled 2. Caregiver did not show 3. Care Giver Left Early 4. Replacement caregiver not available 5. Reserved 6. Other	Explain How Gap was Resolved A. Attendant Care B. Homemaker C. Personal Care D. Respite E. Unpaid Caregiver F. Unpaid Community Organization G. Other (explain) H. Unpaid/Paid Caregivers	Original Hours Authorized	Hours Provided to Resolve Gap	Length of Time Before Services Provided	Was Member Service Preference Level Timeline Met - Y/N	If Member Service Preference Timeline not met explain why: 1. Reserved 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of service gap 5. Other (explain)	If total Authorized Hours not replaced explain why: 1. Full replacement hours not needed 2. Consumer Choice 3. Unable to find replacement 4. Not alerted of service gap 5. Other (explain)	If unpaid Caregiver used explain why: 1. Consumer Choice 2. No Agency staff available 3. Other	To be completed when an explaination is required
XXXXXX	111111	12/10/04	8:00	12/10/04	8:00	13	Smith, J	XXXXX	A11111111	A	1	1	1	A	3	2	2	Y		1		
XXXXXX	222222	12/15/04	7:30	12/15/04	7:00	19	Jones, T	XXXXX	A22222222	A	1	1	1	H	9	9	0	N	3		2	
XXXXXX	333333	12/20/04	7:30	12/20/04	7:30	3	Brown, M	XXXXX	A33333333	C	2	2	1	C	2	2	5.5	Y				
XXXXXX	333333	12/20/04	7:30	12/20/04	7:30	3	Brown, M	XXXXX	A33333333	B	4	2	1		2	0	48	Y		2		
XXXXXX	333333	12/30/04	11:30	12/30/04	11:00	27	White, S	XXXXX	A44444444	B	2	4	2	B	2	2	5	Y				
XXXXXX	6666666	02/13/07	10:15	02/13/07	10:00	17	Johnson, J	XXXXX	A6666666	B	4	4	2		2		96	N	3	3		
XXXXXX	6666666	02/13/07	10:15	02/15/07	10:00	17	Johnson, J	XXXXX	A6666666	B	4	4	2	B	2	2	24	Y				
XXXXXX	6666666	02/27/07	10:00	02/27/07	10:00	17	Johnson, J	XXXXX	A6666666	B	2	4	2		2		48	N	3	3		
XXXXXX	6666666	03/01/07	10:00	03/31/07	10:00	17	Johnson, J	XXXXX	A6666666	B	2	4	2		2		744	N	3	3		

Attachment B-2

AUTHORIZED HOURS WORKSHEET:

Program Contractor:

(a)	(b)	©	(d)	(e)	(f)	(g)
Month	**Program Contractor ID Number**	**Attendant Care**	**Personal Care**	**Homemaker**	**Respite**	**Total**
Insert Previous Month (Jan)	123456	65,266	585	1,579	0	67,430
Insert Current Month (Feb)	123456	67,422	531	1,804	0	69,757

(h)	(i)	(j)	(k)	(l)	(m)	(n)
Month	**# of HCBS Members as of the last day of the month**	**# of Gap Hours Reported**	**Hours Provided to Resolve Gap**	**Average Gap Hours Per Member**	**Total Authroized Hours**	**% of Gap Hours to Authorized Hours**
Insert Previous Month (Jan)	500	125	87	25	67,430	0.19%
Insert Current Month (Feb)	490	91	69	19	69,757	0.13%
(o) %of Variance to Current	<2%>	<37%>	<26%>	<32%>	3.34%	<46%>

_____ Yes/No - Did all providers submit a NPS Report? If no, provide an explanation under separate documentation.

TELEPHONE SURVEY INSTRUCTIONS

Purpose: To determine if a Contractor's provider agencies of critcal services are available to address a member's potential gap in critical services.

Survey Instructions: Contractors are to call **all** provider agencies contracted to provide services deemed as "Critical Services". All calls conducted Monday through Friday are to be made between the hours of 8 pm and 5 am. Calls can be made on the weekends regardless of time. The calls should be split approximately 50/50 between weekdays and weekends. A provider agency is determined to be available to address a member's potential gap in critical services if they immediately answer the phone call or return the phone call within 15 minutes.

Summarize Survey Results: Contractors are to summarize results from the survey and describe any provider specific or overall corrective action plans (if any) that the Contractor may take as a response to Survey results.

Timeframe for Survey: Completed Surveys are to be submitted to ALTCS Operations by close of business on the 10th business day of the month following the end of the quarter – e.g., for quarter ending March 31, 2010 Surveys would have been due April 14, 2010.

Notes: 1) Use military time to record time called and time of response.

2) Do not modify the template

TELEPHONE SURVEY

Contractor Name: ***Date Submitted: xx/xx/xxxx***

Program Contractor ID No.	County Code	Provider Name	Provider ID No.	Phone No. 24/7 hrs/day	Date Called	Time Called	Time Call Returned	Person Returning Call	Explanation If More Than 15 Minutes to Return Call	Corrective Action Taken (if any)
110306	7	XYZ Home Care	xxxxxxxx	602-555-6787	xx/xx/xx	4:45	5:00	Jane Smith		
110003	3	ABC Home Care	xxxxxx	520-555-0845	xx/xx/xx	21:30	21:33	John Doe		
110049	15	YME Home Care	xxxxxxx	928-555-6767	xx/xx/xx	22:00	22:30	Mary Jane	Mary Jane was calling caregivers regarding another case	None

414 – NOTICES OF ACTION FOR SERVICE AUTHORIZATIONS

Effective Date: 08/01/07, 11/01/12, 03/01/13, 06/01/13
Revision Date: 08/01/08, 10/01/09, 01/01/11, 10/11/12, 02/07/13, 05/24/13

Staff responsible for policy: DHCM Medical Management

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (DBHS), Arizona Long Term Care System (ALTCS), Children's Rehabilitative Services (CRS), Comprehensive Medical and Dental Program (CMDP) and Division of Developmental Disabilities (DDD) Contractors, hence forth "Contractor".

This policy provides clarification to the Contractor's contract regarding required content of a Notice of Action (NOA) relating to coverage and authorization of services. Contractors must follow all other requirements regarding Notice of Action set forth in the AHCCCS contract.

II. Policy

When a Contractor makes a decision to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services, the Contractor shall provide a written NOA letter to the member. When a Contractor requires more information to make a decision and it is in the member's best interest, the Contractor shall provide a written Notice of Extension (NOE) letter to the member.

The NOA letter must contain, in easily understood language, the information necessary for the member to understand what decision and action the Contractor has made, and how to appeal that decision. Members must be able to understand from the NOA the reason for the action to help them decide if they want to appeal the decision, and how to best argue their case if they decide to appeal. Additionally, if the reason for the denial is a lack of necessary information, the member must be informed so that they can provide the necessary information.

The NOE letter must contain, in easily understood language, the information that the Contractor requires to make the service determination and how to grieve the NOE decision. The member must be able to understand what information is required to make the service determination so they can provide necessary information in the event they have access to the information.

Contractors must use the NOA template incorporated in this policy. The template can not be altered except for the areas designated in the letter.

Contractors must ensure that the Member Handbooks inform the members that they can complain to the Contractor about inadequate NOAs. Additionally, the Contractor must inform the member that if the Contractor does not resolve the complaints about the NOA letter to the member's satisfaction the member may complain to the AHCCCS Division of Health Care Management, Medical Management Unit.

III. Right to be Represented

Contractors must acknowledge the member's right to be assisted by a representative during an appeal, including an attorney. The Contractor's appeals process must register the existence of the third party and the Contractor must ensure that the required communications related to the appeals process occur between the Contractor and the representative. The member's representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy regulations, Contractors must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member; however, if the Contractor questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

IV. Definitions

Action — The denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.

Appeal — A request for review of an action.

Appeal Computation of Time — Computation of time for appeals is in calendar days and begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the "count" always begins on the day after the event. The due date for the appeal is the working day immediately ***after*** the last day of the "count" if the last day falls on a weekend or legal holiday. If the last day of the "count" falls on a weekday, then that weekday is the due date.

Example 1: A Notice of Appeal Resolution (NAR) received Friday 9/4. The Request for Hearing (RFH) must be filed 30 days from the date the member receive the NAR. The first

(1st) day is Saturday 9/5 and the thirtieth (30th) day is Sunday 10/4. Therefore, the due date is Monday 10/5. **Example 2:** The Notice of Appeal Resolution is received Thursday 9/3. The RFH must be filed thirty (30) days from the date the member receives the NAR. Therefore, the first (1st) day is Friday 9/4 and the thirtieth (30th) day is Saturday 10/3. Therefore, the due date is Monday 10/5. **Example 3:** The Notice of Appeal Resolution is received Wednesday 9/2. The RFH must be filed thirty (30) days from the date the member receives the NAR. The first (1st) day is Thursday 9/3 and the thirtieth (30th) day is Friday 10/2. Therefore, the due date is Friday 10/2.

Expedited Authorization Request

A request for services in which either the requesting provider indicates or the Contractor 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. In these circumstances, the authorization decision must be expedited and must be made within three (3) working days from the date of receipt of the service request.

Legal Holidays

Legal holidays as defined by the State of Arizona are: New Year's Day – January 1; Martin Luther King Jr./Civil Rights Day – 3rd Monday in January; Lincoln/Washington Presidents' Day – 3rd Monday in February; Memorial Day – Last Monday in May; Independence Day – July 4; Labor Day – 1st Monday in September; Columbus Day – 2nd Monday in October; Veterans Day – November 11; Thanksgiving Day – 4th Thursday in November; Christmas Day – December 25. When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday. Legal holiday dates for the current year are posted at: http://www.azlibrary.gov/links/holidays.cfm.

Notice of Action letter

The written notice to the effected member regarding an action by the Contractor.

Notice of Extension letter The written notice to a member to extend the timeframe for making either an urgent or standard authorization decision by up to fourteen days if criteria for a service authorization extension are met.

Receipt of a Service Authorization Request The date the Contractor receives the service request is considered the date of receipt. To calculate the time period for issuing the service authorization decision, the count begins the day after the date of receipt. For example, if a standard authorization request is received on Friday, October 5th, the first day of the 14 day period is Saturday, October 6th. The 14th day falls on Friday, October 19th. The Contractor may use electronic date stamps or manual stamping for logging the receipt. If the Contractor sub-contracts prior authorization to a delegated entity, the date the delegated entity receives the request is the date of the request.

Service Authorization Request A request from the member, their representative, or a provider for a service for the member.

Service Request Computation of Time Computation of time for standard authorization requests (both with and without extensions of time) is in **calendar** days, and begins the day after the act, event (the receipt of request), or decision and includes all calendar days and the final day of the period. The first day of the "count" always begins on the day after the event. However, if the due date for a decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the decision must be made on the day preceding the weekend or holiday. The due date for a decision is the working day immediately *prior* to the last day of the "count" if the last day falls on a weekend or legal holiday. If the last day of the "count" falls on a weekday, then that weekday is the due date. Computation of time for expedited requests is computed in **working days** and begins the day after the act, event or decision and includes all working days as defined by this Policy. **Example 1:** A standard service authorization request is filed Monday 8/24. The Contractor has fourteen (14) days to issue the decision or a NOA letter. The first (1st) day is Tuesday, 8/25 and the fourteenth (14th) day falls on Labor Day, Monday 9/7. Therefore, the due date for the NOA is Friday, 9/4, providing there is no Notice of Extension issued.

Example 2: A standard service authorization request is filed Tuesday 8/25. The Contractor has fourteen (14) days to issue a decision or a NOA. The first (1st) day is Wednesday, 8/26 and the fourteenth (14th) day falls on Tuesday 9/8. Therefore, the due date for the decision or NOA is Tuesday 9/8.

Working Days "Working Day" as defined in 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 a Contractor is closed for business the prior Friday or following Monday.

V. Notice of Action Content Requirements

A. The NOA must contain and clearly explain in easily understood language the following information:

1. The requested service;
2. The reason/purpose of that request;
3. The action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
4. The reason for the action, including factual findings about the member's condition that were the basis for the Contractor's action;
5. The legal basis for the action (citations to general provisions in the AHCCCS statute or regulations or to the Contractor's internal policy manual are not sufficient);
6. Where members can find copies of the legal basis (the local public library and the web page with links to legal authorities; when a legal authority or an internal reference to the Contractor's policy manual is available on-line, the Contractor shall provide the accurate URL site to enable the member to find the reference on-line);
7. The right to and process for appealing the decision;
8. Legal resources for members for help with appeals as prescribed by AHCCCS.

B. A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is unacceptable as a reason for the action. Use of this or similar language as a reason for an action will result in regulatory action by AHCCCS, including but not limited to civil monetary penalties per event (letter) and/or capping of enrollment. Additionally, the Contractor must also explain why a denied/reduced service is not medically necessary in language which is easily understood by the member. Refer to Section II of the Guide for examples where medical necessity is appropriately used in denying/limiting services.

C. Contractors must cite the AHCCCS Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule R9-22-213 and federal law 42 USC 1396d(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than twenty-one (21) years of age when these provisions are applicable. When the Contractor denies, reduces, or terminates services that have been requested for Title XIX members under the age of 21, the Contractor must explain why the requested services do not meet the conditions as described in this policy and the AMPM Chapter 400, Section 430. The Contractor must specify why the requested services do not meet the EPSDT criteria and are not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396(d) (a) to correct or ameliorate (make better) 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.

D. A Notice that does not explain why the service has been denied/ reduced and merely refers the member to a third person for more information is unacceptable. The NOA must state the reasons supporting the denial/reduction. The Contractor may also include a statement referring a member to a third person for more help when the third person can explain treatment alternative in more detail.

VI. Member Complaints regarding the Adequacy and/or Understandability of NOA

If a member complains about the adequacy of a NOA, the Contractor shall review the initial notice against the content requirements of this policy. If the Contractor determines that the original notice is inadequate or deficient, the Contractor must issue an amended NOA consistent with the requirements of this policy. Should an amended notice be required, the timeframe for the member to appeal and continuation of services starts from the date of the amended notice.

If the member complains to the Contractor regarding the adequacy of the amended NOA, the Contractor must promptly inform AHCCCS, the Division of Health Care Management, Medical Management Unit of the complaint. Additionally, the Contractor must inform the member of their right to contact AHCCCS, Division of Health Care Management, Medical Management Unit, if the issue is not resolved to the member's satisfaction.

VII. Timeframes for Decisions and the Notice of Action Letter

Each Contractor must meet the following timeframes for issuing a decision:

A. Standard Authorization Decision Timeframe: For standard authorization decisions, the Contractor must provide a decision as expeditiously as the member's condition warrants but no later than fourteen days from receipt of the request. The Contractor may issue a NOE of up to fourteen additional calendar days, if the criteria for a service

authorization extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday.

B. **Expedited Authorization Decision Timeframe:** For expedited authorization decisions, the Contractor must provide a decision as expeditiously as the member's health condition requires but no later than three **working** days from the receipt of the request, with a possible extension of up to fourteen additional calendar days, if the criteria for an extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday.

C. Expedited authorization request downgraded to a standard request: When a Contractor receives an expedited request for a service authorization and the requested service is not of an urgent medical nature, the Contractor may downgrade the expedited authorization request to a standard request. The Contractor must have a process included in the Contractor's policy for prior authorization that describes how the requesting provider will be notified of the downgrade and given an opportunity to disagree. The requesting provider must be allowed to send additional documentation supporting the need for an expedited authorization.

D. For **service authorization decisions not reached within the timeframes** outlined for standard or expedited requests, this constitutes a denial and is thus an adverse decision on the date that the timeframe expires. The Contractor must issue a NOA letter denying the request on the date that the timeframes expire. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. [42 CFR 404.(c) (5)]

E. When a NOE is issued, and a decision is not reached by the timeframe noted in the NOE letter, this constitutes a denial and is thus an adverse decision on the date that the timeframe expires. The Contractor must issue a NOA denying the request on the date that the timeframe expires. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday. [42 CFR 438.210 (d) (1 and 2)]

F. The Contractor must mail the notice within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least ten (10) days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 4321.213 and 214 providing exceptions to advance notice. [42 CFR 438.404 (c) (1)]
2. For standard service authorization decisions that deny or limit services, the Contractor must provide notice no later than fourteen (14) days from the receipt of the request, unless there is a NOE (refer to Notice of Extension in this Policy). [42 CFR 438.404 (c) (3)]

3. For decisions where NOEs have been sent, the Contractor must mail the notice by the end date of the NOE, not to exceed fourteen additional calendar days from the end of the standard or urgent decision timeframe, and may never exceed twenty-eight calendar days.

VIII. Notice of Extension

A. The Contractor may extend the timeframe to make a service authorization determination outlined for both the standard and urgent request when the member or provider requests an extension, or when the Contractor can justify that the need for additional information is in the member's best interest. [42 CFR 438.404] The Contractor may extend the timeframe to make a decision for a standard authorization request by up to 14 calendar days, not to exceed the 28th day from the service request date. For expedited requests, the Contractor may extend the timeframe to make a decision by up to an additional 14 calendar days.

B. If the Contractor extends the timeframe in order to make a decision, the Contractor must:

1. Give the member written notice of the reason for the decision to extend the timeframe.
2. Include what information is needed in order to make a determination.
3. Inform the member of the right to file a grievance (complaint) if he or she disagrees with the decision to extend the timeframe.
4. Make the decision as expeditiously as the member's condition and no later than the date the extension expires.

NOTE: Contractors are required to use language specific to the members' situation and service request. For examples of easily understood NOA language, please refer to the NOA Dictionary which is a resource available at the following link: AHCCCS Guide to Language in Notices of Action (NOA).

IX. Attachments

- Attachment A - Notice of Action - Letter Template
- Attachment B – Legal Services Program
- Attachment C - Guide to Language in Notices of Action
- Attachment D - Notice of Extension - Letter Template

X. References

- 42 CFR §438.210
- 42 CFR §438.404
- 42 CFR Part 438 Subpart F, Grievance System
- Arizona Administrative Code, Title 9, Chapter34
- AHCCCS/Contractor Contract
- AMPM Chapter 400
- NOA Dictionary

Attachment A:

Insert Logo Here

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it. Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX or (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF ACTION

TO: Date:

FROM:

(You or your doctor- as appropriate) have asked that (*Health Plan Name)* pay for (*describe services requested and the reason for the services in easily understood language*).

Our Decision

(*Insert action being taken here and date effective if terminating or reducing a current service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision

(*Insert the reason for the action, which must be complete and in commonly understood language. The explanation must be both member and fact specific, describing the member's condition and the reasons supporting the Contractor decision. If the reason for the denial is a lack of information, the missing info must be identified so the member has an opportunity to provide it)*

Legal Basis for Our Decision

We based our decision on (*insert correct legal citation here*).

Copies of Legal Citations can be found at the local library or at http://www.azahcccs.gov/Regulations/default.aspx.

Your Rights if You Disagree with This Decision

If you are not happy with this decision, you can ask us to look at the decision again. This is called an appeal. You can appeal by telling us over the phone or in writing. You must call us at (***Insert grievance phone number***) or write us by (***insert date, 60 calendar days after the date of this Notice. If the 60th day falls on a weekend or holiday the Contractor must use the next business day*****).**

If you are writing your appeal, please send it to (*insert Contractor mailing address here*).

You can also see your medical records and get other information about your appeal. Before we make our decision, you can give us any information that you think will be helpful. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing.

After we review your appeal, we will send you our decision in writing within 30 days of the date we received your appeal request.

If You Need a Faster Decision on Your Appeal

If you or your doctor believes that your health or ability to function will be harmed unless a decision is made in the next three days, you or your doctor can ask us for a fast review by calling us and asking for an expedited appeal. If we agree, we will decide your appeal in 3 working days. If we do not agree a fast review is needed, we will write you within 2 days, and we will also try to call you. Then, we will decide your appeal within 30 days.

Getting Help If You Want to Appeal This Decision

You can have someone help you appeal. Your doctor or other health care provider can appeal for you if you write to us giving them permission.

If you would like legal help with this decision, please contact the legal aid program in your county listed on the attached sheet.

Taking More Than 30 Days to Decide Your Appeal

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension, we will write you and tell you why it is needed and how it is helpful to you. If you want an extension, you can ask for it by writing or calling us. If an extension is given, a decision in your appeal will be made in 44 days, rather than 30 days.

Continuing Services While We Make a Decision on Your Appeal ***(Insert: "This paragraph does not apply to you" if the member has not been receiving the requested service)***

If the services you write about in your appeal are already being given to you, but are going to be cut back or stopped, you can ask that the services continue while we make a decision. If you want those services to continue, you must say so when you appeal. Your services will only be continued if you appeal by (***insert date, the later of 10 calendar days from the date of the Notice OR the intended date of the action***). If you do not win your appeal, you may be responsible for paying for these services provided during the appeal.

If you have any questions about filing an appeal or if you need help, you can call us at (*insert Contractor phone number here*).

Sincerely,

(Insert name of Decision Maker)

Attachment B: Legal Services Programs

APACHE COUNTY White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste. 15, Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958	**COCHISE COUNTY** Southern Arizona Legal Aid 2 Copper Queen Plaza, Upstairs PO Box AL, Bisbee, AZ 85603 Phone: (520) 432-1639 / 1-800-231-7106	**COCONINO COUNTY** DNA People's Legal Services 2323 E. Greenlaw Lane Flagstaff, AZ 86004 Phone: (928) 774-0653 / 1-800-789-5781
GILA COUNTY White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste.15 Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958	**GRAHAM COUNTY / GREENLEE COUNTY** Southern Arizona Legal Aid 2 Copper Queen Plaza, Upstairs PO Box AL, Bisbee, AZ 85603 Phone: (520) 432-1639 / 1-800-231-7106	**LA PAZ COUNTY** Community Legal Services 201 S. 1st Ave.Yuma, AZ 85364-2250 Phone: (928) 782-7511/ 1-800-424-7962
MARICOPA COUNTY Community Legal Services P.O. Box 21538 Phoenix, AZ 85036-1538 Phone: (602) 258-3434 / 1-800-852-9075 Community Legal Services East Side Office 20 W. First St. Suite 101, Mesa, AZ 85201 Phone: (480) 833-1442 / 1-800-896-3631	**MOHAVE COUNTY** Community Legal Services 1720 Beverly, Ste. A Kingman, AZ 86409 Phone: 928-681-1177 / 1-800-255-9031	**NAVAJO NATION** DNA – Chinle Agency Office PO Box 767, Chinle, AZ 86503 Phone: (928) 674-5242 / 1-800-789-7598 DNA – Fort Defiance Agency Office PO Box 306, Window Rock, AZ 86515 Phone: (928) 871-4151 1-800-789-7287 DNA – Hopi Legal Services PO Box 558, Keams Canyon, AZ 86034 Phone: (928) 738-2251 / 1-800-789-9586 DNA – Tuba City Agency Office PO Box 765, Tuba City, AZ 86045 Phone: (928) 283-5265 / 1-800-789-8919 Fax: (928) 283-5460 Native American Disability Law
PINAL COUNTY Southern Arizona Legal Aid 766 North Park Ave. Casa Grande, AZ 85222 Phone: (520) 316-8076 / 1-877-718- 8086	**NAVAJO COUNTY** White Mountain Legal Aid a division of Southern Arizona Legal Aid 5658 Highway 260, Ste. 15 Lakeside, AZ 85929 Phone: (928) 537-8383 / 1-800-658-7958	
PIMA COUNTY Southern Arizona Legal Aid (SALA) Southern Arizona Legal Aid, Inc.	Native American Disability Law Center Farmington Office 3535 E. 30th St., Ste. 201	

Continental Building 2343 E. Broadway Blvd., Ste. 200 Tucson, AZ 85719-6007 Phone: (520) 623-9465 / 1-800-640-9465 Tohono O'odham Legal Services a division of Southern Arizona Legal Aid P.O. Box 597, Sells, AZ 85634-0597 Phone: (520) 383-2420 / 1-800-398-0772	Farmington, NM 87402 Phone: 505-566-5880 / 1-800-862-7271 Gallup Office 207 S. Second St., Gallup, NM 87301 Phone: 505-863-7455 / 877-283-3208	Center Farmington Office 3535 E. 30th St., Ste. 201 Farmington, NM 87410 Phone: 505-566-5880 / 1-800-862-7271 Gallup Office 207 S. Second St., Gallup, NM 87301 Phone: 505-863-7455 / 877-283-3208
SANTA CRUZ COUNTY Southern Arizona Legal Aid 1071 N. Grand Ave., Suite 110 Nogales, AZ 85621 Phone: (520) 287-9441	**WHITE MOUNTAIN APACHE TRIBE** White Mountain Apache Legal Aid a division of Southern Arizona Legal Aid 116 East Oak St. or PO Box 1030 Whiteriver, AZ 85941 Phone: (928) 338-4845 / 1-866-312-2291	
YUMA COUNTY Community Legal Services 201 S. 1st Ave.Yuma, AZ 85364-2250 Phone: (928) 782-7511 / 1-800-424-7962	**YAVAPAI COUNTY** Community Legal Services 401 N. Mt. Vernon Prescott, AZ 86301 Phone: (928) 445-9240 / 1-800-233-5114	**STATEWIDE** Arizona Center for Disability Law 5025 E. Washington St; Ste # 202 Phoenix, AZ 85034 Phone (602) 274-6287 Ext. #214 Fax (602) 274-6779

General Legal Information about Your Rights & Website for Each Legal Aid Office: www.azlawhelp.org.

ARIZONA HEALTH CARE

COST CONTAINMENT SYSTEM

GUIDE TO LANGUAGE

IN NOTICES OF ACTION

OCTOBER 1, 2012

ATTACHMENT C, ACOM POLICY 414

This document is only a guide and is intended to provide examples of easily understood language. Contractors are required to use language specific to the member's situation and service request. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action letter requirements. This document is not to be relied upon for legal citations. Legal citations change regularly. The Contractor is responsible for citing the correct legal source when changes to the legal basis occur.

This document is only a guide and is intended to provide examples of easily understood language. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action. Additionally, this document is not to be relied upon for Legal citations. These change regularly and Contractors must verify that the specific regulations are correctly cited in their NOA letters.

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AHCCCS Guide to Notice of Action Letters

BACKGROUND

When an AHCCCS Contractor makes a decision to not pay for a requested service, the Contractor must notice the member, in writing, of that decision. That written notice is called a Notice of Action (NOA) letter. This guide is intended to provide examples of language for use in NOA letters, and is not intended to be a complete reference for Federal, State, and Contractual requirements regarding NOA letters.

The point of the NOA letters is to notify members of adverse decisions and provide them with the factual basis or reason for that decision, and how to appeal that decision. NOA letters must be written such that they are easy for the member to understand. Members need to understand the reason for action so that they can decide if they want to appeal the decision, and how to best argue their case if they do decide to appeal. The better the member understands the reason for the action, the more able the member will be to participate in their health care decisions.

If additional medical information is needed to make a decision, the NOA letter must be clear enough to allow the member the opportunity to provide any additional supportive information that may assist the member in receiving the requested service. The Contractor and member do not need to rely solely on the member's physician or provider to supply any additional information. If the member has information that would help in the decision process, the member should be made aware that they can supply this to the Contractor to aid in the decision. For example, if the member has some test results or therapy notes that support their need for the requested services the Contractor must accept these as additional medical documentation.

If the member files an appeal, the issues to be decided at the hearing will be based on the specific reasons given in the NOA letter. Therefore, it is critical that the NOA letter fully and clearly explain the Contractor's justification for the action. NOA letters must include the following:

a. the requested service;
b. the reason/purpose of that request in layperson terms;
c. the action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
d. the reason for the action, including member specific facts;
e. the legal basis for the action:
Citations to general provisions in the AHCCCS statute or regulations or to the Contractor's internal policy manual are not sufficient. An explanation must be provided in easily understood language.
f. where members can find copies of the legal basis; when a legal authority including an internal Contractor's policy manual is available on-line, the Contractor shall provide the accurate website link to enable the member to find the legal authority on-line.
g. the right to appeal the decision and the process for appealing the decision; and
h. legal resources for members for help with appeals, as prescribed by AHCCCS.

Contractors, via the NOA letter, must help members understand the decisions made by the Contractor. **A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is unacceptable as a reason for the action.** Use of this or similar language as a reason for an action will result in regulatory action by AHCCCS, including but not limited to civil monetary penalties up to $25,000 per event (letter) and/or capping of enrollment. If a Contractor determines that a service is not going to be paid for by the Contractor due to any of the main categories cited below, it is appropriate to cite the relevant regulation as the legal basis for the action. Citations must be accurate and specify the particular section of the law that is applied. However, the Contractor must also explain why a denied/ reduced service is not going to be paid for by the Contractor in language which is easily understood by the member. Refer to specific sections of the Guide for examples where the Contractor is appropriately denying or limiting services.

The NOA letter may not merely refer the member to a third party (e.g., the member's physician or case worker) in lieu of adequately citing in the letter the complete and accurate factual and legal bases for the denial / reduction or termination of a service. For example, simply telling the member to call their physician because a service is denied without providing the member specific reason for the denial is unacceptable.

Contractors must cite the AHCCCS Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule R9-22-213 and federal law 42 USC 1396(d)(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than twenty-one (21) years of age when these provisions are applicable. When the Contractor denies, reduces, or terminates services that have been requested for Title XIX members under the age of 21, the Contractor must explain why the requested services do not meet the conditions as described in this policy and the AMPM Chapter 400, Section 430.

As explained more fully in the guide, reasons for the denial, termination or reduction of requested medical services generally fall into one of several main categories:

I. NOT A COVERED BENEFIT OR EXHAUSTED BENEFIT;
II. NOT MEDICALLY NECESSARY;
III. OUT OF NETWORK PROVIDER;
IV. NOT ENOUGH INFORMATION TO MAKE A DECISION WITHIN THE LEGALLY REQUIRED TIME FRAME;
V. COVERAGE BY ANOTHER ENTITY;
VI. MEMBER REIMBURSEMENT; OR
VII. HOME AND COMMUNITY BASED SERVICES

In the event that more than one reason actually applies to a particular request by an individual or a provider, all applicable reasons should be given and explained in language that would be understood by a member.

Because AHCCCS may revise its rules to comply with program requirements, Contractors must continuously review and update the rules referenced in this Guide to ensure accuracy. It is incumbent upon Contractors to ensure that the rule references and the content in the actual NOA letters are accurate.

I. NOT A COVERED BENEFIT OR EXHAUSTED BENEFIT

This should only be cited as the reason in the NOA letter when the service is not available to anyone in the AHCCCS program or to anyone in the particular demographic group to which the member belongs, such as a member over the age of 21. Additionally, in general, AHCCCS benefits are driven by medical necessity and not by an absolute limit. However, there are some services that do have a limited benefit that may be exhausted.

A. ACCEPTABLE Language Examples: Not a Covered Benefit or Exhausted Benefit

1. Eyeglasses for member 21 years of age and older

Your doctor has asked that we pay for eyeglasses to help you see better.

Our decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for eyeglasses for members 21 years of age and older and if their only problem is not seeing clearly. To get eyeglasses, you must have problems seeing clearly due to surgery for cataracts. A cataract is a cloudy film on the lens of the eye. The notes from your doctor do not say you have this. Please call us at *(insert phone number)* and we will give you the names of some places that might help you get eyeglasses.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	1
EPD/LTC	1 and 2

2. Experimental Device

Your doctor has asked us to pay for a surgery to put in a (*insert device*). This is a device that will *(purpose of device).* Your doctor has asked for this because you have (*condition*).

Our decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for (*insert service)* because there is no medical proof that it will help you. That means it is experimental. Please call your doctor to talk about a different treatment.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	3
EPD/LTC	2 and 3

3. Off-Label Use of Drug

Your doctor has asked us to pay for a drug called (*insert drug).* This drug is a drug commonly used for (*insert reason).* Your doctor says you need this because (*insert reason*).

Our decision: We have reviewed the request and we will not pay for (*insert drug*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: This drug has not been approved by the Federal Drug Administration (FDA) to treat your problem. There are other drugs that have been approved by the FDA to help your problem. Some of these drugs are (*insert formulary drugs*). We have told your doctor about this. Please ask your doctor about which drug might help you.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	3
EPD/LTC	2 and 3

4. Cosmetic Surgery

Your doctor has asked us to pay for a surgery to change the shape of your nose.

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The shape of your nose does not hurt your health. That means it is cosmetic surgery. We can only pay for surgery that improves your health. Please call your doctor to talk about this.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	4
EPD/LTC	2 and 4

5. Dental Services for Member 21 Years of Age and Older

Your dentist has asked us to pay for cleaning of your teeth.

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS only pays for dental care for a medical condition for members who are 21 years of age and older. The medical condition must be acute pain, infection, or a broken jaw. The notes from your dentist do not say that your teeth are painful. The notes from your dentist do not say that your teeth are infected. Please call us at *(insert phone number)* and we will help you find low cost dental clinics.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	5
EPD/LTC	2 and 5

6. Fertility Clinic

Your doctor has asked us to pay for visits to a fertility clinic. A fertility clinic is a place where women go when they have problems getting pregnant. The notes from your doctor say that you are trying to have a baby.

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for care to help you get pregnant. Therefore, we cannot pay for this service. Please talk to your doctor about other ways to help you get pregnant.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	6
EPD/LTC	2 and 6

7. Hearing Aid for Member 21 Years of Age and Older

Your doctor has asked us to pay for a hearing aid. A hearing aid is used to help you hear better. The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for hearing aids for members who are 21 years of age or older. Please ask your doctor if there is something else that can be done for your hearing problem.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	7
EPD/LTC	2 and 7

8. Personal Care Items

Your doctor has asked us to pay for special stockings called support hose. Your doctor says you need these because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: These special stockings can help with swelling, pain in your legs, or to prevent blood clots. The notes from your doctor do not show that you have any of these problems. The stockings would be personal care items if you do not have a medical need. Personal care items are products used to clean or care for your body. Therefore, we cannot pay for these.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	8
EPD/LTC	2 and 8

9. Diapers Exceeding 240 per Month

Your child's doctor has asked us to pay for 300 diapers a month for your child. Diapers are special underwear that

help protect the skin. The doctor's notes say your child needs these because (*insert reason*).

Our Decision: We will pay for 240 diapers a month. We will not pay for 300 diapers a month.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We can only pay for 240 diapers a month unless your child has chronic diarrhea or spastic bladder. Chronic diarrhea is when you have loose, watery stools for a long time. Spastic bladder is a loss of bladder control. The notes from your child's doctor do not say that your child has these problems. We are approving 240 diapers a month.

(If this request is for someone 21 years of age or older and they have no medical need for the diapers, then add the age limitations to the legal basis: Diapers are covered for members who are over 3 years old and only until the member's 21st birthday).

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	20
EPD/LTC	2 and 20

10. Dentures

Your dentist has asked us to pay for dentures. Dentures are false teeth. Your dentist says you need these because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for dentures. Please ask your dentist if there is something else that can be done for your problem. You may be able to get dentures through a dental school or a program that helps people get dentures at a cheaper price. You can talk with your dentist about these programs. (*The health plan may choose to attach a list of the programs that offer reduced cost dental services to adults*.)

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	15
EPD/LTC	2 and 15

11. Physical Therapy Limitation

Your doctor has asked us to pay for physical therapy (PT) 3 times a week for 12 weeks. This is a total of 36 visits. PT is a set of special exercises that will help make your muscles stronger. The notes from your doctor say you need PT because (*insert reason*).

Our Decision: We will pay for 15 PT visits. We cannot pay for 36 PT visits.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: (*Insert member specific information.*) We can only pay for services that AHCCCS will pay for. AHCCCS will only pay for 15 PT visits each contract year. The contract year is from October 1 to September 30. We can pay for more PT next contract year if it helps your problem.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	22
EPD/LTC	2 and 22

12. Podiatry Services

Your doctor wants you to see (*insert doctor name*). (*Insert doctor name*) is a podiatrist. A podiatrist is a special doctor who treats foot problems. The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Arizona state law and rules do not allow AHCCCS to pay for podiatry services. Please ask your doctor if there is something else that can be done for your (insert reason).

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	23
EPD/LTC	2 and 23

B. UNACCEPTABLE Language Examples: Not a Covered Benefit or Exhausted Benefit:

1. AHCCCS does not cover services or medications for cosmetic purposes.

2. AHCCCS does not cover dental services for persons 21 years of age and over except for certain conditions.

3. Treatment for infertility is not a covered benefit under the AHCCCS program.

4. Effectiveness of this treatment has not been established (experimental).

5. This treatment is a phase II clinical trial.

II. NOT MEDICALLY NECESSARY

Medical necessity is the most common reason for denying, limiting or terminating an authorization request. All decisions regarding medical necessity must be made by a Medical Director or other qualified medical professional. It is important that up to date information be reviewed and evaluated when taking an action relative to medical necessity. Criteria for making medical necessity decisions must be available to members and providers. Contractors must notify the members regarding what information is missing that is necessary to make a determination of medical necessity. The member must be allowed to provide needed information that may help in the determination or in the member's appeal. Lack of medical necessity may be cited in several situations, including:

1. The requested service has not been shown to be effective for the member's condition;
2. The amount, duration or scope of services requested is not necessary to treat the member's condition;
3. Other less expensive, less intrusive yet equally effective services have not been tried and failed and these are required to be tried before approving this particular service; (more conservative, less invasive or less risky procedures, plain X-rays before MRIs);

4. Step therapy is required before approving requested drug therapy, including generic drugs or less expensive brand name drugs; or
5. The requested service is considered personal care.

A. ACCEPTABLE Language Examples: Medical Necessity

1. Discontinuation of a Previously Authorized Service

Your child's doctor has asked us to pay for your child's speech therapy. Speech therapy is a service that will help your child talk better. A speech therapist has been coming to your home to help your child (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for more speech therapy after *(10 days from date of letter).*

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The speech therapy notes say that your child (*insert member specific information)*. The notes also say that your child can now talk as well as other children the same age. We can only pay for services that help your child get better. Therefore, we cannot pay for more speech therapy. Please talk to your child's doctor about this.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

2. Diagnostic Testing

Your doctor has asked us to pay for Magnetic Resonance Imaging (MRI) of your (*insert body part*). An MRI is a special picture of the inside of the body. The notes from your doctor say that you need this test because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We require that you have a regular X-ray of your (*insert body part*) before getting an MRI. We also require physical therapy to see if this will help you before an MRI is done. Physical therapy (PT) is a set of special exercises that will help make your muscles stronger. Your medical records do not show that you have had an X-ray or PT. Please talk to your doctor to see if these services are right for you.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

3. Surgery

a.) Hysterectomy

Your doctor asked us to pay for a hysterectomy. A hysterectomy is a surgery to remove your womb. The doctor's notes say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: This surgery is only approved when other treatments have been tried and did not work. We can approve this surgery if the following have been met: (*insert criteria*).

Please talk to your doctor about other treatments.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

b.) Gastric Bypass:

Your doctor has asked us to pay for gastric bypass surgery. This is a surgery to help you lose weight.

The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the gastric bypass surgery.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: This surgery is only paid for when other treatments have been tried and did not work. You must try other treatments first like (*insert criteria*). These treatments are less risky and may help you without the need for surgery.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

4. Durable Medical Equipment (DME)

a.) Power Wheelchair

Your doctor has asked us to pay for a power wheelchair. A power wheelchair is a wheeled device with a motor that lets you move around. Your doctor says you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The notes from your doctor say you can walk around your house and safely use a regular (manual) wheelchair. We can pay for a power wheelchair if the following have been met: (*insert criteria*).

Please talk to your doctor about getting a regular wheelchair.

Legal/Policy Basis Table Reference

Plan Type	Example #

Acute	**9**
EPD/LTC	**2 and 9**

b.) Shower Chair

Your doctor has asked us to pay for a shower chair for you to sit on while you wash yourself. The notes from your doctor say that you want this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The notes from your doctor say you are able to stand without falling. The notes also say you do not get dizzy. We can only pay for items that help you get better. Therefore, we cannot pay for a shower chair. Please talk to your doctor about this.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	**9**
EPD/LTC	**2 and 9**

c.) Brand Name Device

Your doctor has asked us to pay for (*insert brand name device or pro*duct). This is a device used to (*insert information*). The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert brand name device or product*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We can pay for a (*insert generic device*). This does the same thing as a (*insert request name brand device)* and doesn't cost as much. AHCCCS can only pay for things that help you get better and are the least

costly. Please talk to your doctor about using a (*insert generic device*).

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

5. Genetic Testing

Your doctor has asked us to pay for genetic testing. Genetic testing uses blood tests to see what traits have been passed to a person from the parents. The doctor's notes say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision:

Facts about Your Condition or Situation that Support Our Decision: The test findings will not change the treatment for your (*insert condition and explain*). We can only pay for services that will help you get better. Therefore, we can not pay for genetic testing. Please call your doctor to talk about this.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

6. Custom Orthotics for Member 21 years of Age and Older

Your doctor has asked us to pay for custom orthotics. Custom orthotics are shoe inserts that are made special for you. The notes from your doctor say you need these because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Arizona state law and rules do not allow

AHCCCS to pay for custom orthotics for members 21 years of age and older. You are (*insert member's age*). Therefore, we cannot pay for these. You can buy inserts for your shoes at the drug store. Please talk to your doctor to see what other care can be done to help you.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	11
EPD/LTC	2 and 11

7. Specialty Referral

Your doctor has asked us to pay for you to see an allergist.An allergist is a special doctor who treats people with reactions to things found in their surroundings.

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for a special doctor at this time. You need to have tired other treatments that did not work. The notes from your doctor did not tell us you have tried other treatments. We can pay for a visit to a special doctor if the following have been met: (*insert criteria*).

Please talk to your doctor about this.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

8. Pharmacy

a.) Step Therapy

Your doctor has asked us to pay for *(insert drug).* This drug is commonly used for (*insert reason*). The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for (*insert drug*) until you have tried other drugs on our Drug List such as (*insert formulary drug*) and (*insert formulary drug*). These drugs are as good as the drug your doctor has asked for and cost less. We cannot pay for (*insert drug*) unless you have tried these other drugs and they have not worked for you. We have told your doctor about this. Please talk to your doctor about using one of these other drugs.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

b. Brand Name Medication

Your doctor has asked us to pay for a drug called (*insert drug).*This drug is commonly used for (*insert reason).* The notes from your doctor say you need this because (*insert reason).*

Our Decision: We have reviewed the request and we will not pay for (*insert drug*).

The Reasons for Our Decision:

Facts about Your Condition or Situation that Support Our Decision: This is a brand name drug. Before we will pay for a brand name drug, you must first try a generic drug. A generic drug works the same as the brand, but costs less. The generic drug you must try first is (*insert drug).* We have told your doctor that we would pay for the generic drug but your doctor has not said this is ok. Your doctor must tell us why you cannot take the generic drug.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

B. UNACCEPTABLE Language Examples: Not Medically Necessary

1. The medication prescribed for you to treat your diabetes is not on our formulary. Our records do not show your health need qualifies you to use this drug.

2. The medical information supplied does not indicate or document a sufficient need for this service.

3. We have reviewed the records from your doctor. Based on those records, the care your doctor ordered does not meet the AHCCCS standard.

4. This item is not medical in nature and therefore not needed in your medical care.

5. Medical services for incarcerated people are paid by the I incarcerating facility.

6. The information submitted by your doctor does not show you meet guidelines for approval of this request.

7. The information received from your doctor does not explain the need for your treatment.

8. Dentures are not a paid benefit of (*XYZ health plan*), unless they are shown to be medically needed. The information sent by your dentist and primary care doctor does not support the medical need for dentures at this time.

III. Out of Network Provider

AHCCCS Contractors may restrict members to services provided by in-network providers for the provision of non emergency services. Requests for services from out-of-network providers may be denied if the services are available and accessible in the Contractor's network.

A. ACCEPTABLE Language Examples:

1. Out of Network Physician

Your doctor has asked us to pay for you to see (*insert doctor name*). The notes from your doctor say you need to see (*insert doctor name)* because (*insert reason)*.

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: (*Insert doctor name*) does not have an agreement (contract) to work with us. We have other doctors who can treat your problem. These doctors have an agreement to work with us. We will help you in getting an appointment to see one of these doctors. Please call us at (*insert phone number*) for help making the appointment.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	14
EPD/LTC	2 and 14

2. Out of Network Facility

Your doctor has asked that you get (*insert service*) at (*insert facility*). The notes from your doctor say you need this because (*insert problem*).

Our Decision: We have reviewed the request and we will not pay for (*insert service at the facility*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: (*Insert facility*) does not have an agreement (contract) to work with us. There are many other places you can get the care you need. These places have an agreement to work with us. Please ask your doctor for help picking a place we will pay for.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	14
EPD/LTC	2 and 14

B. UNACCEPTABLE Language Examples:

1. This doctor does not participate in our contracted network. Please talk to your doctor about finding another doctor.

2. We have reviewed your request for care at *ABC* facility. We have decided that this request will not be approved at this time. We have looked at your medical file, and decided based on medical standards that your care can be done at *EFG* facility.

IV. NOT ENOUGH INFORMATION TO MAKE A DECISION WITHIN THE LEGALLY REQUIRED TIME FRAME

In some cases Contractors do not have sufficient information to make a coverage determination within the legally required timeframes. The required timeframes are 3 working days for expedited requests, 14 calendar days for standard requests, or up to an additional 14 calendar days when an extension is given. If the Contractor needs additional information and it is in the best interest of the member, the Contractor must use the 14 day extension. The expiration of the timeframe must result in an NOA.

A. ACCEPTABLE Language Examples:

Referral to Specialist
Your doctor wants you to see (*insert doctor name*). The notes from your doctor say you need to see (*insert doctor name*) because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We needed more notes from your doctor to help decide if we would pay for this visit. We had to get these notes by *(insert date)*. We did not get the notes. The information we needed was: *(The Contractor must insert an explanation of the information that they were seeking. The member must be given the opportunity to provide this information to the Contractor, or at the minimum, know what to ask the provider for so that the member can assist in the process.)*

Please talk to your doctor about the information we needed. Then your doctor can ask for this visit again.

Legal/Policy Basis Table Reference

Plan Type	Example #

Acute	**9 and 12**
EPD/LTC	**2, 9, and 12**

B. UNACCEPTABLE Language Examples:

1. Your doctor did not submit the requested medical information to document the need for these services. We must deny any request on day 28 in accordance with federal law.

2. We did not receive the information we needed to make the decision.

V. COVERAGE BY ANOTHER ENTITY

Members or physicians may submit requests to a Contractor for services that are provided by other entities, such as the Behavioral Health System (BHS), Children's Rehabilitative Services (CRS), or Medicare.

A. ACCEPTABLE Language Examples:

1. Behavioral Health System

Your doctor asked us to pay for a drug called *(insert drug).* This drug is commonly used for (*insert reason*). The notes from your doctor say you need this because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for the (*insert drug*).

The Reasons for Our Decision

<u>Facts about Your Condition or Situation that Support Our Decision:</u> This drug has been ordered by your psychiatrist. A psychiatrist is a doctor who treats mental health problems. This drug must be paid for by (*insert RBHA*). Please contact (*insert RBHA*) at *(insert phone number)* for help getting an appointment with the mental health clinic.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	**16**
EPD/LTC	**N/A**

2. Children's Rehabilitative Services (CRS)
Your child's doctor asked us to pay for (*insert service*). The notes from your child's doctor say (*insert name*) needs this because (*insert reason*). (*Explain disease/condition)*

Our Decision: We have reviewed the request and we will not pay for the (*insert service*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Your child has (*insert condition*). Services to help this problem must be paid for by the Children's Rehabilitative Services (CRS). Our records say that your child is already a member of CRS. Please talk to your child's doctor about getting this service from CRS. Your child's doctor can help you with getting an appointment with CRS.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	17
EPD/LTC	2 and 17

3. Medicare Part D
Your doctor has asked us to pay for (*insert drug*). The notes from your doctor say you need (*insert drug*) because (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert drug*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Our records show that you are covered by Medicare Part D. Federal law and Arizona state rules do not allow AHCCCS to pay for medicines that are paid for by Medicare Part D. Please talk to your doctor about this.

Legal/Policy Basis Table Reference

Plan Type	Example #

Acute	**24**
EPD/LTC	**2 and 24**

B. UNACCEPTBLE Language Example:

Your symptoms and diagnosis as documented by your primary care physician require management and monitoring by a behavioral health specialist. You must enroll with (*insert RBHA*). Please contact them at *(insert phone number)* for assistance in obtaining your medication.

VI. MEMBER REIMBURSEMENT

You have asked us to pay you back for (*insert item*). You bought (*insert item*) to help you (*insert reason*).

Our Decision: We have reviewed the request and we will not pay for (*insert item*).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We needed your doctor to order the (*insert item)* and ask us to pay for it. This is called prior authorization. You bought (*insert item*) from a local store. We will not pay you back for this. Your member handbook tells you about prior authorization and how to get services. If you do not understand this, please call us at *(insert phone number)* so we can explain this to you.

Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	**19**
EPD/LTC	**2 and 19**

VII. HOME AND COMMUNITY BASED SERVICES (HCBS)

1.Attendant Care – Initial request:

On (*insert date of case management assessment*), you asked your case manager to have someone (an attendant caregiver) help you 24 hours every week. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry

- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home
- moving from your bed and chair

Our Decision: We are going to pay an attendant care giver to help you 3 hours per day, everyday. You will get 21 hours every week. We will not pay for the other three (3) hours per week that you asked for.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: You told the case manager that you need help with:

- bathing,
- doing your laundry,
- cleaning your house,
- grocery shopping, and
- making your lunches and dinners.

You are able to dress yourself and get your own breakfast. The case manager notes show that the things you need help with could be done in 21 hours per week. You can get a copy of the notes (assessment) from the case management visit from your case manager.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

2. Attendant Care – Reduction (Change in Situation):

Your case manager met with you on (insert date of case management assessment), to go over your home care needs and attendant care needs. You have been getting 40 hours per week of Attendant

Care (8 hours each day, Monday - Friday). Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home

Our Decision: We are reducing your attendant care from 40 hours each week to 38 hours weekly. This is 2 hours less each week. This will start on (*ten days from DATE of letter*.)

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Your caregiver has been spending two hours each week grocery shopping. Your daughter asked us to stop having the attendant shop for you. Your daughter said she would rather do your shopping herself. We will now begin paying for 38 hours of Attendant Care each week. You can get a copy of the notes from the case management visit from your case manager.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

3. Reduction in hours due to a change in condition (Improved Condition):

On (*insert date of case management assessment*), you met with your case manager to go over your home care needs. You started getting more Attendant Care services (56 hours per week, 8 hours per day, 7 days per week) when you hurt your hip and leg 6 months ago. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing

- going to the bathroom
- getting around your home
  moving from your bed and chair

Our Decision: We are changing your Attendant Care hours back to 28 hours each week. This is made up of 4 hours a day for 7 days a week. This is the same number of hours you were getting before you got hurt. This is 28 hours less than you were getting each week. This will start on (*at least ten days from DATE of letter)*.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: You are done with therapy and your hip and leg are better. You are now able to bathe and dress yourself without help, so you do not need someone to do these things for you anymore. You can get a copy the notes from the case management visit from your case manager. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

4. Attendant Care – Substitution:

On (*insert date of case management assessment*) you met with your case manager to go over your home care needs. You told your case manager that you would like to go to Adult Day Health 2 days each week (Wednesday and Friday) for 5 hours each time.

Our Decision: We will approve Adult Day Health services for you 2 days a week for 5 hours. Your Attendant Care hours however, will be reduced from 40 hours per week to 29 hours per week starting *(10 days from DATE of letter*). Your Attendant Care worker will continue to give you care for 8 hours on Tuesdays, Thursdays and Saturdays. On Wednesdays and Fridays, the worker will only help you in the morning (8am-10:30am).

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: You have been getting 40 hours each week of

Attendant Care (8 hours per day, Tuesday – Saturday) to help with bathing, dressing, fixing your lunch and to be with you so you are safe in your home. You will be going to Adult Day Health from 11am to 4 pm on Wednesdays and Fridays starting (*insert start date, 10 days or greater from the date of letter*). You will need 2 ½ hours on those days to get ready for Adult Day Health. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager about getting more care.

Legal/Policy Basis Table Reference

Plan Type	**Example #**
EPD/LTC	**2, 9, and 13**

5. Emergency Alert System:

On (*insert date of case management assessment*), you met with your case manager to review your home care needs. You asked your case manager to pay for an Emergency Alert System. This is an alarm in your home that sends a signal if you need help.

Our Decision: We are not going to pay for an Emergency Alert System for you.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We will not pay for the alarm system for you since you have an Attendant Care worker with you for 40 hours each week and your family has told the case manager that they are with you at all other times. They have said you are rarely left alone but if you were alone that you are able to use the telephone to call for help in an emergency. There are also things you can do at home to let your family or Attendant know if you need help when they are out of the room, such as using a bell or monitor. You can speak with your case manager for some ideas to make you feel safe. You can get a copy of the notes from the case management visit from your case manager. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

6. Home Modification: Other Alternatives to Home Modification:

On (*insert date of case management assessment*) you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification. A Home Modification is when changes are made to your home that make it easier for you to do things on your own. You asked us to redo your bathroom. This includes taking away your tub and replacing it with a roll in shower. You also asked for a raised toilet (higher than normal) with handrails. You asked us to widen your door so you can wheel in with a mobile shower chair you have been given.

Our Decision: We are not going to pay for the removal of your tub to change it to a roll in shower. We will pay to have your shower doors removed. We will also pay to widen your door. We will not pay for a raised toilet with handrails.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The notes from your case manager and the Occupational Therapist (a person trained to look at how to best change your home to meet your needs) do not tell us that these changes to your bathroom are needed. You have a bedside commode with armrests that are raised. This will fit over your toilet so you can use the toilet in your bathroom. Widening the door will let you go into the bathroom with your walker. The Occupational Therapist that visited your home will show you how to use the commode over your toilet once your bathroom door is widened. We are not going to pay to remove your tub so you can have a roll in shower. The bathroom is too small to make this possible. The Occupational Therapist that visited you said you can use your tub with a shower bench once the shower doors are taken off. The Occupational Therapist will visit you once the doors are taken off to show you and your attendant how to do this. You have a shower bench that you have not been using.

The Occupational Therapist says this will be safe and work well for you.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

7. Home Modification: More than one Ramp:

On (*insert date of case management assessment*) you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification (changes to your home that make it easier for you to do things on your own or help with your care) to put in a ramp at the back door of your home so you can go into your backyard.

Our Decision: We are not going to pay for a ramp at your back door.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: You use a wheelchair to get around both inside and outside your home. Your home has a wheelchair ramp built at the side entrance near your driveway that you use to get into and out of your house. You told the case manager that you have no problems using this ramp. AHCCCS will pay for a ramp for a member when the member does not already have a way to safely get into or out of their home and a ramp would help them to do that.

Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

8. Cost Effectiveness Study (CES) Above 100%:

On (*insert date of case management assessment*) you met with your case manager to go over your home care needs. You asked for 40 hours per week of Attendant Care and Home Health Nursing visits 3 times per week. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home
- moving from your bed and chair

Home Health Nursing is a nurse who would visit you for bowel care (help emptying your bowels).

Our Decision: You have been approved for 40 hours per week of Attendant Care and 2 visits every week by a Home Health Nurse.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: You have been approved for 40 hours every week of Attendant Care. AHCCCS policy/rules do not allow Health Plans to spend more for a member's home care than we would spend for their care in a nursing home (unless the extra costs are expected to last less than 6 months). We compare the costs between a nursing home and home services as follows:

1. We start with what a nursing home would cost for you. That amount is $4920.10 per month. Then we subtract the amount that you would have to pay **IF** you were in a nursing home. This amount is called the "Alternate Share of Cost" or "Cost Effectiveness Study (CES) Share of Cost". It is based on the income and expenses that you have reported to AHCCCS. In your case, AHCCCS has told us this amount is $726.90 per month. If you have questions about how that amount is calculated, you can ask your case manager to talk to the AHCCCS office that did your eligibility about this.

2. The difference between the cost of your care in the nursing home and the Alternate Share of Cost is called the "Net Institutional Cost". This is the amount we would have to pay for your care in a nursing home. Your Net Institution Cost would be $4393.20 per month.
3. The total cost per month of the Home Health Nursing ($1341.60) and Attendant Care services ($2924.00) that you have asked for is $4265.60. This total amount is called the "Net Home and Community Based Services (HCBS) Cost". **** *Contractors will have to add similar language to #1 above here to cover the situations where a member has an HCBS SOC that is part of the CES calculation.*
4. If the Net HCBS Cost is more than the Net Institutional Cost, the home care services are not "cost effective" so we can not give you all of those services. Your Net HCBS cost ($4265.60) is more than your Net Institutional Cost ($4193.20). We can only give you services that cost $4193.20 or less per month.

Total Nursing Home Cost	$4920.10
CES Share of Cost	- $726.90
Net Institutional Cost	**= $4193.20**
Services you asked for	
40 hours of Attendant Care	$2924.00
3 Nursing visits per week	+ $1341.60
Net Home Services Cost	**= $4265.60**

You told your case manager that you must have the 40 hours per week of Attendant Care. The case manager has determined that the cost of 2 Home Health Nurse visits a week along with the 40 hours per week of Attendant Care would cost $3818.40 per month. Since this amount is less than your Net Institutional Cost, it is "cost effective" and can be authorized.

Total Nursing Home	

Cost	$4920.10
CES Share of Cost	- $726.90
Net Institutional Cost	**= $4193.20**
Services we **can** provide	
40 hours of Attendant Care	$2924.00
2 Nursing visits per week	+ $ 894.40
Net Home Services Cost	**= $3818.40**

Legal/Policy Basis Table Reference

Plan Type	**Example #**
EPD/LTC	**2, 9, and 13**

9. Adult Day Health for member in an Assisted Living Facility:

On (*insert date of case management assessment*) you met with your case manager to go over your care needs. You and the Assisted Living Facility where you live asked for you attend an Adult Day Health center twice a week. Adult Day Health is a service that gives members a chance to do activities and spend time with people their own age.

Our Decision: We are denying your request for Adult Day Health services twice a week.

The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The type of facility that you live in is required, under their Arizona Department of Health Services license, to offer daily activities that are planned for the people that live there. Your case manager will talk to the Assisted Living Facility manager about the activities your facility has and will ask them to talk with you about what kinds of activities you would be interested in.

Legal Basis for Our Decision: We based our decision on Arizona Administrative Code (AAC) Section R9-10-

712 that says Assisted Living Facilities have to have activities for the people who live there.

REFERENCES

42 CFR 438 et seq

A.A.C. R9-22 et seq

A.A.C. R9-28 et seq

Ekloff v Rodgers Settlement Agreement AAC R9-22-212

AHCCCS Medical Policy Manual

Web address for all Arizona Administrative Codes: http://www.azahcccs.gov/reporting/LawsRegulations/state/state.aspx

AHCCCS Medical Policy Manual web link: http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=contractormanuals

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
1	Not Covered: Eyeglasses for member 21 and older	R9-22-212 (E)(8)(b)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212 (E)(8)(b) that says AHCCCS only pays for eyeglasses for members until a member has their 21st birthday, unless they have had eye surgery for cataracts.
2	EPD / LTC covers same services as Acute	R9-28-202	We based our decision on Arizona Administrative Code (A.A.C.) R9-28-202 that says the Long Term Care Program pays the same services as the Acute Program.
3	Not Covered: Experimental/ Clinical Research	R9-22-202(B)(9)(a) & R9-22-203	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-202(B)(9)(a) that says AHCCCS does not pay for experimental services. The definition of experimental services can be found at Arizona Administrative Code (A.A.C.) R9-22-203. If you would like help understanding the definition please call us at *(insert phone number*.)
4	Not Covered: Cosmetic Services	R9-22-215(C)(4)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(4) that says AHCCCS does not pay for cosmetic procedures.
5	Not Covered: Dental Services for members 21 and older	R9-22-207(B) & AMPM Chapter 300 - dental coverage	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-207(B) that says AHCCCS only pays for dental services for members 21 years of age and older related to a medical condition such as acute pain, infection, or fracture of the jaw. Temporomandibular Joint Dysfunction (TMJ) services are not covered except for reduction of trauma.
6	Not Covered: Infertility Treatment	R9-22-205(B)(4)(a)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-205(B)(4)(a) that says AHCCCS does not pay for infertility services.
7	Not Covered: Hearing Aids for member 21 and older	R9-22-212(E)(8)(a) and AMPM Chapter 300, Policy 310	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(8)(a) that says hearing aids are not paid for members who are 21 years of age or older. There is a list of paid for services for hearing aids in the AHCCCS Medical Policy Manual Chapter 300, Policy 310.
8	Not Covered: Personal Care Items	R9-22-212(E)(5) & R9-22-	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(5) and Arizona Administrative Code (A.A.C.) R9-22-202(B)(9)(c) that says AHCCCS does not pay for personal care items.

This document is only a guide and is intended to provide examples of easily understood language. See the AHCCCS Contract and Polices for all requirements regarding Notice of Action. Additionally, this document is not to be relied upon for Legal citations. These change regularly and Contractors must verify that the specific regulations are correctly cited in their NOA letters.

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
		202(B)(9)(c)	
9	Medically Necessary and Cost Effective	R9-22-202(B)(1)	We based this decision Arizona Administrative Code (A.A.C.) R9-22-202(B)(1) that says AHCCCS only pays for services that are medically necessary, or will help you get better. Also, services must be the least costly service that will give you the same result (cost effective).
10	EPSDT Guideline	R9-22-213 & 42 USC 1396 (d)(r)(5)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-213 and federal law 42 USC 1396(d)(r)(5) that says AHCCCS pays for services listed in federal law 42 USC 1396(d)(a) that help or make better an injury, illness, condition or defect whether or not the service is in the AHCCCS State Plan.
11	Orthotics for Members Age 21 and Older	A.R.S 36 – 2907(B)& R9-22-212 (E)(8)(h)	We based our decision on Arizona Revised Statute (A.R.S.) §36-2907(B) and Arizona Administrative Code (A.A.C.) R9-22-212 (E)(8)(h) that says AHCCCS does not pay for orthotics for members age 21 and older.
12	Decision not made within timeframes and therefore considered denied	R9-34-206(E)	We based our decision on Arizona Administrative Code (A.A.C.) R9-34-206(E) that says that when authorization decisions are not reached within the timeframe allowed by rules, the health plan must deny the request.
13	Definition of medically necessary	R9-22-101(B)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-101(B) that says that to be medically necessary a service must prevent disease or disability; help avoid bad problems that may occur due to your disease process; stop your disease or condition from getting worse; or will help you live longer or keep you in your home.
14	Out of Network	R9-22-705(A)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-705(A) that says that AHCCCS health plans may only pay for services to providers they are contracted with unless the health plan referred you to the provider or the service is an emergency.

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
15	Dentures- not a covered benefit	R9-22-207(B)(2)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-207(B)(2) that says AHCCCS does not pay for dentures for members age 21 years and older.
16	Acute Care Only - services covered by the Division of Behavioral Health	R9-22-1202(A) & R9-22-1202(C)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-1202(A) & Arizona Administrative Code (A.A.C.) R9-22-1202(C) that require the behavioral health system to provide your behavioral health drugs and the medical care related to those drugs.
17	Services covered under the Children's Rehabilitative Services benefit	R9 -7-301(B)	We based our decision on the Arizona Administrative Code (A.A.C.) R9 -7-301(B) that says primary care providers and other practitioners shall refer a child with special health care needs to Children's Rehabilitative Services (CRS).
18	AHCCCS is the payor of last resort	R9-22-1003	We based our decision on the Arizona Administrative Code (A.A.C.) R9-22-1003 that says that AHCCCS must not pay for services if other insurance companies will pay for them.
19	AHCCCS is not obligated to pay for services that require prior authorization, when prior authorization is not obtained	R9-22-202(C)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-202(C) that says a health plan does not have to pay for services or equipment that require prior authorization when prior authorization is not obtained.
20	Incontinence Briefs/Diapers	R9-22-212(E)(5) & R9-22-212(E)(6)	We based our on decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(5) and Arizona Administrative Code (A.A.C.) R9-22-212.E(6) that says: (E)(5) Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
			hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes. (E) (6) Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances: a. The member is over 3 years old and under 21 years old; b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both; c. The PCP or attending physician has issued a prescription ordering the incontinence briefs; d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder; e. The member obtains incontinence briefs from providers in the contractor's network; f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that: i. The member is over age 3 and under age 21; ii. The member has a disability that causes incontinence of bladder or bowel, or both; iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
21	Pancreatic Islet Cell Transplants (applicable to partial and whole pancreas transplants)	R9 - 22-206(B)(3)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-206(B)(3) that says AHCCCS does not pay for partial pancreas or whole pancreas transplants using islet cells from the member.
22	Physical Therapy Limitation	R9-22-215(C)(6)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(6) that says AHCCCS will only pay for 15 physical therapy visits each contract year. The contract year is from October 1 to September 30.
23	Podiatry Exclusion	R9-22-215(C)(5)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(5) that says services provided by a podiatrist are not covered.
24	Medicare Part D	42 USC § 1396u-5(d) and R9-29-302	We based our decision on the Federal code 42 USC § 1396u-5(d) and Arizona Administrative Code (A.A.C.) R9-29-302 that say AHCCCS cannot pay for medications covered by Medicare Part D.

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Revised 10/01/12

Attachment D:

Insert Contractor Logo

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXX-XXX-XXXX o (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF EXTENSION

TO: Date

FROM:

(Your doctor OR name of provider- as appropriate) has asked that (*Health Plan Name)* pay for (*describe services requested and the reason for the services in easily understood language*). (*You or the name of requesting provider – if the member or requesting provider has requested the extension OR Health Plan name)* feels that it is in your best interest to take up to fourteen (14) more days to make a decision. We need this time so we can get more information from (*insert name of requesting provider*). We need (*insert what additional information is needed, e.g. notes from your doctor that tell us if you have tried Drug X before , or notes from your doctor that tell us if you have had a chest x-ray. Be as specific as possible in what information is needed in order to assist the member in getting the service or provides the member with an idea of what information is missing that the member may be able to supply).*

We will make this decision by *(insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date on the letter which represents the mail date.)* If we do not get the information from *(insert name of requesting provider)* then we will have to deny this request.

If you do not agree with us taking extra time to make a decision you can file a grievance (complaint). You can do this by contacting *(insert the Contractor's grievance phone number and insert the address for grievances).*

As your health plan, we can decide to take extra time if we feel it will be of help to you. We felt extra time would help us get the informationneeded to make a decision.

Sincerely,

(Insert name of Health Plan)

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

Effective Date: 06/01/10; 10/01/11, 12/01/11, 11/01/12, 04/01/13,
Revision Date: 09/28/09, 01/28/10, 05/10/10, 08/26/10, 01/24/11, 12/01/11, 10/24/12, 04/04/13

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors. It is critical for Contractors to develop and maintain a provider network that is sufficient to provide all covered services to AHCCCS members. Provider networks must be a foundation that supports an individual's needs as well as the membership in general.

II. Definitions

Geographic Service Area (GSA)	A specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor.
Provider	Any person or entity (including Tribal/Regional Behavioral Health Authorities) who contracts with AHCCCS or a Contractor 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.

III. Policy

The Contractor shall develop and maintain a provider network development and management plan, which assures the Administration that the provision of covered services will occur as stated in the Contract [42 CFR 438.207(b)]. The Network Development and Management Plan must be evaluated; updated and submitted to AHCCCS, Division of Health Care Management, within 45 days from the start of each contract year.

The Contractor shall immediately notify AHCCCS in writing when there has been a significant change in operations that would affect adequate capacity and services. The changes include, but are not limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

Contractors must submit the Network Attestation form (Attachment A) in conjunction with the annual submission of the Network Development and Management Plan. See Attachment A-1 for instructions on completing the form.

Submitted via electronic mail to your:

Operations and Compliance Officer (or her/his designee)
AHCCCS, Division of Health Care Management
701 E. Jefferson, Mail Drop 6100
Phoenix, AZ 85034

IV. Procedure

The Network Development and Management Plan shall include the Contractors process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.

The items below apply to all Contractors, with the exception of the items in bolded parenthetical notation. The items in bolded parenthetical notation are Contractor specific and only apply to those Contractors listed.

The Plan must include the process the Contractor utilizes to ensure:

1. That covered services are accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are to non-AHCCCS persons within the same service area.
2. That covered services are provided promptly and are reasonably accessible in terms of location and hours of operation.
3. That there shall be sufficient personnel for the provision of all covered services, including emergency care on a 24 hour a day, seven day a week basis.
4. (**ALTCS EDP, DDD and BHS**): A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institution or alternative residential setting. To that end the development of home and community based services shall include provisions for the availability of services on a 7 day a week basis, and for extended hours, as dictated by member needs.

The plan must also include a description or explanation of the following:

1. Evaluation of the prior year's Plan including reference to the success of proposed interventions and/or the need for re-evaluation.
2. Current status of the network by service type (Hospital, Nursing Facility, HCBS, Primary Care OB/GYN, Specialist, Oral Health, Non Emergent Transportation, Ancillary Services, etc.) at all levels including:
    a. How members access the system
    b. Relationships between the various levels (focus on provider to provider contact and facilitation of such by the Contractor; e.g. PCP, Specialists, Hospitals, T/RBHAs)
3. Current network gaps and the methodology used to identify them.
4. Immediate short-term interventions when a gap occurs, including expedited or temporary credentialing.
5. Interventions to fill network gaps and barriers to those interventions.
6. Outcome measures/evaluation of interventions.
7. Ongoing activities for network development based on identified gaps and future needs projection.
8. Coordination between internal departments; including a comprehensive listing of all committees and committee membership where this coordination occurs. Identification of members should include the department/area (i.e., QM, MM/UM, GRV, FIN, CLAIMS) that they represent on the committee.
9. Coordination with outside organizations; (**ALTCS EPD, DDD and CRS** Contractors shall address member/provider/parent council activities).
10. A description of network design by GSA for the general population, including details regarding special populations. [**Acute, CMDP, CRS and BHS** Contractors shall understand these populations to include the physically and cognitively impaired (Arizona Early Intervention Program (AzEIP)), the homeless and those in border communities; among others. **ALTCS EPD, DDD** Contractors shall understand these populations to include behavioral health; young adults and children; among others.] The description shall cover:
    i. How members access the system
    ii. Relationships between various levels of the system
    iii. (**Acute, CMDP, CRS and Behavioral Health)** a listing/description of the available alternatives to Nursing Facility placement such as Assisted Living Facilities, alternative residential settings, or home and community based services as required by contract. A similar requirement exists on a larger scale under number 17 of the ALTCS Only listing. If the Contractor requires additional information on procuring such services, they shall contact the ALTCS Contractor in the GSA for assistance in identifying available alternatives
    iv. (**Acute, CMDP and CRS**) the plan for incorporating the medical home for members and the progress in its implementation

v. (**ALTCS EPD and DDD**) the description shall include a list of these providers along with a description of services provided by the program and projected utilization

11. **(Acute, CMDP, CRS , ALTCS EPD and DDD)** A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership.
12. (**Acute, CMDP and CRS**) The assistance provided to PCPs when they refer members to specialists. The methods used to communicate the availability of this assistance to the providers
13. (**Acute, CMDP and CRS**) An analysis of the Contractors Appointment Availability Report statistics as set forth in ACOM Policy 417.
14. The methodology(ies) the Contractor uses to collect and analyze member, provider staff and other stakeholder feedback about the network designs and performance. When specific issues are identified, the protocols for handling them.
15. (**Acute, CMDP and CRS**) If the Contractor does not have contracts with hospitals, they must contract with physicians with hospital admitting and treatment privileges, Attachment B (Non-Contracted Hospital and Physician Admitting and Treatment Privileges) of this policy must be submitted annually.

(For **ALTCS EPD and DDD Contractors Only**)

16. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan. (AMPM Policy 1240) (See Attachment A).
17. The strategies the Contractor has for Work Force Development. Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Contractor must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.
18. Strategies the Contractor will take to provide members with “in-home” HCBS versus placing members in Assisted Living Facilities and Nursing Facilities. A priority shall be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting.

19. **(ALTCS EPD)** A Contractor must include the specific pro-active strategies/actions they will take to reduce the percentage of HCBS members in Alternative Residential Settings once 20% or more of its HCBS membership resides in Alternative Residential Settings. If any GSA served by the Contractor is currently greater than 20%, the Contractor must demonstrate the implementation of its strategies/actions.
20. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval. (See Attachment C)
21. A listing of nursing facilities that have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility. (See Attachment C)
22. Description of how the Contractor will handle the loss (closure, contract termination) of a major healthcare provider (hospital, nursing facility, large provider group).
23. A description of the methods the Contractor will use to ensure that ALTCS members receive needed services in the event of a natural disaster.

The plan must include answers to the following questions:

a. (**Acute, CMDP and CRS**) How does the Contractor assess the medical and social needs of new members to determine how the Contractor may assist the member in navigating the network more efficiently?
b. (**Acute, CMDP and CRS**) What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. (**Acute, CMDP and CRS**) How does the Contractor support the Graduate Medical Education (GME) programs within its contracted GSA(s) and pursue contracting opportunities with graduates and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas?
d. (**Acute and CMDP**) Describe the Contractor's process to increase provider participation in Baby Arizona.
e. What interventions has the Contractor implemented to reduce avoidable/preventable ER utilization? What was the outcome of those interventions?
f. (**Acute, CMDP, CRS , ALTCS EPD and DDD**) Are members with special health care needs assigned to specialists for their primary care needs? If so, what general criteria are used to determine if a member should be assigned in this manner?
g. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?
h. (**Acute, CMDP, CRS , ALTCS EPD and DDD**) What interventions has the Contractor implemented to address and reduce no-show rates and how is information collected to assess the efficacy of these measures?
i. (**Behavioral Health**) How are members with chronic medical conditions identified within the T/RBHA system record keeping mechanism and how are placement options coordinated with/communicated to Acute Care Contractors?

V. Provider/Network Changes Due to Rates Report (Quarterly Submission)

A. Provider Terminations Due to Rates

The Contractor will submit to their AHCCCS Compliance Officer a report of providers who have terminated their contract due to rates 15 days following the end of each quarter using the report template attached (Attachment D) to this policy. Submission of Attachment D for each GSA is required even when the Contractor does not have any terminations to report.

The report will consist of the following information regarding all providers who terminate their contracts for rate related reasons during the reporting period by GSA:

Provider Name	The name of the provider leaving the network. If a provider group has terminated their contract, each provider in the group should be listed separately.
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
Provider Type	The Provider Type code as utilized in PMMIS.
PCP	'Y' yes or 'N' no (Is defined as a 08-MD, 31-DO, 19-NP, 18-PA; responsible for the management of a member's health care)
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during the three month time period prior to the termination date. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility at the time of termination notice by the provider.
Reason for Termination	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (Use only if the termination reason does not fall under one of the first three bullets and ***is a rate related*** reason. Describe using only a ***rate related reason***.)
Attestation	Include a statement if the loss of the provider will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.

B. Providers that Diminish their Scope of Service and/or Close their Panel

The Contractor will submit to their Operations and Compliance Officer a report of providers that have diminished their scope of service and/or closed their panel, 15 days following the end of each quarter using the report template attached (Attachment E) to this policy. Submission of Attachment E for each GSA is required even when the Contractor does not have any providers to report.

The report will consist of the following information regarding all providers who have diminished their scope of service and/or that closed their panel during the reporting period by GSA:

Provider Name	The name of the provider.	
Provider ID Number	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.	
Provider Type	The Provider Type code as utilized in PMMIS.	
Scope of Service Diminished	Type of Service N/A if not applicable	
Panel Closed	'Y' yes N/A if not applicable	A) Medicaid B) Non-Medicaid
Provider Capacity	This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number members (unduplicated) that on average utilize the providers during the three month time period prior to the termination date. In the case of nursing facilities and alternative residential settings indicate the number of members residing in the facility.	
Reason	Insert one of the following reasons: • Increased rate requested (provider initiated) • AHCCCS FFS rate reduction (pass-through) • Contractor rate reduction (not associated with an AHCCCS reduction) • Other (Use only if the termination reason does not fall under one of the first three bullets and ***is a rate related*** reason. Describe using only a ***rate related reason***.)	
Attestation	Include a statement if the change will result in a network gap. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.	

VI. (ALTCS Only) Direct Care Worker Training and Testing and Agency with Choice Roster

ALTCS EPD Contractors and and the DES/DDD shall submit a "HCBS Home Network Roster" to their Operations and Compliance Officer on October 15 and April 15 of each year. The report outlines the plan, and the effective date of the plan, that applicable provider agencies have in place to train and test their direct care workers to meet competencies. Additionally, the report outlines those provider agencies that offer the Agency With Choice member-directed option to members. The report must be updated and maintained on a regular basis and be available upon request to AHCCCS. Information pertaining to the provider agencies offering the Agency With Choice member-directed option should be made available to case managers to use in assisting members to identify a provider agency for the provision of services. ALTCS/EPD Contractors and DES/DDD may provide the agency with choice data in an alternate format for case managers and/or members.

The report shall include the following information using the excel format identified in the following link: Attachment F.

No.	The row number for each provider listed. If you require additional rows insert the rows and number accordingly
PC ID#	Bridgeway Health Solutions (110088) DES/DDD (110007) Evercare Select (110049) Mercy Care Plan-LTC (110306)
County Code	See below listing
Provider Type	If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01). If the provider is not registered with AHCCCS at this time, place "XX" in the column.
AHCCCS Provider No.	The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
Name	The actual name of the provider. Do not use the corporation name.
Address	The address where the provider is located.
City	The city where the provider is located.
Zip Code	The zip code of the provider's address.
Telephone	The telephone number of the contact person.
Contact Person	The name of the person to contact
Services Provided	For each provider listed, place a "Y" in the column to indicate what services are contracted to be provided.

DCW Plan	The provider's plan for complying with the Direct Care Worker Training and Testing program requirements. • Place "AP" in the column for providers that plan to or have already become an Approved Training and Testing Program to train and test their direct care workers. • Place a "C" in the column for providers that plan to or have already contracted with an Approved Training and Testing Program to train and test their direct care workers. Note: The requirement is only applicable to providers that provide Attendant Care, Personal Care and Homemaker Services.
DCW Plan Effective Date	The date the provider's plan will be in effect (XX-XX-XX).
Agency with Choice	For each provider listed, place a "Y" or an "N" to identify whether or not the provider is offering the Agency With Choice member-directed option to members.

The report should identify county using the following codes:

County Code	County	GSA
01	Apache	44
03	Cochise	46
05	Coconino	44
07	Gila	40
09	Graham	46
11	Greenlee	46
29	La Paz	42
13	Maricopa	52
15	Mohave	44
17	Navajo	44
19	Pima	50
21	Pinal	40
23	Santa Cruz	50
25	Yavapai	48
27	Yuma	42

VII. (DDD Only) DDD Therapeutic and HCBS Services Wait Lists

The Departent of Econimic Sercurity's Division of Developmental Disaabilties (DES/DDD) will submit to their Operations and Compliance Officer a semi-annual report on October 15 and April 15 of each detailing information related to service wait lists.

The report will include information in the excel format identified in the following link: Attachment Ga and Gb. Contractors must use the county and GSA code system identified in VII above.

VIII. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438.200
- Acute Care Contract, Section D
- ALTCS EPD Contract, Section D
- ALTCS DDD Contract, Section D
- CMDP Contract, Section D
- CRS Contract, Attachment J
- ADHS\DBHS Contract, Section D
- ACOM Policy 415 Attachment A through G

Attachment A

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

- ❑ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶27 and ¶29; CMDP Contract Section D, ¶27 and ¶29; CRS Contract Attachment J, ¶27 and ¶29; ALTCS EPD Contract Section D, ¶28 and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan; Periodic Network Reporting Requirements and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

- ❑ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶27 and ¶29; CMDP Contract Section D, ¶27 and ¶29; CRS Contract Attachment J, ¶27 and ¶29; ALTCS EPD Contract Section D, ¶28 and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development; Periodic Network Reporting Requirements and Management Plan and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

_____

(Network Administrator Signature) Date

Attachment A-1 Instructions for the Network Attestation Statement

NETWORK ATTESTATION STATEMENT

This Attestation Statement is to accompany the Network Development and Management Plan which is due within 45 days from the start of each contract year. Each Contractor will be required to submit this Attestation Statement for each GSA in which they operate.

Network Attestation Statement

From

❶ Contractor's Name

To The

Arizona Health Care Cost Containment System
Division of Health Care Management, Operations

❷❑ I hereby attest that the Network Development and Management Plan submitted does not meet the Network Standards (Acute Contract Section D, ¶27 and ¶29; CMDP Contract Section D, ¶27 and ¶29; CRS Contract Attachment J, ¶27 and ¶29; ALTCS EPD Contract Section D, ¶28and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan; Periodic Network Reporting Requirements and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and/or county (ies):

❸❑ I hereby attest that the Network Development and Management Plan submitted meets all other Network Standards other than those listed above (Acute Contract Section D, ¶27 and ¶29; CMDP Contract Section D, ¶27 and ¶29; CRS Contract Attachment J, ¶27 and ¶29; ALTCS EPD Contract Section D, ¶28 and ¶29; ALTCS DDD Contract Section D, ¶28 and ¶29; BHS Contract Section D ¶18; ACOM Policy 415 Provider Network Development and Management Plan; Periodic Network Reporting Requirements and ACOM Policy 419 ALTCS Network Standards) for the following GSA(s) and county (ies):

_____

❹(Network Administrator Signature) ❺Date

Contractors must submit a separate Attestation for each Line of Business (LOB)

❶ Insert Contactor's name: Mercy Care Plan
Mercy Care LTC

❷ Check this box if the GSA and county you are reporting does not meet required Network Standards. Insert the Settings/Service types, GSA(s) and/or county (ies) where Network Standards are not met.

Example:

Acute LOB: GSA 4 – Apache, Mohave, Navajo: Speech/hearing Therapist

ALTCS LOB: GSA 44 - Apache County: Assisted Living Centers; Adult Day Health; Speech Therapy

❸ Check this box if the GSA and county you are reporting meets all required Network Standards. Insert the GSA number and the county (ies) meeting the Standards.

Example:

Acute LOB: GSA 4 – Coconino
GSA 12 - Maricopa

ALTCS LOB: GSA 44 - Coconino, Mohave, Navajo
GSA 52 - Maricopa

NOTE: It is possible to have both Bullet 2 and Bullet 3 boxes checked at the same time. One or more counties in a multiple GSA could be in full compliance with the Network Standards while one or more could be out of compliance.

❹ Have the appropriate Network Administrator sign the Attestation Statement

❺ Include the date the Attestation was signed

Attachment B **Non-Contracted Hospital and Physician Admitting & Treatment Privileges Attestation Statement**

I_____ affirm that _____ has contracts with physician(s) with admitting and treatment privileges at the hospitals within the communities identified below as required in Attachment B of the AHCCCS Acute Care and CMDP Contracts.

Signature: _____ Date: _____

GSA 2
- ☐ Blythe, CA
- ☐ Lake Havasu City
- ☐ Parker
- ☐ Yuma
- ☐ GSA Not Applicable

GSA 4
- ☐ Bullhead City
- ☐ Page
- ☐ Flagstaff
- ☐ Payson
- ☐ Gallup, NM
- ☐ Show Low
- ☐ Kanab, UT
- ☐ Springerville
- ☐ Kingman
- ☐ Lake Havasu City
- ☐ Winslow
- ☐ Needles, CA
- ☐ GSA Not Applicable

GSA 6
- ☐ Cottonwood
- ☐ Flagstaff
- ☐ Maricopa County
- ☐ Prescott
- ☐ GSA Not Applicable

GSA 8
- ☐ Casa Grande
- ☐ Globe
- ☐ San Tan
- ☐ Maricopa County Dist. 4
- ☐ Payson
- ☐ GSA Not Applicable

GSA 10
- ☐ Contracts are required
- ☐ Nogales
- ☐ GSA Not Applicable

GSA 12
- ☐ Contracts are required
- ☐ GSA Not Applicable

GSA 14
- ☐ Benson
- ☐ Bisbee
- ☐ Douglas
- ☐ Safford
- ☐ Sierra Vista
- ☐ Tucson
- ☐ Willcox
- ☐ GSA Not Applicable

Attachment C

NETWORK DEVELOPMENT AND MANAGEMENT REPORT

CONTRACTOR:_____**DATE:** _____

Non-Medicare Certified Home Health Agencies (HHA):

	Non-Medicare Certified HHA Name	AHCCCS ID#	Type of Services Provide	Geographic Area Served
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9				
10				

Use of a non-Medicare Home Health Agency(ies) is in compliance with AMPM Chapter 1200, Section 1240, ALTCS Services/Settings, Home Health Services.

List of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval:

	Assisted Living Center	AHCCCS ID#	City / Area Served	Exception Period (10-07 to 9/08)
1.				
2.				
3.				
4.				
5.				

List of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility:

	Nursing Facility	AHCCCS ID#	City / Area Served	Number of Residents
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Attachment D

Provider Terminations Due to Rates

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	PCP	Provider Capacity	Reason for Termination	Attestation

Attachment E

Providers that Diminished their Scope of Service and/or Closed their Panel

Contractor Name: Date:

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

GSA # (Complete one table per GSA)

Provider Name	Provider ID	Provider Type	Scope of Service Diminished	Panel Closed		Provider Capacity	Reason	Attestation

Attachment F: (ALTCS Only) Direct Care Worker Provider Training Roster

(1) No.	(2) PC ID #	(3) GSA	(4) Cty. Code	(5) Prov. Type	(6) AHCCCS Provider No.	(7) Name	(8) Address	(9) City	(10) State	(11) Zip Code	(12) Tel.	(13) Cont. Person	Attend. Care Y/N	Home-Maker Y/N	Hab Y/N	Pers n. Car e Y/N	(14) DCW Plan	(15) DCW Plan Effective Date	(16) Comments
1.																			
2.																			
3.																			
4.																			
5.																			

HCBS HOME NETWORK ROSTER

HCBS Home Roster. (DES/DDD - Do not report independent contractors here).

Name: Insert name of Contractor or Offeror.

GSA: Geographic Service Area. See Section III (B) for GSA numbers. Insert appropriate GSA Number where indicated on the excel submission.

(1) No: The row number for each provider is listed. If you require additional rows insert the rows and number accordingly.

(2) PC ID #: See above listing for Contractor and Identification Number (ID#) affiliation.

(3) GSA: See above listing.

(4) County Code: See above listing.

(5) Provider Type: If the provider is an AHCCCS registered provider insert the Provider Type (See AMPM 610-01 or the Bidder's Library for a list of provider types). If the Provider is not registered with AHCCCS at this time, place "XX" in the Column.

NOTE: in the event of a Contract Award, the Contractor must ensure the Provider has registered with AHCCCS prior to providing services to members.

(6) AHCCCS Provider Identification No: Insert the AHCCCS assigned number identifying the provider. If the Provider does not have an identification leave row blank.

(7) Name: The actual name of the provider. Do not use the corporation name.

(8) Address: The address where the Provider is located.

(9) City: The city where the Provider is located.

(10) State: State where the Provider is located.

(11) Zip Code: Zip Code for the Provider's address.

(12) Telephone: The telephone number of the contact person.

(13) Contact Person: The name of the person to contact.

(14) Services Provided: For each provider listed, place a "Y" in the column to indicate what services are contracted to be provided. A provider may have several "Y"s.

(15) DCW Plan: The Provider's plan for complying with the Direct Care Worker Training and Testing program requirements beginning October 1, 2012. Place "AP" in the column for Providers that plan to or have already become an Approved Training Program to train their direct care workers. Place a "C" in the column for Providers that plan to or have already contracted with an Approved Training Program to train their direct care workers.

(16) DCW Plan Effective Date: The date the Provider's plan will be in effect to comply with the Direct Care Worker Training and Testing program requirements beginning October 1, 2012. Provide the date (XX-XX-XX) the plan noted in column 14 will be in effect.

(17) Comments: List any comments the Contractor has about the provider related to its DCW planning information.

Attachment Ga: (DDD Only) DDD Wait Lists

DDD THERAPUETIC SERVICES WAIT LIST

(1) Therapy	**(2)** GSA Code	**(3)** County Code	**(4)** # Members

(1) Therapy: The therapeutic service offered. Services to be reported are Physical Therapy, Occupational Therapy, Speech Therapy and Respiratory Therapy. Insert any additional rows needed.

(2) GSA Code: See above for GSA Codes

(3) County Code: Above for County Codes.

(4) Number of members served for the listed therapy in the district and listed county.

Attachment Gb: DDD ALTCS HCBS SERVICES WAIT LIST

(1) Service	**(2)** GSA Code	**(3)** County Code	**(4)** # Members

(1) Service: The HCBS service experiencing a wait time. If there are no wait times for any HCBS service, put 'None' in the table. Insert any additional rows needed.

(2) GSA Cose: See above for GSA Codes

(3) County Code: See above for County Codes.

(4) # Members: Number of members served for the listed service in the district and listed county.

416 - PROVIDER NETWORK INFORMATION

Original Date: 12/13/07
Effective Date: 10/01/08, 11/01/12
Revision Date: 08/12/10, 10/24/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Plan (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors. This policy establishes guidelines for Contractors regarding provider information requirements and the content of a Contractor's website.

II. Definitions

Material Change A change which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in the contract.

Provider Any person or entity (including Tribal/Regional Behavioral Health Authorities) who contracts with AHCCCS or a Contractor 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.

III. Policy

The contract contains multiple requirements for communications between Contractors and their provider network. The list below instructs the Contractor on content and timing of these communications. The list does not supersede any additional requirements that may be outlined in the contract.

A. Provider Manual

The Contractor shall develop, distribute and maintain a provider manual. The Contractor shall ensure that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual and is encouraged to distribute a provider manual to any individual or group that submits claim and encounter data. The Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements with regard to covered services, billing, etc. At a minimum, the Contractor's provider manual must contain information on the following (items below apply to all Contractors, with the exception of the items in bolded parenthetical notation. The items in bolded parenthetical notation are Contractor specific and only apply to those Contractors listed):

a. Introduction to the Contractor which explains the Contractor's organization and administrative structure
b. Provider responsibility and the Contractor's expectation of the provider
c. Overview of the Contractor's Provider Service department and function
d. Listing and description of covered and non-covered services, requirements and limitations including behavioral health services
e. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
f. 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 ASIIS and enroll every year in the Vaccine for Children program.
g. Description of Dental services coverage and limitations
h. Description of Maternity/Family Planning services
i. The Contractor's policy regarding PCP assignments
j. Referrals to specialists and other providers, including access to behavioral health services. (as provided to Acute Care enrollees by the ADHS/T/RBHA system)
k. Grievance system process and procedures for providers and enrollees
l. Billing and encounter submission information
m. Information about policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
n. Reimbursement, including reimbursement for dual eligible members (i.e. Medicare and Medicaid) or members with other insurance
o. Cost sharing responsibility
p. Explanation of remittance advice
q. Prior authorization and notification requirements
r. Claims medical review
s. Concurrent review

t. Fraud and Abuse
u. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.
v. Formulary information, including updates when changes occur, must be provided in advance to providers, including pharmacies. The Contractor is not required to send a hard copy, unless requested, of the formulary each time it is updated. A memo may be used to notify providers of updates and changes, and refer providers to view the updated formulary on the Contractor's website.
w. AHCCCS appointment standards
x. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable
y. Eligibility verification
z. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other the English or who use sign language.
aa. Peer review and appeal process.
bb. (**Acute, CMDP, CRS and BHS**) Medication management services as described in the contract.
cc. Information about a member's right to be treated with dignity and respect as specified in 42 CFR 438.100.
dd. Notification that the contractor has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102.
ee. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions.
ff. (**ALTCS EPD and DDD**) Description of the ALTCS Change of Contractor policy.

B. Website

The Contractor must develop and maintain a website capable of the following, provider focused, information and functionality [Section D, Technological Advancement]:

The website must have links to the items listed below:

a. Formulary (both searchable and comprehensive listing)
b. Provider Manual (must contain services requiring prior authorization)
c. Provider Directory (including specialists for referral)
d. Performance Measure Results (contractor-specific and AHCCCS program)
e. Medical Determination Criteria and Practice Guidelines

The Contractor must also provide 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

The Contractor will submit annually 45 days after the start of the contract year the Contractor's Annual Website Certification form (ACOM 404, Attachment B) verifying that all required information is available and current on the Contractor's website.

C. Required Notifications

The Contractor is expected to provide written or electronic communication to contracted providers in the following instances:

a. **Exclusion from Network** – Under Federal Regulation [42 CFR 438.12] the Contractor is required to provide written notice of the reason for declining any written request for inclusion in the network.
b. **Policy/Procedure C**hange – The Contractor is required to notify affected providers 30 days in advance of any material change, as defined in this policy, in Contractor policy or procedure. This requirement includes notification to providers in the event of a material change to network composition that may affect the ability to refer or place members for specialty care (e.g. termination of orthopedic group; SNF). Such notice must also be provided to the AHCCCS Division of Health Care Management Operations and Compliance Officer to which the Contractor is assigned 60 days in advance of the proposed change.
c. **Subcontract Updates** – Periodically, AHCCCS may make changes to the required Minimum Subcontract provisions. In the event of such a change, Contractors are required to amend all subcontracts on their regular renewal schedule or within 6 calendar months of the update, whichever comes first.
d. **Termination of contract**– The Contractor must provide written notice to hospitals and/or provider groups at least 90 days prior to any contract termination without cause. Contracts between Contractors and individual practitioners are exempted.
e. **Chronic Care and Disease Management Information** – The Contractor must disseminate information as required by the AHCCCS Medical Policy Manual Policy 1020(H).

In addition to the updates required above, AHCCCS may require Contractors to disseminate information on behalf of the administration as stipulated in the Network Management paragraph of the Contract. In these instances, AHCCCS will provide prior notification as is deemed reasonable or prudent.

IV. References

- Title 42 of the Code of Federal Regulations (42 CFR) Part 438
- Arizona Administrative Code R9-22, Article 5
- Acute Care contract, Section D
- ALTCS EPD contract, Section D
- ALTCS DDD contract, Section D
- ADHS/DBHS contract, Section D
- CMDP contract, Section D
- CRS contract, Attachment J

417 - APPOINTMENT AVAILABILITY MONITORING AND REPORTING

Original Date: 1/8/08
Effective Date: 10/1/12
Revision Date: 1/8/08, 6/26/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care Contractors. This policy establishes a common process for AHCCCS Contractors to monitor and report the appointment accessibility, availability, and wait time of contracted Primary Care, Specialist, Dental, and Maternity providers to ensure compliance with AHCCCS standards as set forth in Section D, Paragraph 33 of the contract.

II. Definitions

Established Patient	A Member who has received professional services from the physician or any other physician of the exact same specialty and subspecialty that belongs to the same group practice, within the past three years.
New Patient	A Member who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty that belongs to the same group practice, within the past three years .
Wait time	The time a patient has to wait in the provider's office beyond their scheduled appointment time.

III. Policy

A. Monitoring of Appointment Standards

1. Provider Appointment Availability Review: Contractors are required on a quarterly basis to review the availability of Routine, Urgent and Emergent appointments for Primary Care, Specialist and Dental providers. Contractors must also review these standards for Maternity Care providers relating to the first, second, and third trimesters and high risk pregnancies. Additionally, Contractors must review the amount of time members must wait to be seen during a scheduled appointment by contracted providers. Contractors can utilize various methodologies to conduct this review including but not limited to: appointment schedule review, secret shopper phone calls,

calls to providers identified on the 1800 report, review of member quality of care concerns, review of reports from specific providers, and credentialing etc. Contractors must conduct Provider Appointment Availability Reviews in sufficient quantity to ensure that results can be determined statistically significant.

2. Member Appointment Availability Review: Contractors must conduct Member Appointment Availability Reviews in sufficient quantity to ensure that results can be determined statistically significant regarding their experience with the availability of Primary Care, Specialist, Dental and Maternity Care appointments. This review must include the availability of Routine, Urgent and Emergent appointments as well as first, second, and third trimesters and high risk pregnancies. Contractors can utilize various methodologies to conduct this review including but not limited to: phone calls, monitoring of member complaints, etc.

B. Tracking and Reporting

1. Contractors must track provider compliance with appointment availability on a quarterly basis for both New and Established Patients by Provider Type.

2. AHCCCS will review Contractor monitoring and corrective action plans implemented as a result of provider non compliance with appointment standards, during the Operational and Financial Reviews.

3. Contractors will submit the Appointment Availability Report, found in sections C and D, as a component of the Network Development and Management Plan. Contractors must also include an attestation of the validity of the methodologies utilized, including the statistical significance of the results, and a cover letter that summarizes the data; explains significant trending in either direction (positive or negative) and any interventions applied to areas of concern.

C. Instructions For Completing the Appointment Availability Provider Report: PCPs, Specialist, and Dentist

Section

Surveys: Enter the total number of provider surveys conducted for both New and Established patients for each provider type.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards.

Compliance

Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards.

Maternity Care

Section

Surveys: Enter the total number of provider surveys conducted with Maternity care providers related to compliance with the AHCCCS standards for initial prenatal care appointments.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards for maternity care.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards for maternity care.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards for maternity care.

Wait Times

Section

Surveys: Enter the total number of surveys conducted related to compliance with the AHCCCS wait time standards.

Pass: Enter total number of providers that were in compliance with the AHCCCS wait time standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS wait time standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS wait time standards.

D. Instructions for Completing the Appointment Availability Member Report: PCPs, Specialist, and Dentist

Section

Surveys: Enter the total number of member surveys conducted for both New and Established patients for each provider type.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards.

Maternity Care

Section

Surveys: Enter the total number of member surveys conducted with Maternity care providers related to compliance with the AHCCCS standards for initial prenatal care appointments.

Pass: Enter total number of providers that were in compliance with the AHCCCS appointment standards for maternity care.

Fail: Enter total number of providers that were not in compliance with the AHCCCS appointment standards for maternity care.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS appointment standards for maternity care.

Wait Times

Section

Surveys: Enter the total number of surveys conducted related to compliance with the AHCCCS wait time standards.

Pass: Enter total number of providers that were in compliance with the AHCCCS wait time standards.

Fail: Enter total number of providers that were not in compliance with the AHCCCS wait time standards.

Compliance Percentage: This column automatically calculates the percentage of providers that are compliant with the AHCCCS wait time standards.

IV. References

- Title 42, Code of Federal Regulations (42CFR) 438.206 (c)(1)(i) [Availability of Services]
- Title 42, Code of Federal Regulations (42CFR) 438.206 (c)(1)(iv), (v) and (vi) [Availability of Services]
- AHCCCS Acute Care contract, Section D

Appointment Availability Provider Report: PCPs, Specialist, and Dentist		Routine				Urgent				Emergent			
Provider Type		Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage
PCP	New												
	Established												
Specialist	New												
	Established												
Dentist	New												
	Established												
Total													

Maternity Care	Request	Surveys	Pass	Fail	Compliance Percentage
1st trimester	14 days				
2nd trimester	7 days				
3rd trimester	3 days				
High risk pregnancy	3 days*				
Total					

*within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

Wait Times	Surveys	Pass	Fail	Compliance Percentage
PCP				
Specialist				
Total				

Member Appointment Availability Report PCPs, Specialist, and Dentist		Routine				Urgent				Emergent			
Provider Type		Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage	Surveys	Pass	Fail	Compliance Percentage
PCP	New												
	Established												
Specialist	New												
	Established												
Dentist	New												
	Established												
Total													

Maternity Care	Request	Surveys	Pass	Fail	Compliance Percentage
1st trimester	14 days				
2nd trimester	7 days				
3rd trimester	3 days				
High risk pregnancy	3 days*				
Total					

*within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

Wait Times	Surveys	Pass	Fail	Compliance Percentage
PCP				
Specialist				
Total				

418 - PROVIDER AND AFFILIATE ADVANCE REQUEST

Original Date: 01/31/08
Effective Date: 10/01/08, 10/1/12
Revision Date: 01/31/08, 5/1/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to the Acute, ALTCS, CRS, CMDP, and DES/DDD Contractors. The policy establishes the procedure for Contractor approval or notification to AHCCCS of provider and affiliate advances and loans as required by Section D, Paragraph 49 of the Acute Care, CRS, and CMDP contracts and Section D, Paragraph 50 of the ALTCS and DES/DDD contracts.

II. For purposes of this policy definitions are as follows:

Advance	Includes but is not limited to payment to a provider by a Contractor which 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.
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.
Day	Calendar day unless otherwise specified.

Provider Any person or entity who submits a claim and receives payment 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. For the purposes of this policy, a provider shall be further defined as all individuals associated by the same Tax Identification Number, utilized for claiming purposes.

III. Policy

A. Provider Advances

The Contractor shall submit written notification of any cumulative loan or advance equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. For any individual advances or loan equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year, the Contractor must request approval from AHCCCS at least 10 days prior to disbursement of the funds. In exigent circumstances, AHCCCS may waive the 10 day notification requirement. All requests for approval must be submitted in writing to the DHCM Operations and Compliance Officer in the format detailed below:

1. A detailed letter of explanation must be submitted that delineates:

    a. A copy of the written communication that will serve as notification to the affected provider(s).
    b. The provider(s) name(s) and AHCCCS Identification Number(s).
    c. The date the provider and contractor initiated discussions relating to the need for the advance or loan;
    d. The systemic organizational causes resulting in the need for an advance or loan;
    e. The process that will be utilized to reconcile the funds against claims payments;
    f. The anticipated timeline for the project ;
    g. The corrective action(s) that will be implemented to avoid future occurrences; and
    h. Total advance or 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.

2. Upon completion of the advance(s) or loan(s), AHCCCS may request that the Contractor make available within three working days a listing of the payments to be advanced, organized by provider Tax Identification Number if multiple providers are affected, that should include the following:

    a. AHCCCS Member ID
    b. Date of Service
    c. Original Claim Number
    d. Date of Payment
    e. Amount Paid
    f. Amount Advanced or Loaned
    g. Balance Due to/from the Provider

B. Routine/Scheduled Advances to Provider and Any Advances to Affiliates

Routine/scheduled advances to providers as a result of contractual arrangements or **any** advance or to an affiliate must be submitted to AHCCCS for prior approval. The request for approval must be submitted 30 days in advance of the effective date of the contractual arrangement or advance and 30 days prior to any amendments to contractual arrangements.

All contractual arrangements regarding routine/scheduled advances in existence at the start of new contract award resulting from a Request for Proposal must be reported to AHCCCS 15 days prior to the start of the new contract cycle.

AHCCCS may request additional information or periodic reconciliations related to these advances.

C. AHCCCS Responsibilities

All requests submitted will be reviewed by the Division of Health Care Management to evaluate the appropriateness of the Contractors plan to advance payment and resolve any future occurrences with accurate and timely claims payment. AHCCCS reserves the right to discuss any advance with the provider community to such extent as it is appropriate to determine the appropriate communication and approval action. Communication will be at the timing and discretion of AHCCCS.

DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail no later than 30 days from the date of receipt of all required information from the Contractor.

IV. References

- Acute Contract Section D
- ALTCS Contract, Section D
- CMDP Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D

419 – ALTCS NETWORK STANDARDS

Effective Date: 10/01/10, 10/01/11, 01/25/12, 04/01/13
Revision Date: 01/18/11, 01/25/12, 04/04/13

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD) Contractors. Contractors shall develop and maintain a provider network that is supported by written agreements which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. This policy establishes network standards for all levels (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) by county. If established network standards are not met, it must be explained in the Network Development and Management Plan.

II. Definitions

Facility Location	The location of the provider within the county.
Geographic Service Area (GSA)	An area designated by the Administration 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 9 A.A.C. 28, Article 1.
Letter of Intent (LOI)	Letter of Intent to contract with a provider
Provider Affiliation Transmission (PAT)	A data file submitted by the Contractor using the format established in the AHCCCS Provider Affiliation Transmission User Manual found at: http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/PATManual.pdf
Services & Settings	Refer to ALTCS/EPD Contract, Section D for services and settings.

III. Policy

A. General Requirement

Contractors shall have contracted providers that represent the minimum providers for a county/GSA. The standard (either an "X" or a number of facilities/providers required in the tables below) will indicate the number of providers by a specific city, zone, facility location or countywide coverage.

Conformance with these standards will be measured using data from the PAT data file submission.

Example:

- For Apache County, due to the limited availability of providers in rural areas, nursing facilities and HCBS Community settings have been set at the location of available providers. HCBS Home, Behavioral Health and Acute Services must be provided county-wide.

- For Cochise County, the Contractor must have signed contracts with one nursing facility in Benson, one in Douglas, two in Sierra Vista and one in Willcox. HCBS Community settings have been established by the location of available providers. HCBS Home, Behavioral Health and most Acute Services must be provided county-wide. Inpatient hospital standards have been set in Benson, Bisbee, Douglas, Sierra Vista and Willcox.

B. Geographic Service Areas

Counties have been assigned to GSAs; Minimum Network Standards have been set by GSA.

County	GSA
Apache	44
Cochise	46
Coconino	44
Gila	40
Graham	46
Greenlee	46
La Paz	42
Maricopa	52
Mohave	44
Navajo	44
Pima	50
Pinal	40
Santa Cruz	50
Yavapai	48
Yuma	42

Apache County - GSA 44

	Springerville	St. Johns	Countywide Coverage	Facility Location
Long Term Care				
Nursing Facility				X
HCBS Community	**Must hae 1 or more Assisted Living Facilities**			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)				X
Behavioral Health Facilities (Level II, Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)				X
HCBS Home				
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	
Behavioral Health				
Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial Rehabilitation			X	

Apache County - GSA 44

	Springerville	St. Johns	Countywide Coverage	Facility Location
Acute Services				
Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

Cochise County - GSA 46

	Benson	Bisbee	Douglas	Sierra Vista	Willcox	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1		1	2	1		
HCBS Community	**Must have 10 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	

Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	

Behavioral Health

Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Cochise County - GSA 46 Continued

	Benson	Bisbee	Douglas	Sierra Vista	Willcox	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X	X	X	X		
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		
Podiatrist						X	
Physician Specialist						X	
Therapies						X	
Transportation						X	

Coconino County - GSA 44

	Flagstaff	Fredonia	Page	Sedona	Williams	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	2			1			
HCBS Community	**Must have 6 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted							X

Living Home)							
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X

HCBS Home

Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	

Behavioral Health

Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Coconino County - GSA Continued
44

	Flagstaff	Fredonia	Page	Sedona	Williams	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X		X				
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X		X	X	X		
Podiatrist						X	

Physician Specialists						X	
Therapies						X	
Transportation						X	

Gila County - GSA 40

	Globe/Miami/ Claypool	Payson	Hayden/ Winkelman	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	2	2			
HCBS Community	**Must have 3 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	

Gila County - GSA 40 Continued

	Globe/Miami/ Claypool	Payson	Hayden/ Winkelman	Countywide Coverage	Facility Location
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X			
Laboratory				X	
Medical Imaging				X	
PCP	X	X			
Pharmacy	X	X	X		
Podiatrist				X	
Physician Specialists				X	
Therapies				X	
Transportation				X	

Graham County - GSA 46

	Safford	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	1		
	Must have 3 or more Assisted Living Facilities		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	

Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	

Behavioral Health

Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Graham County - GSA 46

Continued

	Safford	Countywide Coverage	Facility Location

Acute Services

Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

Greenlee County - GSA 46

	Clifton/Morenci	Countywide Coverage	Facility Location

Long Term Care

Nursing Facility	Within 1 hour drive of Morenci		

HCBS Community

Assisted Living Facilities (Adult Foster Care,			

Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X

HCBS Home

Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	

Behavioral Health

Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Greenlee County - GSA 46 Continued

	Clifton/Morenci	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	Within 1 hour drive of Morenci		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

La Paz County - GSA 42

	Parker	Countywide Coverage	Facility Location
LLONG TERM CARE			
Nursing Facility	Within 1 hour drive of Parker		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	

Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	

Behavioral Health

Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

La Paz County - GSA 42 Continued

	Parker	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

Maricopa County – GSA 52

Part I – Institutional and Alternative Residential Settings

AHCCCS has divided Maricopa County into 9 zones (defined by zip code boundaries). The following tables list the required number of contracts for 4 key provider settings.

Zone 1 – Phoenix

Zone 1 is comprised of the following zip codes:

85022, 85023, 85024, 85027, 85029, 85032, 85046, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331,85377

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	20	X
Assisted Living Center	4	X
Assisted Living Home	20	X

Zone 2 – Phoenix

Zone 2 is comprised of the following zip codes:

85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, , 85051, 85253, 85274

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	10	X
Assisted Living Center	6	X
Assisted Living Home	14	X

Zone 3 – Buckeye, Goodyear, Phoenix & Tolleson

Zone 3 is comprised of the following zip codes:

85031, 85033, 85035, 85037, 85043, 85320, 85322, 85323, 85326, 85338, 85339, 85353

Setting	Standard	Facility Location Within Zone
Nursing Facility	2	X
Adult Foster Care	2	X
Assisted Living Center	0	X
Assisted Living Home	10	X

Zone 4 – Phoenix

Zone 4 is comprised of the following zip codes:

85001, 85002, 85003, 85004, 85006, 85007, 85008, 85009, 85010, 85025, 85034, 85036, 85040, 85041, 85042, 85044, 85045, 85048, 85055, 85056, 85271

Setting	Standard	Facility Location Within Zone
Nursing Facility	5	X
Adult Foster Care	0	X
Assisted Living Center	2	X
Assisted Living Home	7	X

Zone 5 – Gila Bend, Glendale & Wickenburg

Zone 5 is comprised of the following zip codes:

85301, 85302, 85303, 85304, 85305, 85306, 85308, 85310, 85311, 85313, 85337, 85342, 85358, 85361, 85390

Setting	Standard	Facility Location Within Zone
Nursing Facility	3	X
Adult Foster Care	24	X
Assisted Living Center	4	X
Assisted Living Home	20	X

Zone 6 – El Mirage, Peoria, Sun City, Sun City West. & Surprise

Zone 6 is comprised of the following zip codes:

85275, 85307, 85309, 85335, 85340, 85345, 85351, 85355, 85361, 85363, 85372, 85373, 85374, 85375, 85376, 85379, 85380, 85381, 85382, 85383, 85387,85388,85396

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	4	X
Assisted Living Center	10	X
Assisted Living Home	16	X

Zone 7 – Carefree, Cave Creek, Fountain Hills & Scottsdale

Zone 7 is comprised of the following zip codes:

85250, 85251, 85255, 85256, 85257, 85258, 85259, 85260, 85262, 85263, 85264, 85268

Setting	Standard	Facility Location Within Zone
Nursing Facility	6	X
Adult Foster Care	4	X
Assisted Living Center	2	X
Assisted Living Home	2	X

Zone 8 – Mesa, Tempe

Zone 8 is comprised of the following zip codes:

85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282

Setting	Standard	Facility Location Within Zone
Nursing Facility	8	X
Adult Foster Care	5	X
Assisted Living Center	8	X
Assisted Living Home	20	X

Zone 9 – Chandler, Tempe, Gilbert, Queen Creek & Sunlakes

Zone 9 is comprised of the following zip codes:

85222, 85224, 85225, 85226, 85227, 85233, 85234, 85236, 85242, 85243, 85246, 85248, 85249, 85283, 85284, 85296, 85297

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	2	X
Assisted Living Center	4	X
Assisted Living Home	20	X

TOTAL FOR ZONES 1 THROUGH 9

Setting	Standard
Nursing Facility	48
Adult Foster Care	71
Assisted Living Center	40
Assisted Living Home	129

Maricopa County – GSA 52

Part II – Acute Care, Behavioral Health and Home and Community Based Services

In addition to the standards for the 4 settings covered in Part I, Part II delineates the standards for coverage of acute care, behavioral health and home and community based services. Inpatient Hospitals, PCP Services and Pharmacy Services have city-specific requirements. County-wide coverage is required for all other covered services. Also see contract Section D for further requirements.

ACUTE CARE SERVICES CITIES

Inpatient Hospitals
- Metropolitan Phoenix **
- Wickenburg

PCP
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Gila Bend
- Metropolitan Phoenix **
- Queen Creek
- Wickenburg

Pharmacy
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Metropolitan Phoenix **
- Wickenburg

**For purposes of the RFP/Contract, Metropolitan Phoenix encompasses the following: Phoenix, Paradise Valley, Cave Creek/Carefree, Fountain Hills, Scottsdale, Glendale, Sun City/Sun City West, Tempe, Mesa, Gilbert, Chandler, Apache Junction, Peoria, El Mirage, Surprise and Youngtown. Contractors are expected to contract with at least one PCP and one pharmacy in each of these cities. Additionally, within this area, standards must be met as specified in Section D: Program Requirements, Paragraph 28. Network Development.

For inpatient hospital services, Contractors are expected to contract with at least one hospital in the Central District (Zones 1, 2 &4), at least one in the Northwest District (Zones 3, 5, 6 & 7) and at least one in the Southeast District (Zones 8 & 9).

County-wide Coverage*
Services include but are not limited to the following:

Acute Care Services	HCBS Services
Dentist	Adult Day Health Care
Durable Medical Equipment & Supplies	Attendant Care
Laboratory	Emergency Alert
Medical Imaging	Home Modifications
Podiatrist	Habilitation
Physician Specialists	Home Health Care
Therapies	Home-Delivered Meals
Transportation	Homemaker
	Hospice
	Personal Care
	Respite Care

Maricopa County – GSA 52

Part II – Acute Care, Behavioral Health and Home and Community Based Services

County-wide Coverage*

Behavioral Health Facilities
- Level II, Behavioral Health
- Level III, Behavioral Health
- Rural Substance Abuse Transitional Agency

Behavioral Health
- Emergency Care
- Evaluation
- Individual, Group, family Counseling
- Partial Care
- Medication Monitoring
- Behavioral Health Day program/Partial care
- Psychosocial Rehabilitation

* See contract Section D, Program Requirements, for a complete listing of services to be provided.

Mohave County - GSA 44

	Bullhead City	Kingman	Lake Havasu City	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	1	2	2		
HCBS Community	**Must have 28 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	

Mohave County - GSA 44 Continued

	Bullhead City	Kingman	Lake Havasu City	Countywide Coverage	Facility Location
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X	X		
Laboratory				X	
Medical Imaging				X	
PCP	X	X	X		
Pharmacy	X	X	X		
Podiatrist				X	
Physician Specialists				X	
Therapies				X	
Transportation				X	

Navajo County - GSA 44

	Winslow	Show Low/ Pinetop/ Lakeside	Snowflake/ Taylor	Holbrook	Countywide Coverage	Facility Location
LONG TERM CARE						
Nursing Facility	1	1				
HCBS Community	**Must have contract with 5 or more Assisted Living Facilities**					
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)						X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)						X
HCBS Home						
Adult Day Health					X	
Attendant Care					X	
Emergency Alert					X	
Home Modifications					X	
Durable Medical					X	

Equipment						
Home Health Care					X	
Home-Delivered Meals					X	
Homemaker					X	
Hospice					X	
Personal Care					X	
Respite Care					X	

Behavioral Health

Inpatient Services					X	
Emergency Care					X	
Evaluation					X	
Individual, Group, Family Counseling					X	
Medication Monitoring					X	
Behavioral Health Day Program/Partial Care					X	
Psychosocial Rehabilitation					X	

Navajo County - GSA 44 Continued

	Winslow	Show Low/ Pinetop/ Lakeside	Snowflake/ Taylor	Holbrook	Countywide Coverage	Facility Location

Acute Services

Dentist					X	
Durable Medical Equipment & Supplies					X	
Inpatient Hospital	X	X				
Laboratory					X	
Medical Imaging					X	
PCP	X	X	X	X		
Pharmacy	X	X	X	X		
Podiatrist					X	
Physician Specialists					X	
Therapies					X	
Transportation					X	

Pima County – GSA 50

AHCCCS has divided Tucson in Pima County into 4 zones (defined by zip code boundaries). The following tables list the standard Number of Nursing Facilities and Assisted Living Facility LOI/contracts within each zone.

Tucson - Northwest Zone

The Northwest Zone is comprised of the following zip codes:
85321, 85653, 85654, 85701, 85704, 85705, 85737, 85738, 85741, 85742, 85743, 85745

Long Term Care	Northwest Zone	Facility Location Within the Zone
Nursing Facility	3	X
HCBS Community	**Must have 16 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)		X

Tucson - Southwest Zone

The Southwest Zone is comprised of the following zip codes: (Includes Green Valley)
85601, 85614, 85713, 85714, 85723, 85724, 85735, 85736, 85746

Long Term Care	Southwest Zone	Facility Location Within the Zone
Nursing Facility	2	X
HCBS Community	**Must have 10 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)		X

Pima County – GSA 50 Continued

Tucson - Northeast Zone

The Northeast Zone is comprised of the following zip codes:
85619, 85702, 85712, 85715, 85716, 85717, 85718, 85719, 85731, 85739, 85749

Long Term Care	Northeast Zone	Facility Location Within the Zone
Nursing Facility	8	X

HCBS COMMUNITY	**Must have 14 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**
Assisted Living Facilities (Adult Foster Care, Assisted Living Home)	**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)	X

Tucson - Southeast Zone

The Southeast Zone is comprised of the following zip codes: (Includes Sahuarita)
85601, 85629, 85641, 85706, 85708, 85710, 85711, 85730, 85732, 85734, 85747, 85748 85757,

Long Term Care	Southeast Zone	Facility Location Within the Zone
Nursing Facility	1	X

HCBS COMMUNITY	**Must have 37 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)	**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)	X

Pima County - GSA 50 Continued

HCBS HOME	Tucson	Green Valley	Countywide Coverage	Facility Location
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	

Behavioral Health

Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial rehabilitation			X	

Acute Services

Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

Pinal County - GSA 40

	Apache Junction	Casa Grande	Coolidge	Eloy	Florence	Kearney	Mammoth / San Man./ Oracle	County-wide Coverage	Facility Location
Long Term Care									
Nursing Facility	*1 – A.J. **5 – E. V.	1					3 - Tucson		
HCBS Community **Must have 17 or more Assisted Living Facilities**									
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)									X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)									X
HCBS Home									
Adult Day Health								X	
Attendant Care								X	
Emergency Alert								X	
Home Modifications								X	
Habilitation								X	
Home Health Care								X	
Home-Delivered Meals								X	
Homemaker								X	
Hospice								X	
Personal Care								X	
Respite Care								X	
Behavioral Health									
Inpatient Services								X	
Emergency Care								X	
Evaluation								X	
Individual, Group,									

Family Counseling								X	
Medication Monitoring								X	
Behavioral Health Day Program/Partial Care								X	
Psychosocial Rehabilitation								X	

Pinal County - GSA 40 Continued

	Apache Junction	Casa Grande	Coolidge	Eloy	Florence	Kearney	Mammoth / San Man./ Oracle	County-wide Coverage	Facility Location
Acute Services									
Dentist								X	
DME & Supplies								X	
Inpatient Hospital		X							
Laboratory								X	
Medical Imaging								X	
PCP	X	X	X	X	X	X	X		
Pharmacy	X	X	X		X	X	X		
Podiatrist								X	
Physician Specialist								X	
Therapies								X	
Transportation								X	

*1 – Apache Junction; **5– East Valley, Maricopa County

Santa Cruz County - 50

	Nogales	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	Within one hour drive of Nogales		

Must have with 3 or more Assisted Living Facilities

HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II			X

Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			

HCBS Home

Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	

Behavioral Health

Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Santa Cruz County – 50 Continued

	Nogales	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

Yavapai County - GSA 48

	Cottonwood	Prescott	Camp Verde	Sedona	Prescott Valley	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1	3	1	1	1		
HCBS Community	**Must have 20 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	

Hospice						X	
Personal Care						X	
Respite Care						X	

Behavioral Health

Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	

Yavapai County - GSA 48

	Cottonwood	Prescott	Camp Verde	Sedona	Prescott Valley	Countywide Coverage	Facility Location
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X					
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		
Podiatrist						X	
Physician Specialists						X	
Therapies						X	
Transportation						X	

Yuma County - GSA 42

	Yuma	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	4		

HCBS Community **Must have 11 or more Assisted Living Facilities**

Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II			X

Behavioral Health, Level III Behavioral Health, Rural Substance Abuse Transitional Agency)			

HCBS Home

Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Environmental Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	

Behavioral Health

Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	

Yuma County - GSA 42 Continued

	Yuma	Countywide Coverage	Facility Location
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

IV. References

- ACOM Policy 415
- AHCCCS Provider Affiliation Transmission User Manual
- ALTCS Contract, Section D
- ALTCS Contract, Section D
- ALTCS Contract, Section D

420 – RESERVED

421 – CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE RESIDENTIAL SETTINGS

Effective Date: 04/08/09, 11/01/12
Revision Date: 10/11/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to the Arizona Long Term Care System (ALTCS) Contractors in a Geographic Service Area (GSA) with more than one Contractor for Title XIX covered services, (hereafter known as Contractors), AHCCCS registered Nursing Facilities (NF) and Alternative Residential Settings (ARS).

This policy is limited to and defines the relationship between a NF and/or an ARS and a Contractor 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 Contractor, NF and ARS will collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

II. Definitions

Add-on — Generally refers to contract standards that a Contractor may have with a NF to establish criteria for additional payment to the Class 1, 2 or 3 levels determined by the UAT.

Alternative Residential Setting (ARS) — 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 9 A.A.C. 28 Article 1 and AMPM Chapter 1200, section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH) and Adult Foster Care (AFC) Homes.

Anniversary Date	The month the member is able to make an annual enrollment choice. The Anniversary Date is in most situations 12 months from the date the member was enrolled with the Contractor and annually thereafter. Only members in a GSA with more than one Contractor have a choice of Contractors.
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 a Contractor. Non-contracted NFs are those facilities that do not have a contract with a Contractor.
Room and Board (R & B)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF/MR). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Level 2) or an apartment like setting that may provide meals.
Subacute or Specialty Care	Generally refers to contract standards that a Contractor 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.
Share of Cost (SOC)	The amount an ALTCS member is required to pay toward the cost of long term care services is called the share of cost.
Universal Assessment Tool (UAT)	A standardized tool that is used by Contractors to assess the acuity of NF residents and commonly used for ARS residents residing in ALC, ALH and AFC settings. The use of the UAT is not intended to impact how Contractors 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.

III. Policy

A. Member / Resident Options When Contract is Terminated

Affected members residing in a NF and/or ARS 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 a Contractor that is contracted with the facility, or move to a setting that is contracted with their current Contractor.

A meeting between the Contractor, NF and/or ARS and AHCCCS 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 Contractor in collaboration with the NF and/or ARS and AHCCCS 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 Contractor must receive approval of their member / representative communication plan from the Division of Health Care Management Operations Unit. The plan must be submitted to AHCCCS within five business days of the termination decision.

B. Reimbursement

1. Nursing Facilities
   The Contractor shall 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 Contractor shall reimburse the NF at the greater of the AHCCCS fee for service schedule rates or the Contractor's previously contracted rates. Should AHCCCS reduce its fee schedule, the Contractor shall reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

   If the Contractor had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the Contractor shall apply those rates. Should AHCCCS adjust its fee schedule, then the Contractor will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Residential Settings
   The Contractor shall reimburse the ARS at the previously contracted rate. Should AHCCCS adjust its HCBS Fee Schedule rates, the Contractor will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

C. Quality of Care

In the event that a Contractor or other entity, such as Arizona Department of Health Services (ADHS) Licensure or AHCCCS, identifies instances where the overall quality of care delivered by a NF or ARS places residents in immediate jeopardy, the Contractors will inform residents /representative of the problems and offer the residents alternative placement. Members may have the option to continue to reside in the NF or ARS. In some cases, ADHS or AHCCCS may require that the Contractor find new placements for residents. In such cases, the Contractor shall work with the resident/representative to identify an appropriate placement that meets the needs of the resident. AHCCCS may also advise the Contractor in cases where the NF or ARS is under a bankruptcy or foreclosure order. In these instances, the Contractor should review the financial, health and safety status prior to placing a resident in a placement owned by the same entity. In the event that a Contractor identifies a member specific quality of care concern, the Contractor shall identify that to the NF or ARS for resolution. The Contractor shall also report to external entities, and to AHCCCS as required by Chapter 900 of the AMPM**.**

D. Admissions / Discharges / Readmissions

1. NFs or ARSs are not required to accept new admissions of members who are enrolled with a non-contracted Contractor.
2. NFs are required to otherwise follow admission, readmission, transfer and discharge rights as per 42 CFR 438.12.
3. The Contractor may authorize bedhold days up to the allowed limit (Short Term Hospitalization Leave – 12 days and Therapeutic – 9 days) as per Chapter 100 of the AMPM.

IV. References

- 42 CFR 483, Subpart B.
- A.A.C. 9-34
- AHCCCS/ALTCS Contract
- AHCCCS Medical Policy Manual, Chapter 900
- AHCCC Medical Policy Manual, Chapter 1200
- AHCCCS Medical Policy Manual, Chapter 1600

422 – AZSH COORDINATION

Effective Date: 01/15/09, 10/01/12
Revision Date: 01/15/09, 08/30/12

Staff responsible for policy: DHCM

I. Purpose

This policy establishes requirements for Acute Care, Arizona Long Term Care System (ALTCS), Comprehensive Medical and Dental Program (CMDP), and Division of Developmental Disabilities (DDD) Contractors to provide payment for services provided at the Maricopa Integrated Health Systems Clinics and or Medical Center to AHCCCS members residing in the Arizona State Hospital (AzSH).

II. Definitions

There are no definitions for this policy.

III. Policy

AzSH Coordination

All medical services for enrolled members residing in the AzSH who require medical services that are not provided by AzSH during their stay will be provided by Maricopa Integrated Health Systems Clinics and/or Medical Center. The Contractor will provide reimbursement for medically necessary services under one of the following arrangements:

- The Contractor will develop a contractual agreement with Maricopa Integrated Health Systems including Maricopa Medical Center, Clinics and MIHS physicians to provide all medically necessary services. The Contractor will assign MIHS PCPs to all members residing in AzSH.

OR

- In the absence of a contractual agreement, the Contractor will designate two staff members responsible for coordination of care, prior authorization processes, claims payments, provider and member issues for all services delivered by Maricopa Integrated Health Systems. These staff members will have knowledge of the Health Plans responsibility to arrange care for AzSH residents and provide a seamless and obstacle free process for the provision of services and payment and be available to AzSH and MIHS 24 hours a day.

Emergency medical services for AzSH residents will be provided by the MIHS Maricopa Medical Center and reimbursed by the Contractor regardless of prior authorization or notification.

Non-behavioral health related pharmacy services for AzSH residents will be provided by AzSH in consultation with the Contractor and the Contractor is responsible for payment.

IV. References

- Acute Care Contract Section D
- ALTCS Contract Section D
- CMDP Contract Section D
- DDD Contract Section D

423 – FINANCIAL RESPONSIBILITY FOR COURT ORDERED TREATMENT FOR DUI/DOMESTIC VIOLENCE OR OTHER CRIMINAL OFFENSES

Effective Date: 07/01/09, 09/01/13
Revision Date: 08/17/09, 08/29/13

Staff responsible for policy: DHCM Behavioral Health Administrator

I. Purpose

This policy applies to ADHS/DBHS, ALTCS/EPD, CRS, and DES/DDD (DDD) Contractors. 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 as a result of a judicial ruling.

II. 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) (R9-20-101)
DUI Services	DUI Screening, DUI education, or DUI treatment provided to an AHCCCS member. (R9-20-101)
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) (R9-20-101)

III. Policy

A. Driving Under the Influence (DUI)

The Contractor is responsible for covering and reimbursing services when they are AHCCCS covered services described in statute, rule, contract and policy. A court order is not necessarily a substitute for the Contractor's obligation to determine the amount, duration and scope of medically necessary services. The Contractor should not assume that a court or administrative agency ordering DUI screening, education or treatment services is aware of the scope of AHCCCS covered services or of how medical necessity is defined for purposes of the AHCCCS program. Nevertheless, the Contractor may take into consideration, the medical information and factual findings of the court or administrative agency in making the Contractor's 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 a charge against the county, city, or town whose court ordered the screening, education and/or treatment. See A.R.S. §36-2027 (E) (and refer to R9-20-101). As such, the county, city or town is a source of third party liability for any evaluation and/or treatment services that are also AHCCCS covered services. Upon receipt of the claim, the Contractor should deny the claim and return it to the provider with directions to bill the responsible county, city or town.

B. 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, an AHCCCS member cannot be considered a legally responsible third party with respect to themselves. As a result, it is AHCCCS' expectation that the Contractor

responsible for the provision of behavioral health services will provide domestic violence offender treatment when the service is deemed medically necessary. When required prior authorization is obtained and/or the service is provided by an in-network provider, the member is not a source of first or third party liability as those terms are defined in A.A.C. R9-22-1001. The Contractor should not deny the claim based on the court order. The Contractor will provide medically necessary services and document the member's record to justify medical necessity for the services rendered.

C. 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: (1) it appears the person is an alcoholic, and (2) such person chooses the evaluation and treatment procedures. The court cannot order the person to undergo treatment and evaluation for more than thirty days. The cost of evaluation and treatment of an indigent patient treated pursuant to a court order under A.R.S. §36-2027 is a charge against 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 AHCCCS covered services, the Contractor may deny the provider's claim and direct the provider to bill the appropriate county, city, town or charter city.

IV. References

- Arizona Revised Statute Title 36, Chapter 18, Article 2
- Arizona Revised Statute §28-1381, §28-1382, or §28-1383
- Arizona Revised Statute §28-1301
- Arizona Revised Statute §13-3601.01
- Arizona Revised Statute §36-2027
- Arizona Revised Statute §36-2028
- Arizona Administrative Code R9-22-1001
- Arizona Administrative Code R9-20-101

424 - VERIFICATION OF RECEIPT OF PAID SERVICES

Original Date: 01/01/10
Effective Date: 04/01/10
Revision Date: 07/01/10, 10/28/10, 10/01/2012

Staff responsible for policy: DHCM Finance

I. Policy

This policy applies to the Acute, ALTCS, CRS, CMDP, DES/DDD, and ADHS/BHS Contractors. All Acute Contractors will be responsible for verifying member receipt of paid services according to Federal and contractual requirements to identify potential service / claim fraud. The Contractor will be expected to perform periodic audits through member contact and report the results of these audits to AHCCCS DHCM.

II. Definitions

Validation Receipt of affirmative confirmation from the member (written or verbal)

III. Procedure

A. General Requirements

1. Contractors shall perform, at a minimum, quarterly audits to determine member receipt of paid services.

2. A Quarterly Verification of Services Audit Report, shall be due on January 15th; April 15th; July 15th; and October 15th; using the format in Attachment A.

B. Sampling

1. Shall 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 C.F.R. § 455.20 and 433.116(e). The report is due the 15th day after the end of the quarter that follows the reporting quarter. 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.

2. Members who are surveyed shall have been enrolled with the Contractor during the period under review.

3. Shall consist of claims that resulted in payment.

4. Shall be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility, assisted living facility and in-home services).

5. Sample size shall be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an ALTCS Contractor with less than 2,000 members shall be 50 claims. (The minimum sample size refers to completed surveys.)

C. Methodology

1. The audit can be performed by mail, telephonically or in person (e.g., ALTCS case management on-site visits). Concurrent review will be allowed, however, if used it must be recorded and tied back to a successfully adjudicated claim.

2. 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.

3. Individual survey results indicating that paid services may not have been received shall be referred to the Contractor's fraud and abuse (F&A) department for review and on to the AHCCCS OIG department as appropriate.

D. Reporting

1. Shall include 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 department for further review (Attachment A).

2. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the Contractor's F&A department and analysis and interventions where appropriate.

IV. References

- Acute Care Contract, Section D, Surveys
- Acute Care Contract/CRS, Attachment J, Surveys
- ALTCS Contract, Section D, Surveys
- ALTCS/DDD, Section D, Surveys
- CMDP Contract, Section D, Surveys

Attachment A: Quarterly Verification of Services Audit Report

Contractor Name:
Reporting Quarter:
Date of Submission:

Type of Service Reviewed	Total Surveys Sent Out	Number of Surveys Completed	Survey Percentage	Total Services Requested for Validation	Number of Services Validated	% of Services Validated	Number of Services Referred to AHCCCS OIG Department	Notes
Assisted Living Facilities			0.0%			0.0%		
Dental			0.0%			0.0%		
DME			0.0%			0.0%		
Emergency Facility Services (ER and Urgent Care)			0.0%			0.0%		
Evaluation & Management (PCP, Physician, and Specialists), Referral, and Other			0.0%			0.0%		
Home Health Services and HCBS			0.0%			0.0%		
Inpatient			0.0%			0.0%		
Lab. X-ray (Medical Imaging and X-ray			0.0%			0.0%		
NF/			0.0%			0.0%		
Outpatient (All other outpatient)			0.0%			0.0%		
Pharmacy			0.0%			0.0%		
Physical Therapy, Occupational Therapy, Speech Therapy			0.0%			0.0%		
Transportation			0.0%			0.0%		
Vision			0.0%			0.0%		
Total	**0**	**0**	**0.0%**	**0**	**0**	**0.0%**	**0**	

425 - SOCIAL NETWORKING

Original Date: 02/01/2010
Effective Date: 02/01/2010
Revision Date: 02/25/2010, 01/01/2011

Staff responsible for policy: DHCM Operations

I. Purpose

The purpose of this policy is to provide requirements for policy development, permitted uses of applications, and acceptable content for Social Networking. This policy shall also apply to all communications included in Policy 404, Member Information; Policy 416, Provider Network Information; and all future Website Requirements policy, when conducted through Social Networking applications.

II. Scope

This policy applies to all AHCCCS Medical and Behavioral Health Contractors (Acute, Long Term Care, CMDP, the CRS Contractor, and ADHS/DBHS) if/when the Contractor chooses to use Social Networking applications/tools for a Medicaid line of business.

III. Definitions

Broadcast: Video, Audio, or text messages transmitted through an internet, cellular or wireless network for display on any device.

Friends/Followers: Persons that choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

Interactions: Conversational exchange of messages.

Intermediary: Steps that allow review and approval prior to publication.

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

Static Content: Copy written by the Contractor or taken from an outside authoritative source for web posting, for any period of time, shall be defined as Static Content and

considered member materials under Policy 404 of the AHCCCS Contractors Operations Manual. Static Content does not include individualized e-mails or "status" messages.

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.

Username: An identifying pseudonym associating the author to messages or content generated.

Web Blog (Weblog): A type of website, usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order.

IV. Policy

A. General Requirements:

1. Contractors must establish a Social Networking Administrator; who can hold another position, but is ultimately responsible for policy development, implementation and oversight of all activities.

2. Contractors shall develop an internal company policy, based on the content of this policy, for the use of Social Networking to interact with its membership and/or providers with regard to the AHCCCS lines of business. The policy must include a statement of purpose/general information stating how the Contractor uses Social Networking (i.e., customer service, community outreach, notifications; members and/or providers). This policy must be evaluated and submitted on an annual basis no later than 45 days after the beginning of the contract year, or 45 days prior to initiation of a new policy, to AHCCCS DHCM for approval.

3. Intended uses and initial content must be submitted to DHCM for approval 30 days prior to launch of any new Social Networking capability.

4. Contractor employees shall receive instruction and/or training on the AHCCCS and Contractor's policy before using Social Networking applications on behalf of the Contractor.

5. The policy must include the requirement that, when using Social Networking applications, the protection of Personal Health Information (PHI) and all HIPAA Privacy Rules related information must be maintained and monitored. This includes the maintenance of records under federal regulation, state law and Contract, for the purposes of monitoring compliance with this requirement.

6. Contractors shall develop and maintain a Social Networking Matrix that identifies personnel and subcontractors participating in social networking activities on behalf of the Contractor which shall include the Social Networking application name (i.e., MySpace, Twitter, Facebook, Nixle.com, etc.), first and last name of the individual, username (if applicable), e-mail address, and password.

7. The Social Networking Plan shall also identify management resources, internal teams, external management resources (subcontractors) and human resource needs to monitor usage, analyze information trends and prepare responses for the public or private individuals/organizations. (Such information and trends can be an invaluable tool for gathering public and private information, identifying future training requirements or focus group information, or outreach programs and to improve public awareness).

8. All web blogs shall be clear, direct, professional, honest, ethical, and written in the first person.

9. Contractors shall comply with copyright and intellectual property law. They shall also reference or cite sources appropriately.

10. AHCCCS reserves the right to monitor, or review the Contractor's monitoring of, all web blog and blogging activity without notice.

B. Social Networking Applications:

If the site or medium is not listed in this section, you may submit the URL of a page describing the requested media to AHCCCS for review/approval. However, unless separately approved or listed below, the Contractor can assume the site or medium is prohibited.

Permitted:

Communication

- **Blogs**: Blogger, LiveJournal, Open Diary, TypePad, WordPress, Vox, ExpressionEngine, Xanga
- **Micro-blogging / Presence applications**: Twitter, Plurk, Tumblr, Jaiku, fmylife
- **Social networking**: Bebo, Facebook, LinkedIn, MySpace, Orkut, Skyrock, Hi5, Ning, Elgg
- **Social network aggregation**: NutshellMail, FriendFeed

- **Events**: Upcoming, Eventful, Meetup.com

Prohibited (includes but is not limited to):

Collaboration

- **Wikis**: Wikipedia, PBwiki, wetpaint
- **Social bookmarking** (or social tagging)[3]: Delicious, StumbleUpon, Google Reader, CiteULike
- **Social news**: Digg, Mixx, Reddit, NowPublic
- **Opinion sites**: epinions, Yelp

Multimedia

- **Photo sharing**: Flickr, Zooomr, Photobucket, SmugMug, Picasa
- **Video sharing**: YouTube, Vimeo, sevenload
- **Livecasting**: Ustream.tv, Justin.tv, Stickam
- **Audio and Music Sharing**: imeem, The Hype Machine, Last.fm, ccMixter

Reviews and Opinions

- **Product Reviews**: epinions.com, MouthShut.com
- **Community Q&A**: Yahoo! Answers, WikiAnswers, Askville, Google Answers

Entertainment

- **Media & Entertainment Platforms**: Cisco Eos
- **Virtual worlds**: Second Life, The Sims Online, Forterra
- **Game sharing**: Miniclip, Kongregate

Other

- **Information aggregators**: Netvibes, Twine (website)
- **Platform providers**: Huzu

C. User Requirements:

1. The Contractor's presence on such sites must include an Avatar and/or a Username that clearly indicates what company is being represented; and cannot use the AHCCCS logo or State of Arizona seal. When registering for Social Networking applications, all contractors shall use their company email address. If the application requires a username, the following syntax shall be used:
   http://twitter.com/< contractor_identifier><username>

2. Interactions must be personalized from the Contractor to include an identifying handle or representative code so as to specify which Contractor employee has issued the communication. Records must be kept of each update and who is responsible for the update as it occurs.

3. All Social Networking connections must be initiated by the external user and not the Contractor.

4. All interactions with the public must either be general broadcast message of information availability or responses to inquiry that contain only referral to authoritative resources such as Contractor, State Agency, or Federal Agency websites (including emergency public health advisories). Contractors shall not reference, cite, or publish information, views or ideas of any third party without their written consent and only as permitted by AHCCCS for the purpose of conducting business on behalf of AHCCCS.

5. Updates, messages and reminders must only be distributed to registered friends/followers who have chosen to receive these types of communication whether actively or passively (through a subscription initiated by the external user).

6. External user-generated content (comments/posts) is not permitted unless an intermediary approval process is in place.

7. All static, distributed, or broadcast content must be generated by the Contractor and submitted for approval to AHCCCS DHCM.

8. Under no circumstance should AHCCCS authorized business that involves the communication of personal identifying, confidential or sensitive information be conducted on a Social Network, web blog or blog system.

9. Photographs placed on pages must be hosted on the site and not linked from outside web pages. Contractors shall not post information, photos, links/URLs or other items

online that would reflect negatively on any individual(s), its citizens, AHCCCS or the state.

10. No video may be placed/embedded on Social Networking sites.

11. Additionally, the Contractor is prohibited from tagging photographic or video content and must remove all tags placed by others upon discovery.

12. No ads, whether targeted or general, will be permitted on Social Networking sites.

13. No affiliate/referral links or banners are permitted. This includes links to other non-Medicaid lines of business that the Contractor or a parent company is engaged in. Any site that automatically generates such linkage, recommendation, or endorsement on side bars or pop-ups must contain a message prominently displayed in the area under the Contractor's control that such items, resources, and companies are NOT endorsed by the Contractor or AHCCCS.

D. Functionalities

The Following Functionalities are Permitted:

1. Search - Finding information through keyword search

2. Links - Guides to other related information

3. Signals - The use of syndication technology such as RSS to notify users of content changes.

The Following Functionalities are Prohibited:

1. Authoring - The ability to create and update content leads to the collaborative work of many rather than just a few web authors. In wikis, users may extend, undo and redo each other's work. In blogs, posts and the comments of individuals build up over time.

2. Tags - Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories.

3. Extensions - Software that makes the Web an application platform as well as a document server.

V. References

Government Information Technology Agency, Statewide Policy P505, Social Networking
PARIS IT Plan AHCCCS 2010

426 - ELIGIBILITY REVIEWS FOR CRS APPLICANTS AND REFERRALS

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: The Division of Health Care Management, Medical Management and Operations departments.

I. Purpose

This policy defines the processes used to accept and process applications and referrals to the CRS program. The CRS Contractor is responsible for processing and responding appropriately to all requests for acceptance and coverage of AHCCCS enrolled members who have been identified as having a CRS-covered condition as defined in AHCCCS Medical Policy Manual Policy 330, Covered Conditions in the CRS Program.

II. Definitions

III. Policy

The CRS Contractor will accept and process a referral and application for CRS service coverage of an AHCCCS member that is submitted in the manner described in this policy. CRS provides covered services defined in AMPM Policy 340 only to individuals who have been confirmed as having a CRS-covered condition as defined in AMPM Policy 330. AHCCCS will monitor, through required reporting and periodic audit, adherence to the criteria and the quality of decision-making by the CRS Contractor.

IV. Procedure

A. Eligibility Requirements

All AHCCCS enrolled children under the age of twenty-one (21) are eligible for enrollment in the CRS Program when the presence of a CRS-covered condition – as defined by AMPM Policy 330 – is confirmed through medical review by the CRS Contractor.

B. Form Requirements

1. The CRS Contractor shall place a copy of all required referral/application documentation on their website in an area that is accessible to any qualified physician or health plan regardless of contract status.
2. Referral/application forms will be submitted to AHCCCS for review and approval at any time that there is a change to content or requirements. Approval of forms will follow the process and timelines for material changes to policy outlined in Section D, Paragraph 29, Network Management.
3. Any qualified provider - regardless of CRS affiliation - or any AHCCCS Contractor, may submit a referral for CRS services.
4. The CRS Referral/Application Form may be faxed, mailed, or delivered in person to the CRS Contractor as indicated at the website address. And must contain, at a minimum, the following information:
    a. Name; Address; and Phone number of Referral Source
    b. Relationship of person completing the referral/application form to the applicant.
    c. Applicant's name; DOB; Social Security Number; Sex; Home Address and Contact Information; Race; Citizenship; and Preferred Language
    d. If the applicant is a child, the name of at least one parent/guardian of the applicant.
    e. If known to the referral source:
        i. Diagnosis;
        ii. List of allergies;
        iii. PCP name;
        iv. Previous CRS enrollment dates;
        v. The reason that the referral source believes the applicant may be eligible for CRS services.
5. The following additional documentation may be submitted with the application:
    a. Documentation supporting the medical diagnosis
    b. Diagnostic testing results that support the medical diagnosis

C. Processing

1. Within fourteen (14) calendar days of receipt of a referral/application, the CRS Contractor’s Medical Director or designee must review the documentation provided to determine an applicant’s eligibility for CRS.

2. The CRS Contractor will use the Prepaid Medical Management Information System (PMMIS) as verification of Title XIX/XXI enrollment, age, residency, and citizenship/qualified alien status. Applicants who are not enrolled in Title XIX/XXI cannot be enrolled in CRS.

3. The CRS Contractor Medical Director or designee shall review all submitted referral/application materials in accordance with Attachment J of the Contract with the following possible outcomes.
    a. The applicant is eligible;
    b. The applicant is not eligible;
    c. Further information is needed to determine eligibility; or
    d. A physical examination is needed to determine the presence of a CRS medical condition. The physical examination must be scheduled within 30 calendar days of the decision.

D. Notifications

1. When an applicant is determined eligible for CRS, notification will be made to the following parties:

    a. Applicant
    b. Referral Source
    c. AHCCCS – Upon identification of the member as a CRS recipient, the Contractor will notify AHCCCS through the appropriate Recipient Roster Reconciliation tape. AHCCCS will make appropriate update to the AHCCCS Contractors' enrollment files.
    d. Health Plan/Program Contractor – The Contractor will notify the Health Plan/Program Contractor of enrollment, through a documented process, of the:
        i. Recipient's CRS Qualifying Diagnosis;
        ii. Enrollment Effective Date; and
        iii. Assigned CRS Specialty Clinic.

2. When an applicant is determined ineligible for CRS, notification will be made to the following parties:

    a. Applicant – the applicant shall receive a notification of denial, in writing, that contains the statement of denial; the reasons for the denial and any information regarding potential gaps in documentation that may be resolved; and outlines all appeal rights and processes; within fourteen (14) calendar days of the determination of ineligibility.
    b. Referral Source – The Contractor shall inform the referral source, in writing, within five (5) working days of the determination of ineligibility.
    c. Health Plan/Program Contractor – The Contractor shall inform the Health Plan/Program Contractor within five (5) working days of the determination of ineligibility.

Notice Requirements

The Children's Rehabilitative Services (CRS) Contractor must issue a Notice of Eligibility/Enrollment Determination for the following reasons:

a. The CRS Contractor's denial of an applicant's request for CRS eligibility and enrollment, or
b. The CRS Contractor's disenrollment of a CRS member for any reason.

The CRS Contractor must use Attachment 1 of this policy when issuing a Notice of Eligibility/Enrollment Determination. This form may not be modified without prior approval by AHCCCS other than as directed on the form in those areas marked [Insert]. The inserted language must accurately and adequately describe the following:

a. The factual basis for the CRS Contractor's determination of ineligibility or disenrollment, and
b. The legal basis supporting that decision.

3. If further information is needed in order to make a determination of medical eligibility for the CRS program, the Contractor will issue notifications to the following:

   a. Applicant – The applicant shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty- (30) days from the date of the notice).
   b. Referral Source - The referral source shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty- (30) days from the date of the notice).

4. If a physical examination is needed to determine the presence of a CRS qualifying medical condition, notice shall be provided to:

   a. Applicant – upon deciding that a physical examination is needed to determine the presence of a CRS qualifying medical condition, the Contractor shall notify the applicant within fourteen (14) calendar days of receipt of the referral/application of the need for the examination, indicate a scheduled appointment date and time for the evaluation (must occur within (30) days of the notification), and outline the possible outcomes should the applicant not complete the indicated steps.

E. Enrollment Requirements

The CRS Contractor will enroll an AHCCCS member as a CRS recipient if the requirements of Section IV(A) of this policy are met.

1. The CRS Contractor shall enroll the applicant in CRS effective on the same date as the eligibility determination.
2. The expiration date at the time of enrollment is the day before the recipient's 21st birthday.
3. If an applicant is inpatient at the time of the eligibility determination, enrollment cannot occur until the applicant has been discharged.

F. Termination of Enrollment

The CRS Contractor may terminate a recipient's enrollment in the CRS Program for the following reasons:

1. The CRS Contractor determines that the recipient no longer meets the medical and/or any of the non-medical eligibility requirements for CRS (age, residency, citizenship/qualified alien, and a CRS medical condition).
2. The recipient is terminated from Title XIX/XXI eligibility.
3. The recipient or, if the recipient is a minor, the recipient's parent requests termination of the recipient's enrollment in the CRS program. A recipient who does not have third-party insurance shall be advised by the CRS Contractor of the financial implications of termination and referred back to the AHCCCS Health Plan Contractor of enrollment for additional information on seeking services related to the CRS condition.

Notification Requirements Regarding Termination

a. The CRS Contractor shall complete a CRS Clinic Patient Discharge Form and place the form in the medical record.
b. Notify the AHCCCS Administration, through established mechanisms, of the termination through the eligibility update process.
c. Send written notice of termination to the recipient or, if the recipient is a child, a parent of the recipient that includes hearing rights or instruction of hearing process for AHCCCS eligibility.
d. Send a copy of the written notice of termination to the recipient's Primary Care Physician, if known, and the Health Plan/Program Contractor of enrollment.

G. Re-enrollment

1. Re-enrollment shall occur, without the necessity of a new referral/application, upon re-enrollment in the AHCCCS program or upon request.
2. Re-enrollment shall be effective on the date that the request for enrollment is made, provided that eligibility is confirmed.
3. If re-enrollment occurs as a result of a determination of eligibility for Title XIX/XXI services that contains a Prior Period Coverage segment, written notification of re-enrollment should advise the recipient/parent that appointments should be rescheduled and that any services provided during the PPC period may be reimbursed with proper documentation of the request.
4. Upon re-enrollment, the CRS Contractor shall review any previous service plan documentation to determine if disruptions to treatment occurred and update the service plan accordingly.

H. Appeals of CRS eligibility determinations

1. A decision made by a CRS Contractor to deny a request for eligibility and enrollment, or to disenroll a CRS member, is subject to appeal by requesting a review through the CRS Contractor.
2. Who May File
   a. The applicant or disenrolled member, or if the member is a minor, the member's parent or other legal guardian.
   b. The person's legally authorized representative.
3. An applicant or authorized representative must submit a written request for review of the determination to the CRS Contractor within thirty- (30) days of receiving the Notice of Eligibility Determination.
4. The written request shall minimally contain:
   a. The name and address of the applicant or member, or if
   b. The member is a minor, the name and address of the parent, legal guardian, or other legally authorized representative;
   c. The adverse decision made by a CRS Contractor; and
   d. The reason for the review request.

Notice of Eligibility Determination Review

The CRS Contractor shall mail a written notice to the recipient/recipient's representative stating that the request for eligibility determination review was received and will be reviewed and responded to within thirty- (30) days.

Notice of Final Eligibility Determination

The CRS Contractor will review all pertinent information regarding the eligibility determination, including any additional information submitted with the appeal letter,

to make a final decision regarding the validity of the original determination. The Contractor will issue a formal response, in writing, to the recipient/recipient's representative within thirty (30) days of receipt of the request for Eligibility Determination Review; which will contain an explanation of the determination including reference to any pertinent policies, rules, or statutes and describing the right to request a State Fair Hearing.

Request for State Fair Hearing regarding Eligibility Determinations

The recipient/recipient's representative may file a written request for State Fair hearing within sixty- (60) days of receipt of the Final Eligibility Determination. The request for State Fair Hearing must include the Final Eligibility Determination reason and a statement that the recipient continues to disagree with this determination.

Requests for State Fair Hearing will be forwarded to the AHCCCS Office of Administrative Legal Services (OALS), within five- (5) days of receipt by the Contractor, for scheduling.

Notice of Request for State Fair Hearing

The Office of Administrative Hearings shall mail a Notice of Hearing to all parties under A.R.S. § 41-1092.05 if the request for an Administrative Hearing is timely and contains the information listed above.

The Notice shall contain:

a. A statement of time, place, and nature of the hearing;
b. A statement of the legal authority and jurisdiction under which the hearing is to be held;
c. A reference to the statutes and rules involved; and
d. A short plain statement as to the matters in question.

Denial of a Request for a State Administrative Hearing

The Office of Administrative Legal Services shall deny a request for an Administrative Hearing if:

a. The request for an Administrative Hearing is untimely;
b. The request for an Administrative Hearing is moot based on the factual circumstances of the case; or
c. The sole issue presented is a Federal or State law requiring an automatic change adversely affecting some or all similarly situated applicants.

Withdrawal of a Request for a State Administrative Hearing

The Office of Administrative Legal Services shall accept a written request for withdrawal from the applicant, member, or authorized representative if Notice of Hearing has not been mailed. If OALS has mailed a Notice of Hearing, OALS shall forward the written request for withdrawal to the Office of Administrative Hearings (OAH).

Notice of Hearing Decision

AHCCCS shall mail a Decision to the applicant or member or if the member is a minor, the parent, legal guardian, or other legally authorized representative, no later than thirty- (30) days after the date of the administrative law judge's recommended decision.

Motion for Rehearing or Review

Under A.R.S. § 41-1092.09, AHCCCS shall grant a rehearing or review for any of the following reasons materially affecting an applicant or member's rights:

a. Irregularity in the proceedings of a State Fair Administrative Hearing that deprived a person filing a petition (petitioner) of a fair hearing;
b. Misconduct of AHCCCS, OAH, or a party;
c. Newly discovered material evidence that could not, with reasonable diligence, have been discovered and produced at the hearing;
d. The decision is the result of passion or prejudice;
e. The decision is not justified by the evidence or is contrary to law; or
f. Good cause is established for the nonappearance of a party at the hearing.

V. References

427 - CRS CONTRACTOR NO-SHOW POLICY

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: DHCM Operations; CRS Contractor

I. Purpose

This policy shall explicitly describe no-show monitoring and notification processes to ensure medically necessary care is received according to the recipient's Service Plan.

II. Definitions

Appointment: A scheduled medical visit to a specialist or clinic that has been documented in the recipient's Service Plan.

CRS Contractor: The AHCCCS Contractor responsible for provision of CRS-Covered Services.

Health Plan: The AHCCCS Contracted health plan in which a CRS recipient is enrolled for Acute medical services.

Contractor: The AHCCCS Contracted health plan in which a CRS recipient is enrolled for Long Term Care medical services.

III. Policy

In addition to monitoring appointment accessibility under Policy 417 of this manual, the CRS Contractor is expected to ensure that recipients receive scheduled care for their complex medical conditions. The CRS Contractor is expected to have proactive monitoring mechanisms for ensuring completion of scheduled care indicated in the recipient's Service Plan. The Contractor will monitor completed appointments using the process outlined in this policy.

IV. Procedure

For the first and second missed appointments, the CRS Contractor shall contact the recipient/recipient's representative by phone or letter to reschedule appointments. If the recipient/recipient's representative does not respond after two attempts to contact (with at least forty-eight (48) hours between attempts), the CRS Contractor must send a letter to the recipient/recipient's representative requesting a rescheduled appointment.

For the third missed appointment, the CRS Contractor shall send a letter to the recipient/recipient's representative, and the Health Plan/Contractor of enrollment, stating that the recipient/recipient's representative needs to contact the CRS Clinic to reschedule the appointment.

If the recipient/recipient's representative do not respond within ninety (90) days to any of the CRS Contractor's verbal and written notifications regarding missed appointments, the CRS Contractor shall send a written notice to the recipient/recipient's representative, and the Health Plan/Contractor of enrollment, stating that the recipient/recipient's representative need to contact the CRS Clinic to reschedule an appointment. The notice must inform the recipient that the Health Plan/Contractor will not cover CRS related services.

The CRS Contractor must document all attempts to contact the recipient/recipient's representative.

A CRS Contractor cannot terminate a recipient from the program for no-show appointments.

V. References

Acute Care Contract, Attachment J, Paragraph 33

428 - CRS SERVICE AUTHORIZATION PROCESSES

Original Date: 01/01/11
Effective Date: 01/01/11
Revision Date:

Staff responsible for policy: DHCM Medical Management; CRS Contractor

I. Purpose

To define the processes specific to the CRS program with regard to Prior Authorizations as defined in the AHCCCS Medical Policy Manual Chapter 1000, Medical Management.

II. Definitions

CRS Contractor: The AHCCCS Contractor responsible for provision of CRS-Covered Services.

Provider Service Requisition (PSR): The form, or electronic version of the same form, that is uniformly utilized by all subcontracted and non-contracted providers to request service authorization for a CRS Recipient, related to the CRS Condition.

III. Policy

The CRS Contractor is responsible for administering benefits for AHCCCS members who have been enrolled as CRS recipients for the treatment of specific covered conditions. In providing these services, care coordination is of paramount importance. The CRS Contractor is responsible to develop internal policies and procedures that comport with this Policy.

IV. Procedure

A. Provider Service Requisitions (PSR)

1. The provider/physician shall complete a Provider Service Requisition Form (PSR) and transmit it to the CRS Contractor.
2. A PSR form shall include (at a minimum) the following required elements:
   a. CRS member name and date of birth;
   b. Requesting physician's name and specialty;
   c. Requesting physician's National Provider Identifier number;
   d. Service provider's name and specialty if different from requesting physician;

e. Service provider's National Provider Identifier number if different from requesting physician;
f. CRS diagnosis;
g. Proposed date of service, (if known);
h. Proposed service to be provided;
i. Narrative description or supporting documentation/reason of medical necessity for the proposed service;
j. Record date that PSR request is received by CRS Contractor;
k. Type of authorization request (standard or expedited);
l. Complete referral/service type requested (place of service and/or type of service inpatient, ambulatory, physician's office);
m. Place for name of authorizing medical professional and date of prior authorization approval;
n. Date authorization notice was sent to provider, physician, or facility.

3. CRS Contractor shall have a process for authorizing the PSR that shall determine whether the requested services are medically necessary and appropriate. Decisions on CRS coverage and medical necessity shall be based on the criteria found in AMPM Chapters 300, 900 and 1000.
4. CRS Contractor shall investigate or verify other coverage(s) to which the individual may be entitled, including any requirements for pre-certification by other carriers or liable parties.
5. CRS Contractor's prior authorization staff (RN, BSN, MD) shall be named and date the authorization for services and send notice of the authorization to the requesting provider when completed.
6. CRS Contractor shall place appropriate limits on services based on a reasonable expectation that the amount of services authorized will achieve the expected outcome.

B. Out-of-State Services Requirements

1. Services provided outside the state of Arizona are covered for CRS recipients when all of the following are verified:
   a. The out-of-state services are related to a CRS condition;
   b. The medical specialty, treatment, or procedure is not available in Arizona;
   c. Two CRS physicians of the appropriate medical specialty recommend out-of-state treatment;
   d. The treatment is considered to be lifesaving or will result in significant functional improvement based on favorable data published in peer reviewed national medical literature;
   e. Prior authorization is obtained from the CRS Medical Director and Administrator.
2. The procedures for obtaining out-of-state services are as follows:
   a. The request will be reviewed by the CRS Contractor Medical Director to determine medical necessity; appropriateness of request based on in-state

availability of the service requested; and, in consultation with an appropriate sub-specialist, whether the requested provider/facility is capable, willing, and certified to perform the service.

b. The CRS Contractor will be responsible for scheduling, coordinating transportation and lodging as appropriate, and ensuring that any acute or long term care needs are coordinated with the Health Plan/Contractor of enrollment for the duration of the necessary stay.
c. Payment for travel and lodging are not covered by the CRS Contractor and are considered patient responsibility.
d. The out-of-state treatment site must provide a discharge summary for the recipient in order to receive reimbursement for services rendered regardless of prior approval.

C. Denial or Reduction of Services

CRS Contractor procedures for determining that a requested service is not a CRS-covered benefit shall include:

1. A clinical review by the CRS Medical Director of decisions to deny authorization on the grounds of medical appropriateness, medical necessity, or CRS coverage;
2. The ability of the CRS Medical Director to consult with another appropriately credentialed CRS physician(s) regarding the requested procedure when the requesting physician challenges the denial;
3. Written notification to the requesting provider of any decision to refer, deny, limit, or discontinue authorization of services, including appropriate steps for appealing the decision (See AMPM Chapter 1000, and ACOM Policy 417);
4. Proper documentation regarding the reasons behind the adverse decision; and
5. Assurance that adverse decisions shall only be rendered by the CRS Medical Director or designee; who must sign all adverse decisions or denials.

V. References

- AHCCCS Medical Policy Manual Chapter 1000
- Acute Care Contract, Section D, Paragraph 24
- Acute Care Contract, Attachment J, Paragraph 24
- 42 CFR 438.400 et seq.

429 – DIRECT CARE WORKER TRAINING AND TESTING PROGRAM

Effective Date: 01/01/2012, 10/01/12
Revision Date: 4/01/11; 12/08/11; 03/08/12, 09/13/12, 10/03/12

Staff responsible for policy: DHCM/ALTCS Unit

I. Purpose

This policy applies to Arizona Long Term Care System (ALTCS) Contractors and the agencies / programs training and testing Direct Care Workers (DCW). This policy addresses the program requirements that are applicable to the training and testing of DCWs (See AMPM Policy 1240-A).

II. Definitions

Approved Direct Care Worker Training and Testing Program ("Approved Program")	An Approved Program is any entity that is approved by AHCCCS to provide training and testing of DCWs. These Approved Programs can be an AHCCCS registered agency that provides Direct Care Services, a private vocational program or an educational institution (e.g., high school, college or university).
Corrective Action Plan (CAP)	A written work plan that identifies the root cause(s) of the deficiency, includes goals and objectives, actions / 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 and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.
Direct Care Services	See AMPM, Chapter 1200. http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1200.pdf
Direct Care Worker	See AMPM, Chapter 1200, Policy 1240-A. http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap1200.pdf

Principles of Caregiving

A curriculum prepared under the guidance of the Direct Care Workforce Alliance and made available to the public at no cost. The curriculum consists of Caregiving Fundamentals and two modules:

1. Aging and Physical Disabilities, and
2. Developmental Disabilities

The content of this curriculum addresses the DCW competencies; and will be updated periodically. Adopting the Principles of Caregiving curriculum satisfies the requirements for curriculum approval, but no guarantee is made that students completing the training will have all skills needed to provide services to a particular client. The curriculum is available on the AHCCCS website (www.azahcccs.gov/dcw).

Direct Care Worker Agency

An agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care and Homemaker. The agency by registering with AHCCCS warrants that it has the ability, authority, skill, expertise and capacity to perform the services as specified in AHCCCS policy.

Program

An entity that is approved to provide the training and testing of DCWs as required by AMPM Chapter 1200. (Same as "Approved Direct Care Worker Training and Testing Program" and "Approved Program")

Contractor

An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services as specified by the Arizona Long Term Care System contract, AHCCCS statute and rules and federal laws and regulations.

Test, Arizona Standardized DCW

The Arizona Standardized DCW Test (Test) is the test that an individual must pass to demonstrate the required knowledge and skills to become a qualified DCW.

Test, Challenge

The standardized test that an individual with education similar to what is required for DCWs or work experiences similar to that performed by DCWs can request to take without having to complete the required DCW training.

Trainer	Individuals designated by an Approved Program and qualified to conduct training of DCWs. Trainers must have passed all the tests at the level required of Trainers for competencies they teach (Caregiver Fundamentals, Aging and Physical Disabilities and/or Developmental Disabilities), have experience providing direct care and experience in teaching groups of adults.
Private Vocational Program	An Approved Program that does not have an AHCCCS Provider ID for providing services or is a training program that is subsidiary of a DCW agency. This can include private businesses. Individuals not established as a business organization cannot be a private vocational program.

III. Policy

A. Requirements for an Approved Direct Care Worker Training and Testing Program

Approved Direct Care Worker Training and Testing Programs (Approved Programs) must comply with all policies for training and testing of DCWs. Only Approved Programs may administer the required Arizona Standardized DCW test. Training and tests administered by an organization that is not an Approved Program are not valid.

1. Curriculum Standards
    a. An entity using the "Principles of Caregiving" need only attest that it is utilizing these instructional materials. There is nothing that restricts an entity seeking approval or an Approved Program from including other training material.
    b. An entity not using the "Principles of Caregiving" must submit evidence that its training curriculum meets the competencies established for the "Principles of Caregiving".
    c. An Approved Program must routinely update their curriculum to align with updates posted to the AHCCCS website at www.azahcccs.gov/dcw.

2. Trainer Qualifications and Protocols
   An Approved Program is responsible to prepare and/or qualify (initially and ongoing) their trainers. An Approved Program must ensure each trainer:
    a. Before they begin teaching has achieved a score of 92% for the knowledge test(s) and 100% for the skills test for any curriculum modules they teach. Approved Programs can train their own trainer, but the testing of a trainer must be administered by a trainer from another Approved Program. The same testing standards apply to trainers and DCWs (See III.A.3.). DCWs who become trainers, do not need to retake the knowledge and tests if the original test scores were at or above the level required of a trainer. However, skills tests must be

retaken because the skills-based testing requirements are more stringent for trainers than DCWs.

b. Has substantive hands-on experience as a caregiver of at least one year. Experience must include providing personal care and working with relevant client populations, such as older adults or individuals with disabilities, including family members.
   If the trainer, employed by the Approved Program as a trainer prior to 10/01/2012, has passed both the knowledge and the skills tests but does not have the minimum one year of experience, they must obtain at least 40 hours of hands-on experience. The trainer is not eligible to train until the hands-on experience requirements have been met.
c. Has at least one year experience in teaching groups of adults (any field) or three months (100 plus hours) preparation to become an instructor in direct care. Preparation can include coaching, mentoring, co-teaching, and coursework.
d. Conducts at least two (2) DCW training classes per year.

Additionally, the following protocols apply to DCW trainers.

e. Individuals who are "experts" or licensed / certified on a training subject (e.g., Physical Therapist or Registered Nurse to train on body mechanics) may provide training related to their area of expertise in the absence of the qualified trainer. The Approved Program is responsible to ensure that "experts" used to provide training is capable / competent to conduct a portion of the training.
f. Trainers may have assistant trainers to assist with training. The trainer must be present for all training if the assistant trainer is not a qualified trainer.
g. Trainers who are also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per ARS 32, Chapter 15 must meet all of the aforementioned requirements to become a qualified trainer outlined in this section.

3. Training and Testing Standard
   a. An Approved Program must have access to the necessary space to conduct training. The knowledge based aspect of training can be provided through a variety of approaches, including video and e-learning. Portions of the skills training can also be provided through video and e-learning techniques; however there must be hands-on training of skills to ensure the student is able to appropriately perform the task (e.g., wheelchair to bed transfer).
   b. An Approved Program must have access to the basic necessary supplies and training equipment (e.g., wheelchair, hospital bed) to facilitate skills training and testing. Appropriate alternative supplies or training equipment may be used. A list of required and recommended supplies and equipment is available on the AHCCCS website (www.azahcccs.gov/dcw).
   c. An Approved Program must use standardized tests provided by AHCCCS. The Program may integrate the test (knowledge and skills) into the training program. The testing may be split into smaller units. A "final" test is not required if the

testing is conducted in this manner. The Program must ensure that all knowledge and skills testing documents and questions remain secured.

d. If an individual is unable to take a written test they may request to take an oral knowledge test. If an oral knowledge test is provided it must be read from a prepared text in a neutral manner. An Approved Program may offer the tests to a student in a language other than English.
e. A DCW agency may request the challenge test one time for an employee if they have education similar to what is required for DCWs or work experiences similar to that performed by DCWs. The DCW agency and the Approved Program administering the challenge test must verify and document the DCWs related educational and work experience. The challenge test cannot be repeated. A student who takes the challenge test and fails (either knowledge or skills tests or both) must be trained and, then, retake and pass the knowledge and skills tests in order to become a qualified DCW**.**
f. Trainers who are also Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants per ARS 32, Chapter 15 are exempt from completing the training. They are permitted to take the tests and, then, retest if tests are failed without training.
g. Retesting is permitted if the student has been trained or is exempt from the training requirement (e.g., Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per ARS 32, Chapter 15). If a knowledge test is failed, the student must retake the entire test. If one or more skills are failed, only the failed skill(s) need to be retested. Trainers shall provide additional training as needed before retesting. Retesting cannot occur the same day the failed tests were administered.
h. A DCW who is also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per ARS 32, Chapter 15 is exempt from the DCW training and testing requirements. This exemption allows the DCW agency the discretion to test and train their employees as desired. Note: Trainers who are also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per ARS 32, Chapter 15 must meet all the requirements to become a qualified trainer (See III.A.2.), including the requirement to pass the knowledge and skills tests.
i. A DCW with an initial hire date prior to 10/01/2012 is deemed to meet the training and testing requirements with the DCW agency (ies) they are currently employed. However, if the DCW becomes employed with another agency on or after 10/01/2012 they must meet the training and testing requirements. j. Unless deemed as noted above, a DCW must have achieved a score of 80% for each knowledge test that they complete and pass all (100%) of the skills test for any curriculum modules they complete.
k. All DCWs with an initial hire date on or after 10/01/2012 must meet the DCW training and testing requirements within 90 calendar days from date of hire. It is permissible for DCWs to provide care during the 90 day training period. In the event the DCW's 90 day training period has expired prior to the DCW getting

trained and passing the knowledge and skills tests, the DCW must stop providing care until the training and testing requirements are met.

l. Test administration guidelines are available on the AHCCCS website (www.azahcccs.gov/dcw).

4. Program Policy Standard
   a. An Approved Program must maintain polices for: training program structure and process; validating/verification and sharing individual DCW and trainer test results; and testing process and maintaining test integrity
   b. Policies must be reflective of the training and testing requirements.

5. Training and Testing Records
   a. An Approved Program shall maintain accurate and complete records of all training and testing. This includes but is not limited to names of trainers including the names of any individual experts used, schedules (dates and times), class rosters with evidence of student attendance (student and trainer signatures) and individual student records (test type, modules and results).
   b. The current/former employer of a trainer or DCW shall share testing records upon request by a new/prospective employer, with the permission of the trainer or DCW using the Verification of Direct Care Worker Testing form available on the AHCCCS website (www.azahcccs.gov/dcw). The employer shall maintain copies of the Verification Testing forms provided to requesting entities.
   c. Records of all training and testing shall be retained for six (6) years.

6. Continuing Education
   a. Continuing Education requirements are the responsibility of the DCW's employer and not that of an Approved Program. See AMPM Chapter 1200, Policy 1240-A.

B. Initial Program Approval

1. Application
   a. The applying entity must submit a completed, signed and dated Application for Approval for DCW Training and Testing form to AHCCCS. The form is available on the AHCCCS website (www.azahcccs.gov/dcw).
   b. An entity that charges individual students for DCW training and testing must be licensed by the Arizona Board of Postsecondary Education (A.R.S 32.3001 et. seq. and A.A.C R4-39-103).

2. Review of Application
   The initial application review is a "paper review," with no planned onsite review. AHCCCS personnel will
   a. Compare the application to the requirements.
   b. Request, as needed, additional documents from the applicant before making a final determination to approve an application.

3. Final Approval of Application and Notice
   a. A written notice of approval will be sent to the requesting entity by AHCCCS. The written notice will include the effective date of the approval.
   b. Training and testing of DCWs may begin no sooner than the date of program approval.
   c. All Approved Programs will be listed at www.azahcccs.gov/dcw.

C. Continuing Program Approval

After a DCW training and testing program is approved by the AHCCCS an ALTCS Contractor will conduct a post-initial audit within 180 days of the initial program approval. AHCCCS will coordinate with the Contractors to determine which Contractor shall conduct the year one audit and subsequent onsite annual audits (+/- 2 months). AHCCCS may perform audits in lieu of Contractors. An onsite review of an Approved Program, outside of the audit cycle, can be performed at the discretion of AHCCCS, the Contractor or the assigned auditing Contractor.

1. Year One Audit
   a. The post-initial audit is a desk audit and does not constitute an onsite visit. The post-initial audit occurs once and within 180 days of an Approved Program's initial approval. The Contractor shall provide at least a 30 day advance notice of a scheduled audit in order for the Approved Program to prepare for the audit.
   b. Information, documents and evidence to be provided by the Approved program and reviewed by the auditor include, but are not limited to policies and procedures, evidence of adequacy of training space and evidence of access to the necessary equipment and supplies to provide the skills training and testing and qualification of trainers. Other documents must be available to the auditor upon request.

2. Onsite Audit
   a. The onsite audit occurs annually on the anniversary of the year one audit (+/- 2 months). Auditors will visit the Approved Program's main training site, but the audit will be inclusive of all training sites.
   b. The Contractor shall provide at least a 30 day advance notice of a scheduled audit in order for the Approved Program to prepare for the audit.

c. Information, documents and evidence to be provided by the Approved Program and reviewed by the Contractor include but are not limited to policies and procedures, evidence of adequacy of training space, evidence of access to the necessary equipment and supplies to provide the skills training and testing, qualifications of trainers, curriculum and training and testing records including training and testing records of individual students. Other documents must be made available to the Contractor upon request.
d. Upon request from the Contractor, the Approved Program will provide data (e.g., rosters) reflecting all individuals that were trained and tested for the audit period under review. A random sample of 50%, but no more than 10 individual training records will be selected by the Contractor to evaluate compliance of DCW training and testing requirements. The sample selection shall not be selected from a sole training session, but shall be representative of training sessions from multiple training sites that have occurred throughout the audit period.
e. A record review to determine if the DCW providing services has met the training and testing requirements is not part of the process for continuing program approval. Contractors will need to review this type of information when monitoring a DCW agency to ensure a member's caregiver is a qualified DCW as required by AMPM Chapter 1200. For Approved Programs that also serve as a DCW agency, Contractors are encouraged to conduct their monitoring oversight of DCW services at the same time as the continuing program approval review in an effort to reduce the administrative burden.

3. Notice of Audit Findings
   a. Contractors will issue a letter indicating the findings of the audit (compliant, compliant with recommendations or provisional approval pending corrective action) and the completed report to the Approved Program within 30 days of completing the audit.
   b. AHCCCS will update the Approved Programs listing with the audit findings to the AHCCCS website (www.azahcccs.gov/dcw) on a monthly basis.
   c. Contractors will promptly provide the full report to other Contractors upon request.

4. Provisional Approval Pending Corrective Action
   a. If the Contractor determines the Approved Program is not compliant in one or more areas of the audit, the Approved Program will be granted provisional approval pending a correction action plan (CAP). . The Contractor shall summarize the deficiencies noted in the audit report to support the Approved Program in developing and implementing a CAP. Approved Programs with a provisional approval status can continue to provide training and testing of DCWs. See III.C.4. if the program is not in agreement with the decision.
   b. The Approved Program shall submit their CAP to the Contractor within 15 days of receipt of the audit findings and report. The CAP shall include a timeline for

the deficiencies to be corrected, not to exceed 30 days from the CAP submission.
c. The Contractor has the discretion to require the Approved Program to submit evidence or documentation and/or conduct an on-site review to determine if the CAP was implemented successfully.

d. The Contractor shall send a notice updating the continuing program approval status to the Approved Program and to AHCCCS. If the Contractor determines that the program is still out of compliance, 3.a. b. and c. will be repeated one more time.

e. Upon failure to correct deficiencies after two attempts at a CAP, the Contractor will notify AHCCCS. AHCCCS will notify the Approved Program the continuing program approval has been denied and no longer an approved direct care worker training and testing program. See III.C.4. if the Program is not in agreement with the decision.

f. A training and testing program that has been denied continuing program approval based on the findings from an audit shall wait at least 90 days from the date of the denial notice before submitting a new application to become an Approved Program.

5. Disagreement with Audit Findings

a. An Approved Program disagreeing with the audit findings shall submit their dispute along with evidence to the auditing Contractor within 15 days of receipt of the audit findings and report.

b. The auditing Contractor will reconsider the results of the review based on the evidence provided by the disputing Approved Program. The Contractor shall submit findings to the Program and AHCCCS within 30 days of receipt of the dispute.

c. If the Approved Program disagrees with the findings they will submit to the Contractor a request for reconsideration along with evidence within 15 days of receipt of the findings. The Contractor will submit to AHCCCS the request for reconsideration along with the evidence submitted by the Program and other available evidence that would be necessary for reconsideration.

d. AHCCCS will issue a final decision to the program and Contractor within 30 days of receipt of the request for reconsideration and evidence. The Program's continuing program approval for training and testing will be denied if the final decision is that the Program is not in compliance with the training and testing requirements. AHCCCS will post the final results to the AHCCCS website and notify all Contractors in writing.

6. Audit findings and reports and other related documents shall be maintained by the Contractor that performs the audit for six (6) years.

D. Exemptions

1. Educational Institution: An educational institution (e.g., high school, college or university) is exempt from the initial and continuing program approval requirements if it submits a signed copy of the Application for Approval for DCW Training and Testing form (Available on the AHCCCS website, www.azahcccs.gov/dcw) form attesting that its DCW training and testing program meets the DCW competencies as established through the Principles of Caregiving. This form must be completed and submitted to AHCCCS for initial program approval and annually thereafter.

2. Approved Programs licensed by the Arizona State Board for Private Postsecondary Education (AZPPSE) : A program licensed by the AZPPSE is exempt from the initial and continuing program approval requirements if it submits a signed copy of the Application for Approval for DCW Training and Testing form (Available on the AHCCCS website, www.azahcccs.gov/dcw) form attesting that its DCW training and testing program meets the DCW competencies as established through the Principles of Caregiving. This form must be completed and submitted to AHCCCS for initial program approval and annually thereafter.

IV. References

- AMPM Chapter 1200
- www.azahcccs.gov/dcw

430 – ELECTRONIC MEMBER CHANGE REPORT (MCR)

Effective Date: 05/01/2012
Revision Date: 05/01/2012

Staff responsible for policy: DHCM/ALTCS Unit/Case Management

I. Purpose

This policy applies to Arizona Long Term Care System (ALTCS) Contractors. This policy provides a tutorial on the process for reporting to AHCCCS, via the electronic Member Change Report (MCR), when a change needs to be made on a member's eligibility or enrollment record.

II. Overview/General Information

Prior to November 2007, Member Change Reports were submitted in hard copy form to either the local eligibility office (Division of Member Services) or the Division of Health Care Management (DHCM) for a variety of member change types.

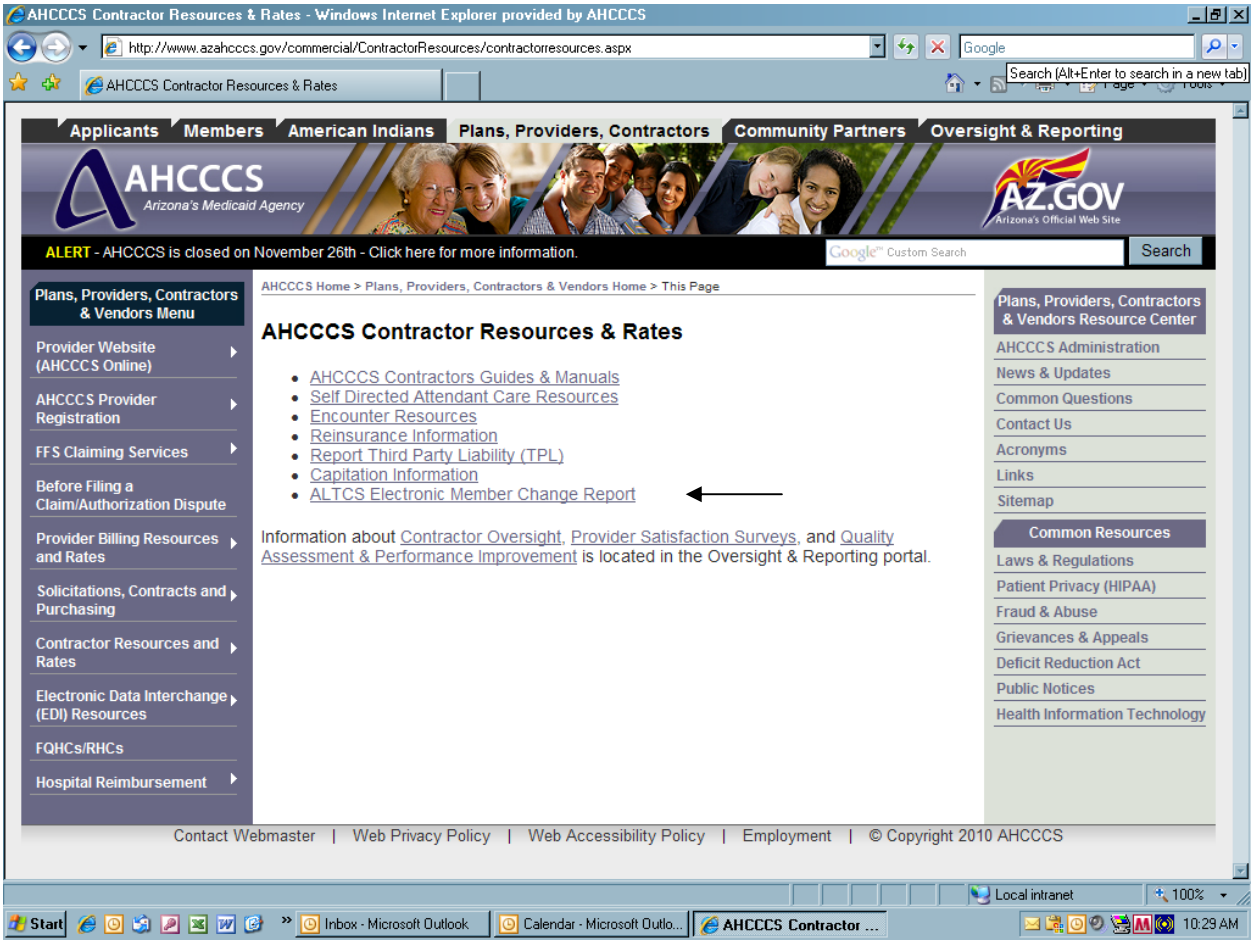
That was replaced by the electronic process to increase efficiency and create better tracking and reporting mechanisms for both AHCCCS and the Contractors.

III. Electronic Member Change Report

The pages that follow will show examples of all the screens used to complete the various types of Member Change Reports.

A. Accessing the Electronic Member Change Report link

The Electronic Member Change Report is accessed via the AHCCCS website (www.azahcccs.gov) on the Contractors Resources and Rates page as shown below.

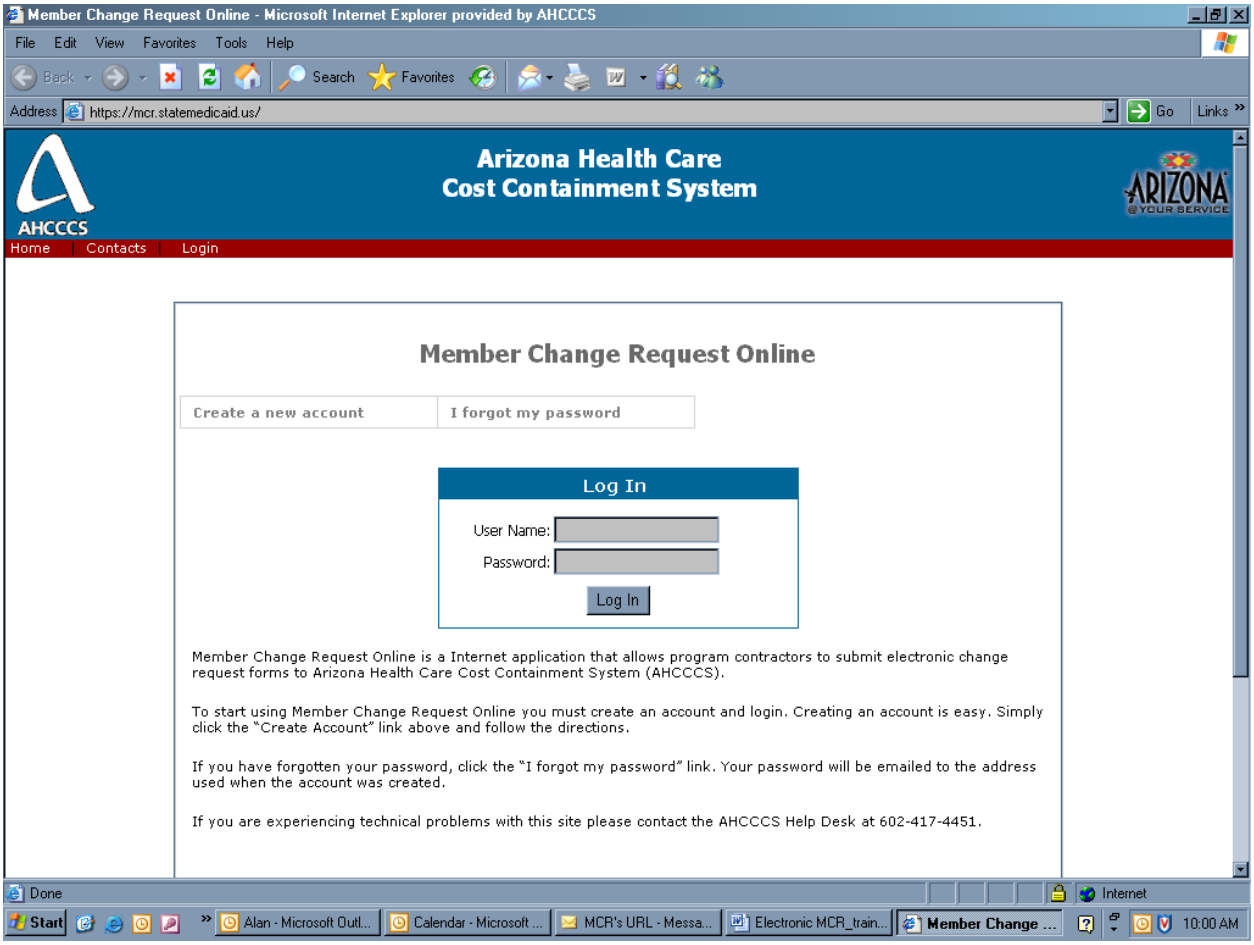


B. Log-In screen

The screen shown below is used to log-in to the Contractor's home page once a user has created an account.

First time users must click on the "Create a new Account" button before being able to access the home page. See the next 2 pages for details about how to create an account.

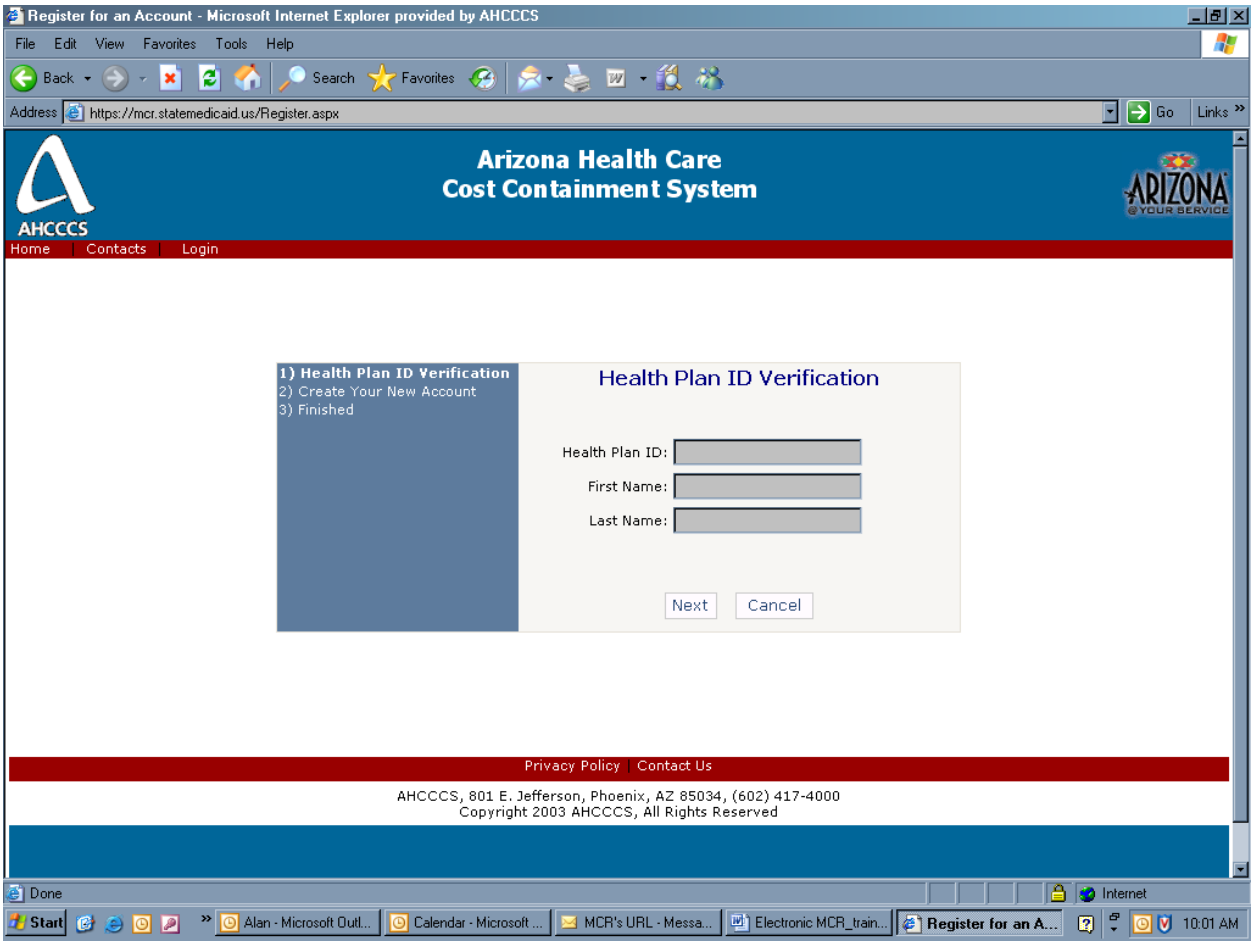
Once an account is created, users may try up to 5 times to enter their password in this log-in before getting locked out and needing to have the password reset. It is strongly recommended for users who have forgotten their password that they click on "I forgot my password" to request their password be emailed to them before trying 5 times. If locked out, the user must call AHCCCS Customer Support at (602) 417–4451 to be reset.



C. Creating a new Account

1. Health Plan ID Verification

Accounts will be created for individuals to be associated with a specific Program Contractor. The user must enter the 6-digit Health Plan ID# of the Program Contractor they work with, their First and Last Name as shown below and then click on NEXT.



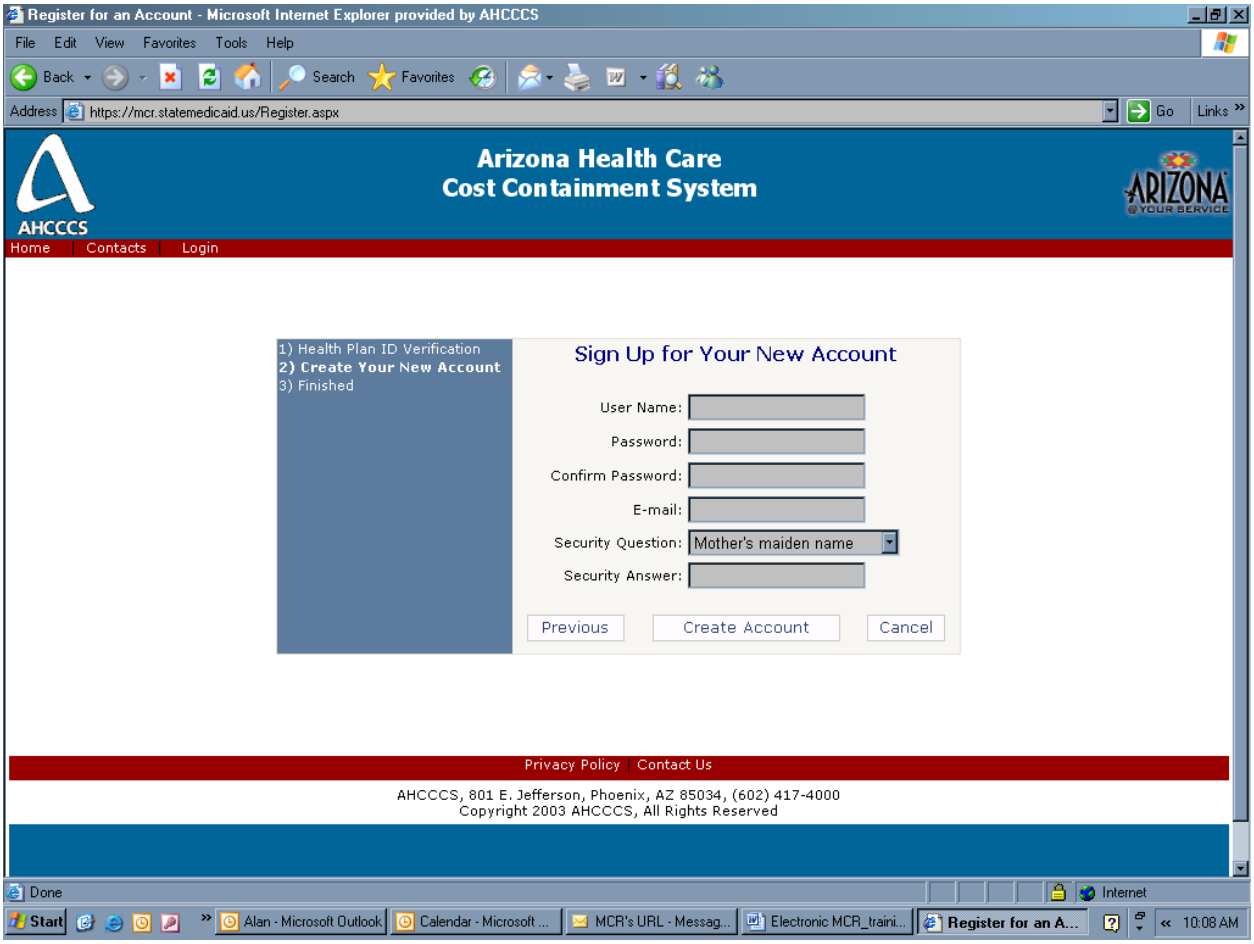
ALTCS Health Plan ID#s:

Program Contractor	Health Plan ID
Bridgeway Health Solutions	110088
DES/DDD	110007
Evercare Select	110049
Mercy Care Plan	110306

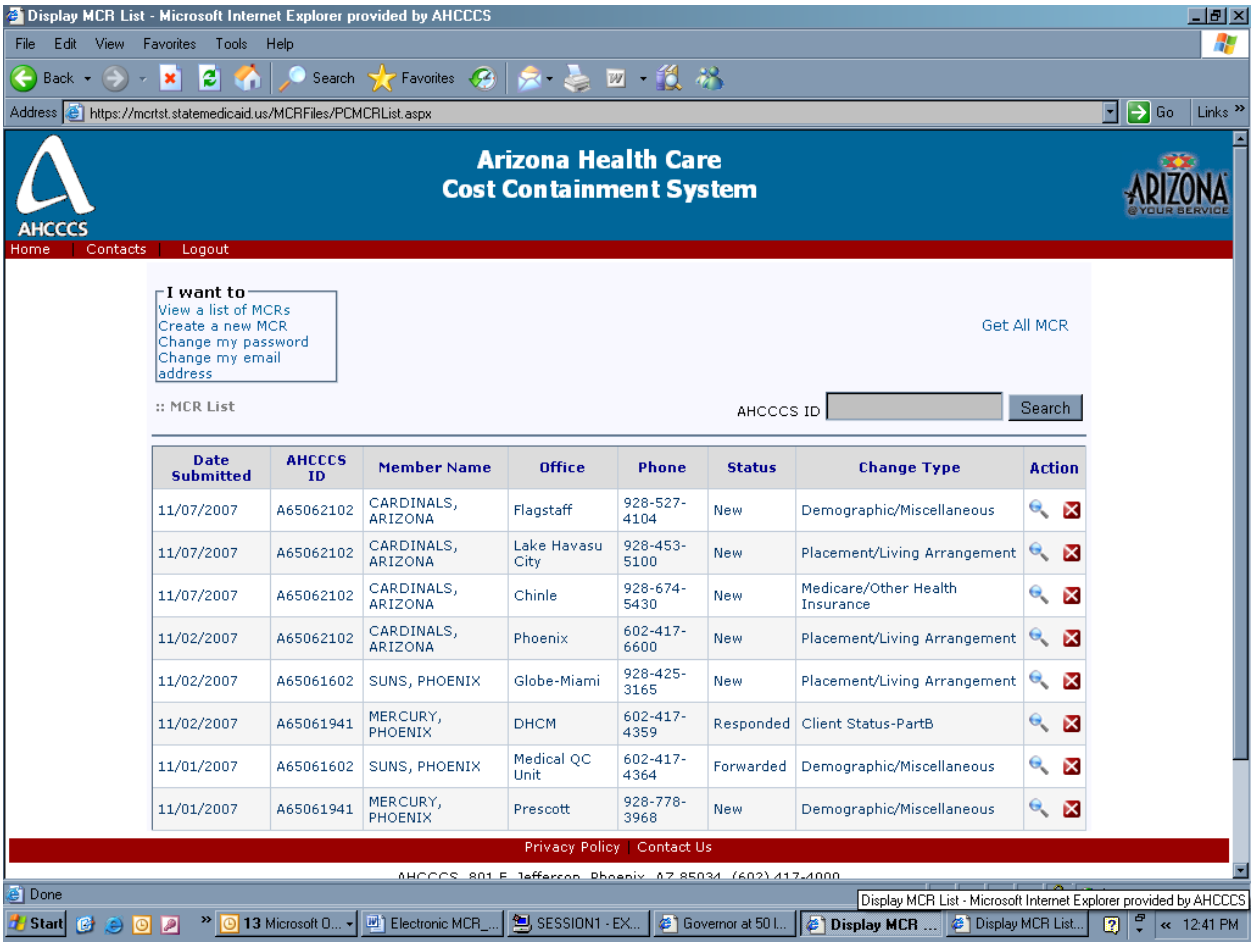
2. User Name

Users will be registered with their Program Contractor account using an email address and a password. The email address will be used to communicate with the user in the event the password is forgotten.

- User Names are case sensitive but there are no specific requirements regarding length and/or alpha/numeric characters. It is recommended that users use their real name for this entry.
- Passwords must be a minimum of 6 characters long and can be alpha or numeric or a combination of both. Passwords are also case sensitive.
- Each user can only be assigned to one Health Plan by email address at a time.
- The user should choose a security question from the drop down list and enter an answer to that question. These will be used to verify the user if the password is forgotten.



D. Contractor "Home" Page



Whenever a user associated with a Program Contractor logs in, a page similar to the one shown above will appear as the "home page" for that Contractor. This page will list all MCRs submitted by the Contractor. The default sort is by "Date Submitted" but the list can be re-sorted by any column data by clicking on the header name, for example, "Member Name" or "Change Type".

Clicking on the image in the "Action" column of a specific MCR will display the details of that MCR. The "Status" for each MCR listed will show one of the following:

- New – submitted by the Contractor but not yet assigned or processed by AHCCCS
- Assigned – the MCR has been assigned to an AHCCCS staff person to process the change but that action has not yet been taken. Who the assigned staff person is and their contact information can be viewed in the details of the MCR by clicking on the image.
- Forwarded – the MCR was forwarded from the AHCCCS location where the Contractor sent it to another AHCCCS location that is more appropriate to process it.

- Responded – AHCCCS has responded to the submitted MCR. Typically this will be following action taken to process the change reported but it may also indicate that no action was taken for some reason. Comments from the AHCCCS location responding should be included to explain any non-action.

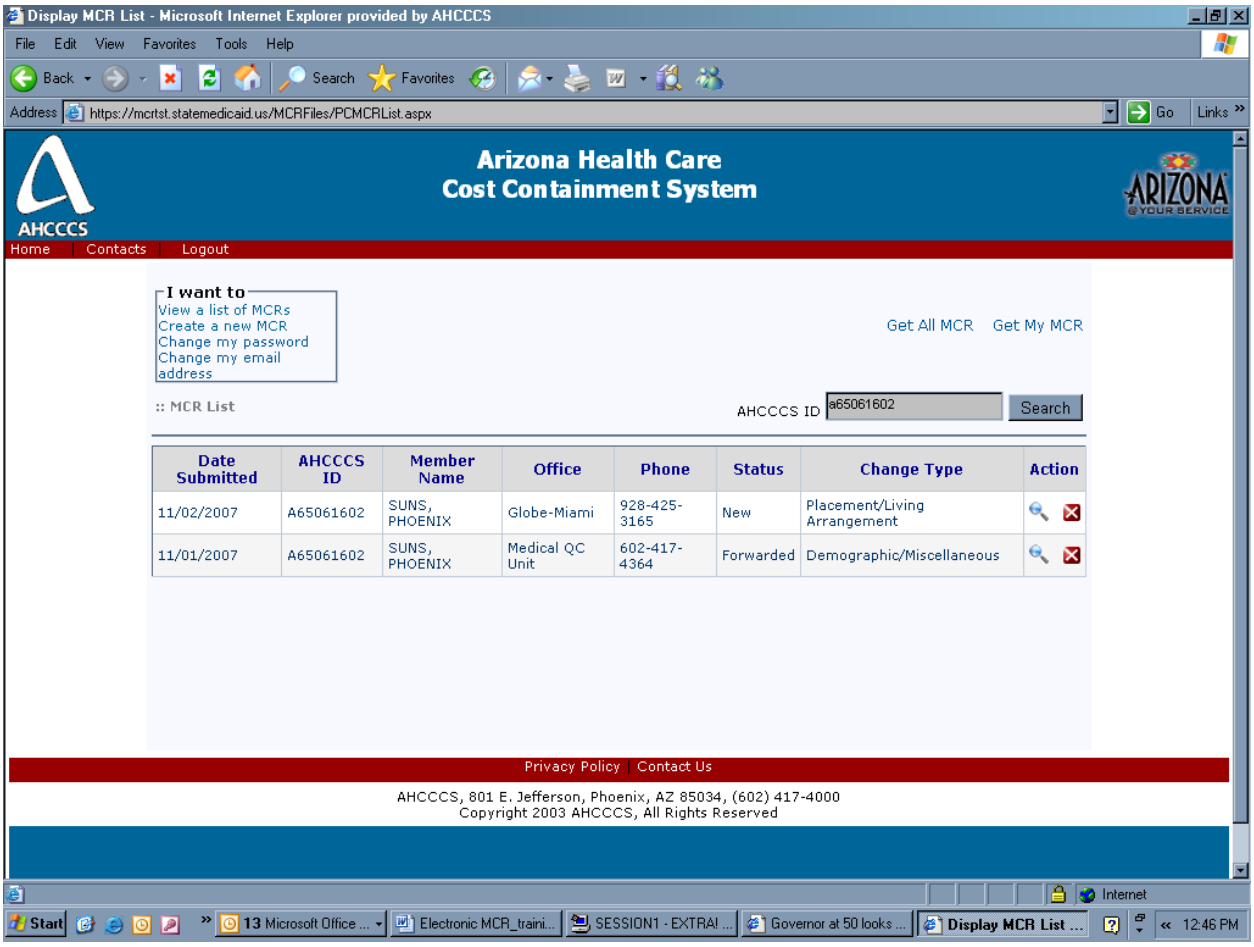
Clicking on the image in the "Action" column of a specific MCR will "close" that MCR and remove it from the Program Contractor's list. **This should only be done after an MCR has been responded to by AHCCCS** (either action taken or information to indicate why no action was or will be taken) because the MCR can **not** be retrieved once it is closed.

The "Create a new MCR'' button in the "I Want to" box (upper left) will display a screen where a new MCR can be created.

The "Search" button (upper right) can be used to search, by AHCCCS ID#, the Contractor's master list of MCRs for all MCRs submitted and not yet closed for a specific member. A filtered list will be displayed (see page 8 of this policy). Clicking on "Get all MCRs" will then return the user to the unfiltered, master list of MCRs.

From this screen, users can also change their password and/or email address that was entered when their account was created.

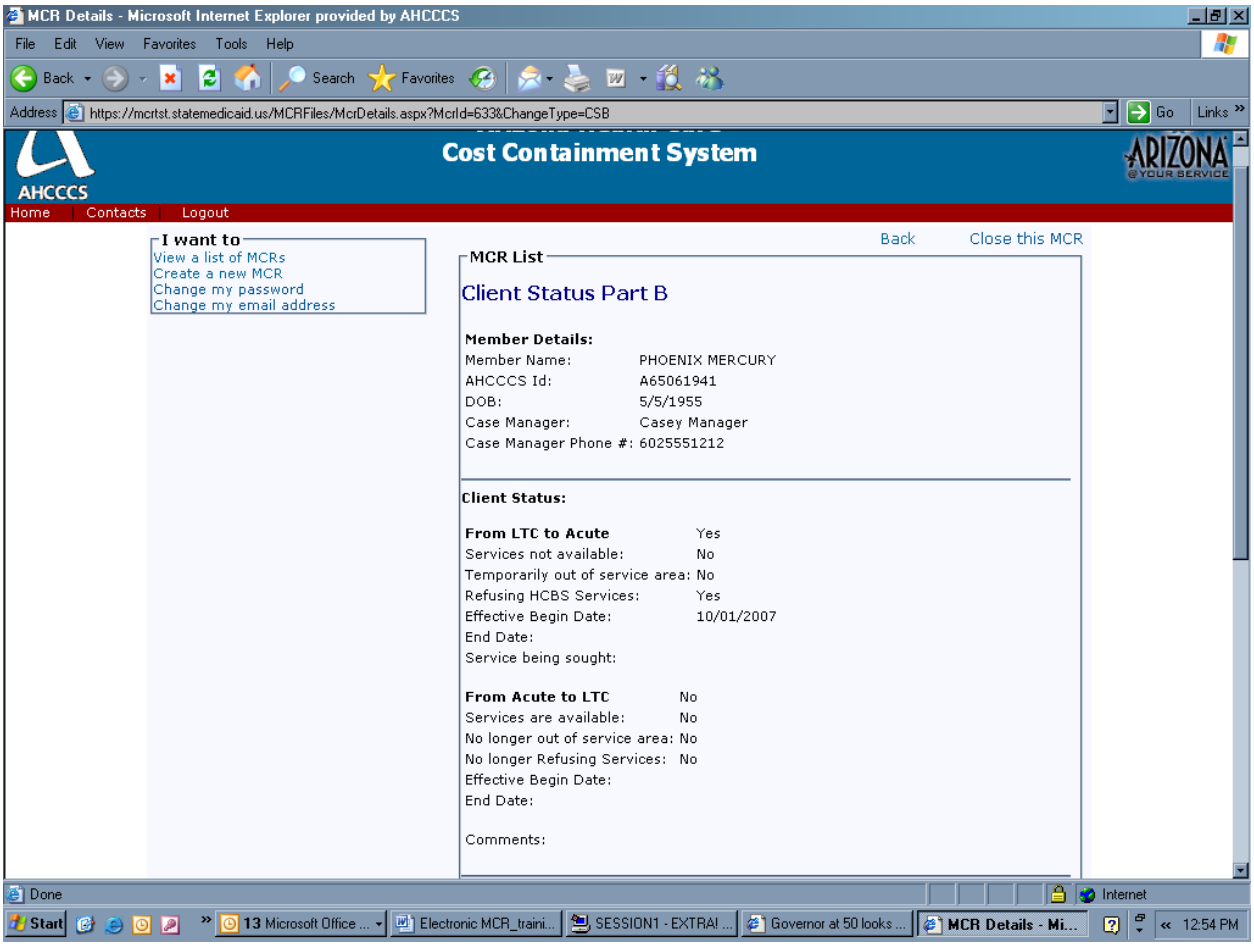
1. Home Page - Search by AHCCCS ID



This screen example shows how all the still-open MCRs for a selected member will be displayed when the member's AHCCCS ID# is entered and the "Search" function is used.

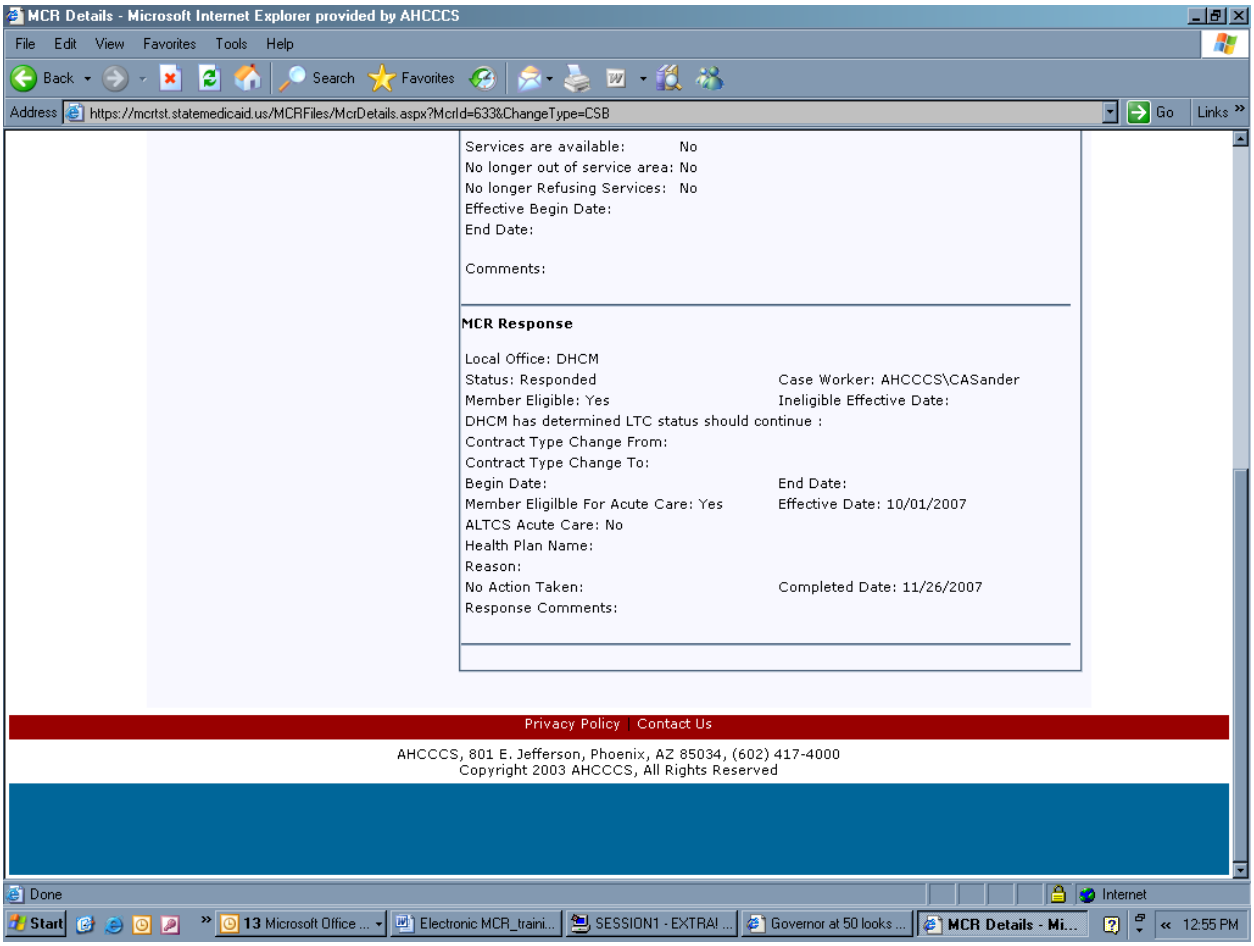
The "Get all MCR" button can be used to return the user to the master list of all still-open MCRs for the Contractor on their "home" page.

2. Home Page - Responded MCR view



- This screen, and the continuation on the following page, shows an example of the view of a "Responded" MCR that the user will see by clicking on the image in the "Action" column of the specific MCR.

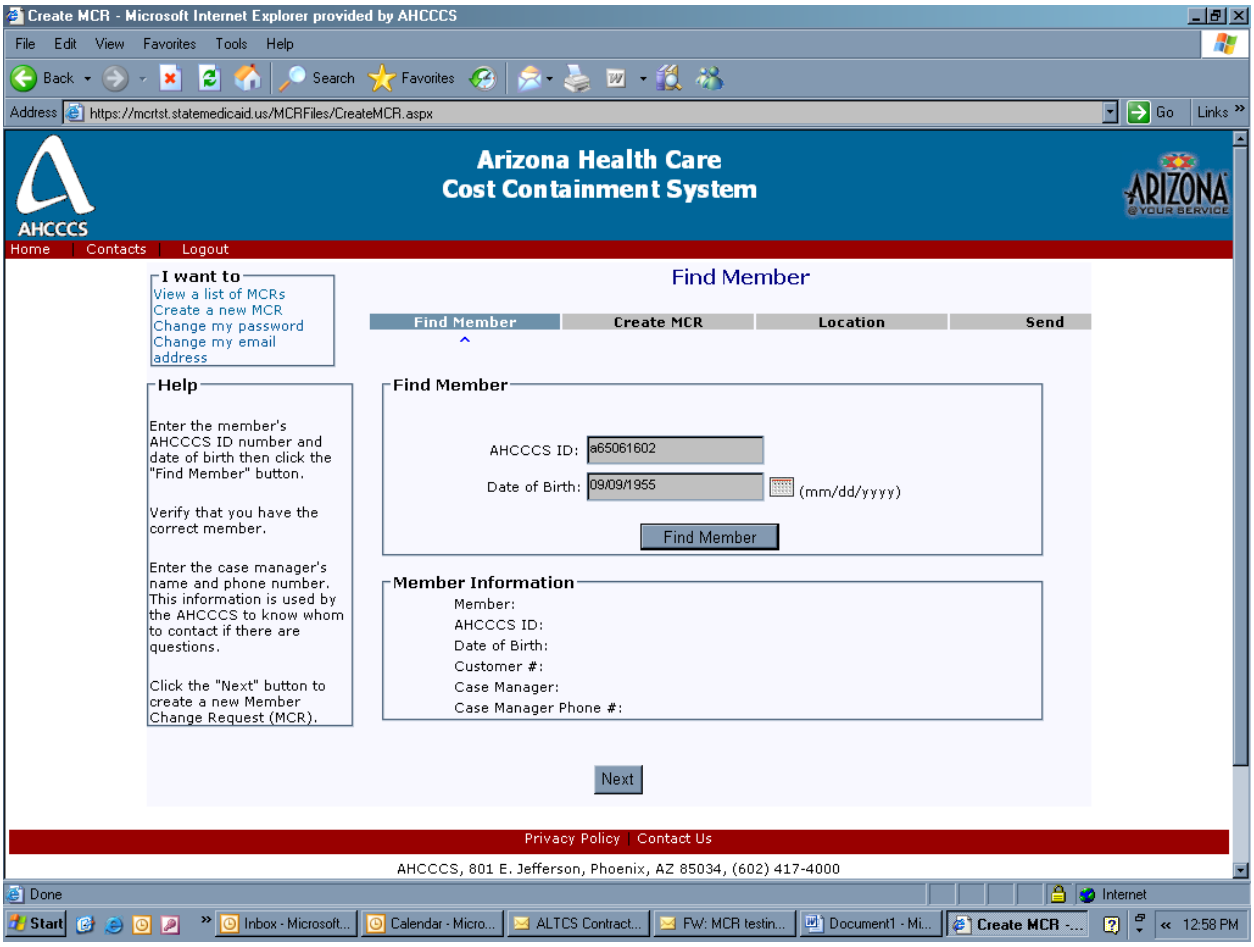
Responded MCR view – cont'd



- The bottom of this screen, as shown above, shows the action(s) taken by AHCCCS based on the MCR submitted by the Contractor and any comments that the AHCCCS representative may have with regard to that action.
- "No Action Taken" may be the action response sent by AHCCCS if the change requested could not be made for some reason. Comments should be included to explain that.
- The Contractor/user should click on "Close this MCR" at the top of the screen after reviewing the response to remove this completed MCR from the list of pending MCRs on the Contractor's home page. Once closed, an MCR can not be retrieved.
- If the Contractor feels further action is still required on this case, the case manager should contact the appropriate AHCCCS staff regarding the action. Another MCR will likely be needed but may need to be clarified or submitted differently. The original MCR can not be re-submitted.

E. Create a New MCR

1. Find Member Part 1

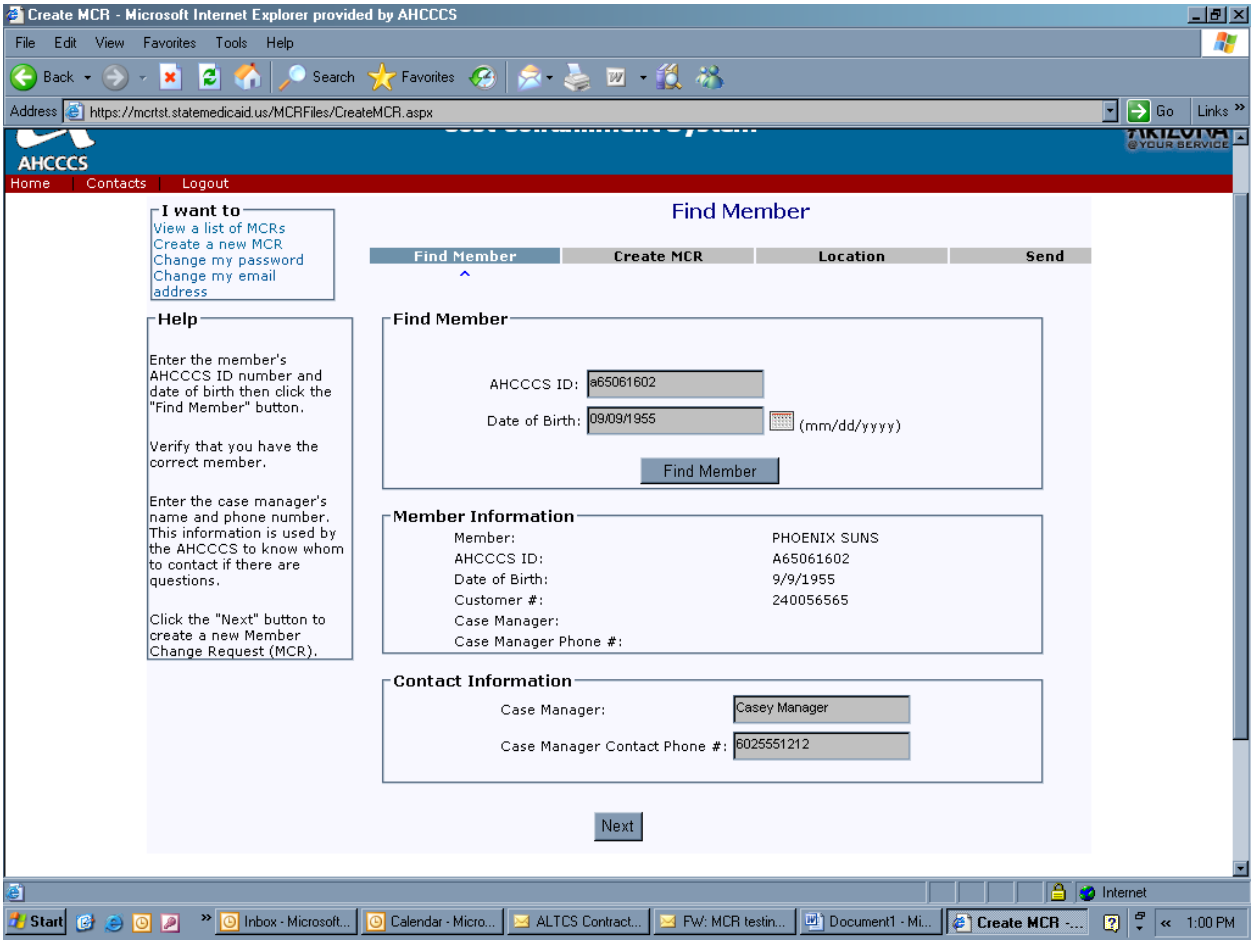


- This page is shown when "Create a New MCR" is chosen from the "I Want to" box.
- In order to begin this process, an AHCCCS ID# and Date of Birth for the member must be entered and then "Find Member" clicked. Only members currently enrolled with the Contractor will be available and displayed in the "Member information" box at the bottom of the page when/if found.
- A message "Member not Found" will be displayed under the following conditions:
  - The member ID# entered is not recognized
  - The Date of Birth entered does not correspond to the member ID# entered
  - The member is not currently enrolled with the Contractor
- After the desired member is "found", his/her information will be displayed in the "Member Information" box. The user will then be prompted to enter case manager information as shown on the following page.

- If an MCR needs to be sent to AHCCCS on a member who is not currently enrolled with the Contractor, a hard copy MCR needs to be completed and mailed or faxed in. A copy of the paper MCR can be found in the AHCCCS Medical Policy Manual, Chapter 1600.

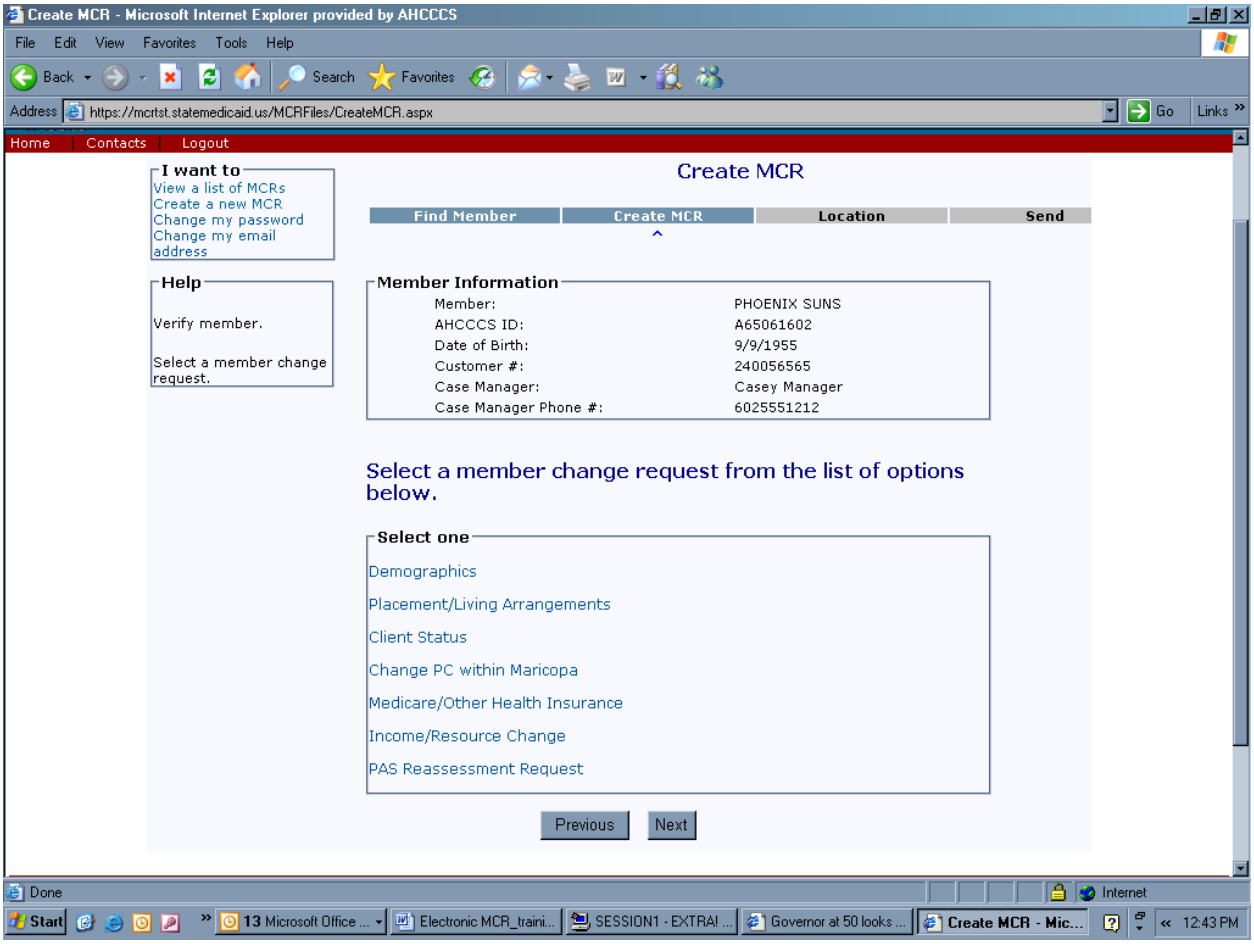
- Help information about each screen will be displayed in the column on the left.

2. Find Member Part 2 – Case Manager Data



- Once the member sought from the previous screen is displayed, the user must enter the name and phone number of the member's case manager as shown above in the "Contact Information" box.
- This information will be used by AHCCCS staff processing the MCR who may have a question about the MCR. The person's name entered here could be the assigned case manager or anyone at the Contractor who would be able to answer questions about the member status being reported on the MCR.
- Once the "case manager" information is entered, the user should click "Next" to continue the process.

3. Change Type

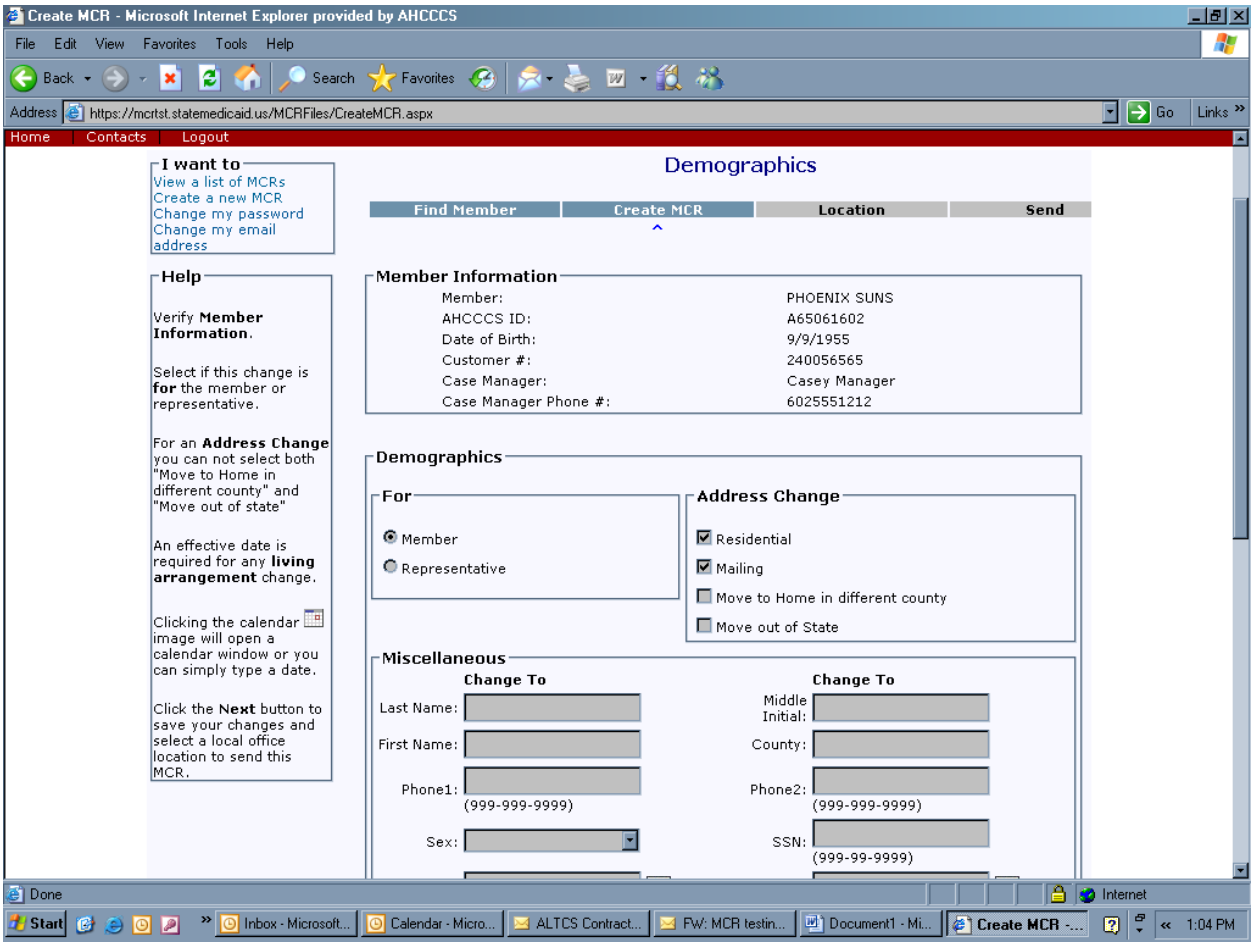


- From the page shown above, the user will select the type of change to be reported with this MCR for the member. The options are:
  - **Demographics** – address or phone number changes for member and/or representative, change of county for member, changes to name, date of birth or death and Social Security Number. This does **not** include placement changes.
  - **Placement/Living Arrangements** – changes to member's placement type (for example, home to NF, ALF to home, ALF to NF, etc).
  - **Client Status** – Voluntary Discontinuances, temporarily out of state, changes from LTC to Acute Care Only and from ACO to LTC.
  - **Change PC within Maricopa County** – changes in Contractor in Maricopa County requested by member/representative outside of Annual Enrollment Choice period.
  - **Medicare/Other Health Insurance** – changes in enrollment in Medicare or other health insurances

- **Income/Resource Change** – changes in member's or spouse's income and/or resources
- **PAS Reassessment Request** – to request a PAS reassessment due to change of member's condition (no longer appears eligible), Transitional member admitted to a nursing facility or, for DD members, when member is no longer DD eligible.

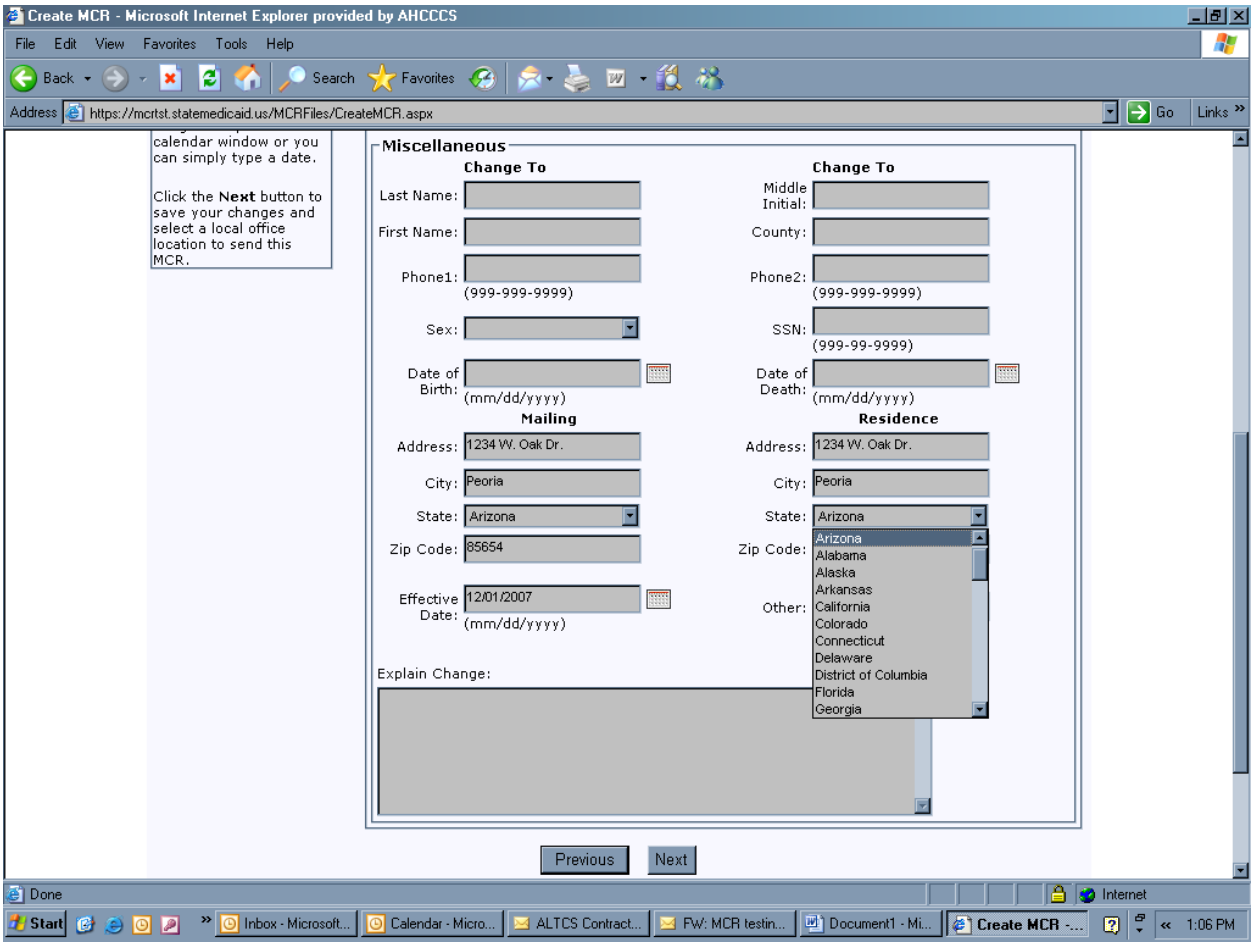
- Clicking the "Next" button will take the user to the first screen for the Change Type selected above.

F. Create a New MCR – Demographics



- This page and the following page show those fields on the Demographic screen which may be completed to report a demographic change for the member and/or representative. Using the scroll bar on the right makes those on the following page visible.
- In the box marked "Demographics", the user must indicate who the change to be reported is for, the member or the member's representative.
- In addition, the type of change(s) must be checked in the "Address Change" box. Address changes can be Residential and/or Mailing and Move to Home in a different county or Move out of State (these last 2 may not be chosen together).
- In the top portion of the "Miscellaneous" section visible on this page, the user will begin to enter applicable changes. Only the "Change To" information needs to be provided.
- If "Move to Home in a different county" is checked, new county information must be entered in the box labeled "County".
- Note the required format for entering phone numbers and the Social Security Number – dashes are required.

Create a New MCR – Demographics, cont'd

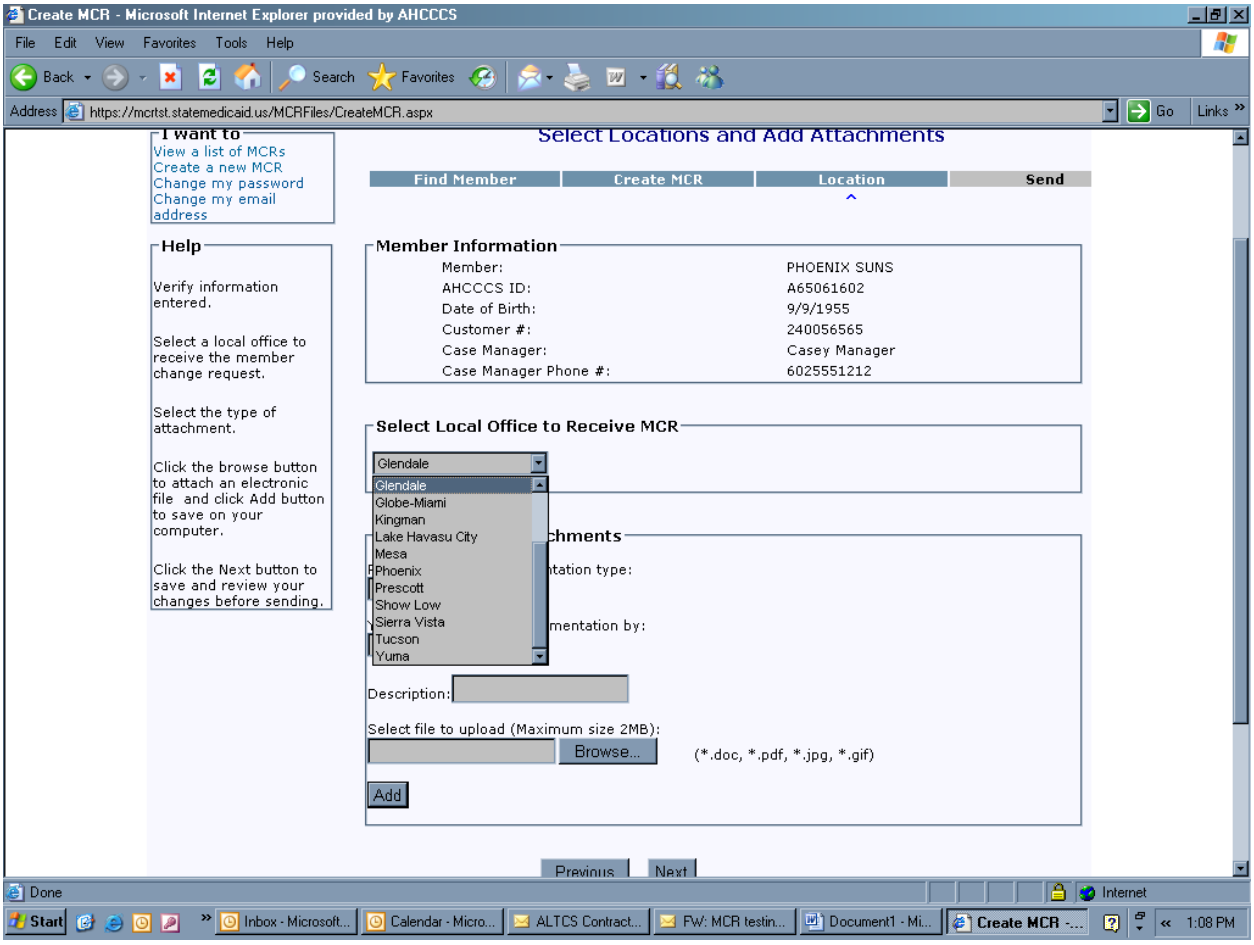


- In this bottom half of the Demographic screen, the user may enter a change of Date of Birth and/or Date of Death. Please note the required format (mm/dd/yyyy). Clicking on the calendar icon will display a calendar of the current month. The user will need to scroll backwards to find an earlier date.
- Once the calendar icon is clicked, the user must pick a date from the calendar. The date chosen can be changed but can **not** be deleted except by clicking on the "Previous" button and starting over. **It is recommended that users simply enter the desired date in the format shown (mm/dd//yyyy) rather than using the calendar icon.**
- Mailing and/or Residence address changes should be entered as shown in the example above. The system does **not** edit for misspelled street or city names, incorrect zip codes or mismatches between zip code and city.
- **Address changes associated with Placement changes (admissions to and discharges from residential settings) should be reported as a Placement/Living Arrangements change, not a Demographic change. Address changes in the Demographic section are limited to moves between "own home" settings.**

- Arizona will appear as the Default if/when the user simply types an "A" in the state field. Alternately, Arizona can be chosen from the drop down list. It appears at the top of that list and all other states are in alphabetical order following this.
- An "Effective Date" of the change reported must be entered.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

G. Select Location and Add Attachments

This screen is the same for all types of MCR changes

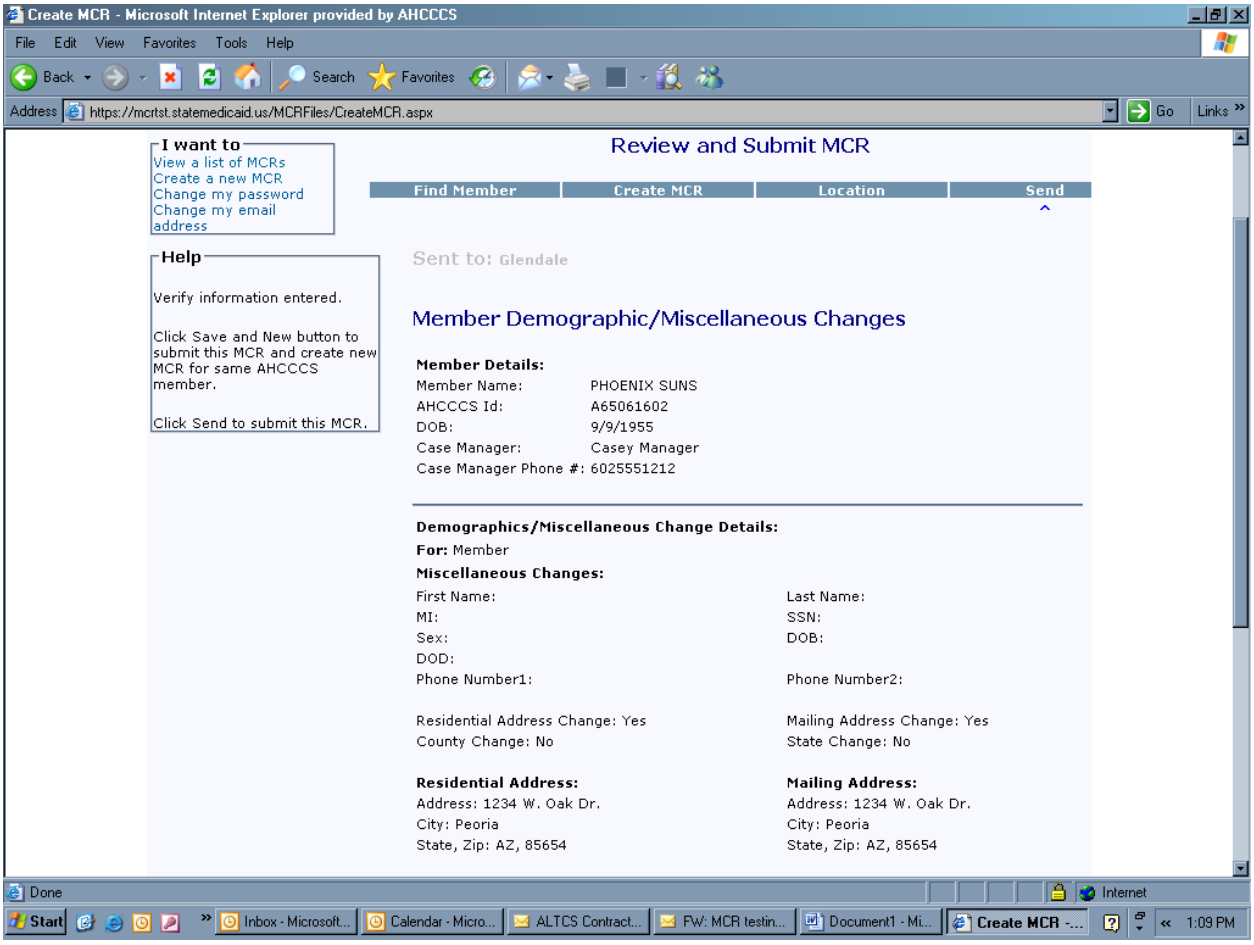


- This screen will appear after the data entry screens for all Change types.
- From the drop down list available in the "Select Local Office to Receive MCR", the user should choose where the MCR should be sent. The choices available in the list will depend on the type of change being reported. For example, Demographic, Placement and Income/Resource changes can only be sent to one of the local eligibility offices whereas Client Status changes for LTC to ACO and vice versa can only be sent to the Division of Health Care Management.
- For changes to be reported to the local eligibility office, the user must know which office is responsible for the case. This information is available on CA166 with an "Office" code (list of code definitions can be found in Policy 411 of this manual on PMMIS).
- From this screen, the user can either add attachments or indicate attachments will be sent via fax or US Mail. More information is provided on how to add attachments on page 27 of this policy.
- Clicking the "Next" button will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

- If the user moves on to the next screen for review and then finds something that needs to be changed, s/he must scroll backward to the appropriate screen to make that change as described on the following pages.
  When the user then scrolls forward again, the location where the MCR should be sent must be chosen again on this Select Location screen as it will not have been saved. Any attachments previously added will have been saved, though.

H. Review and Submit MCR

This screen is the same for all types of MCR changes

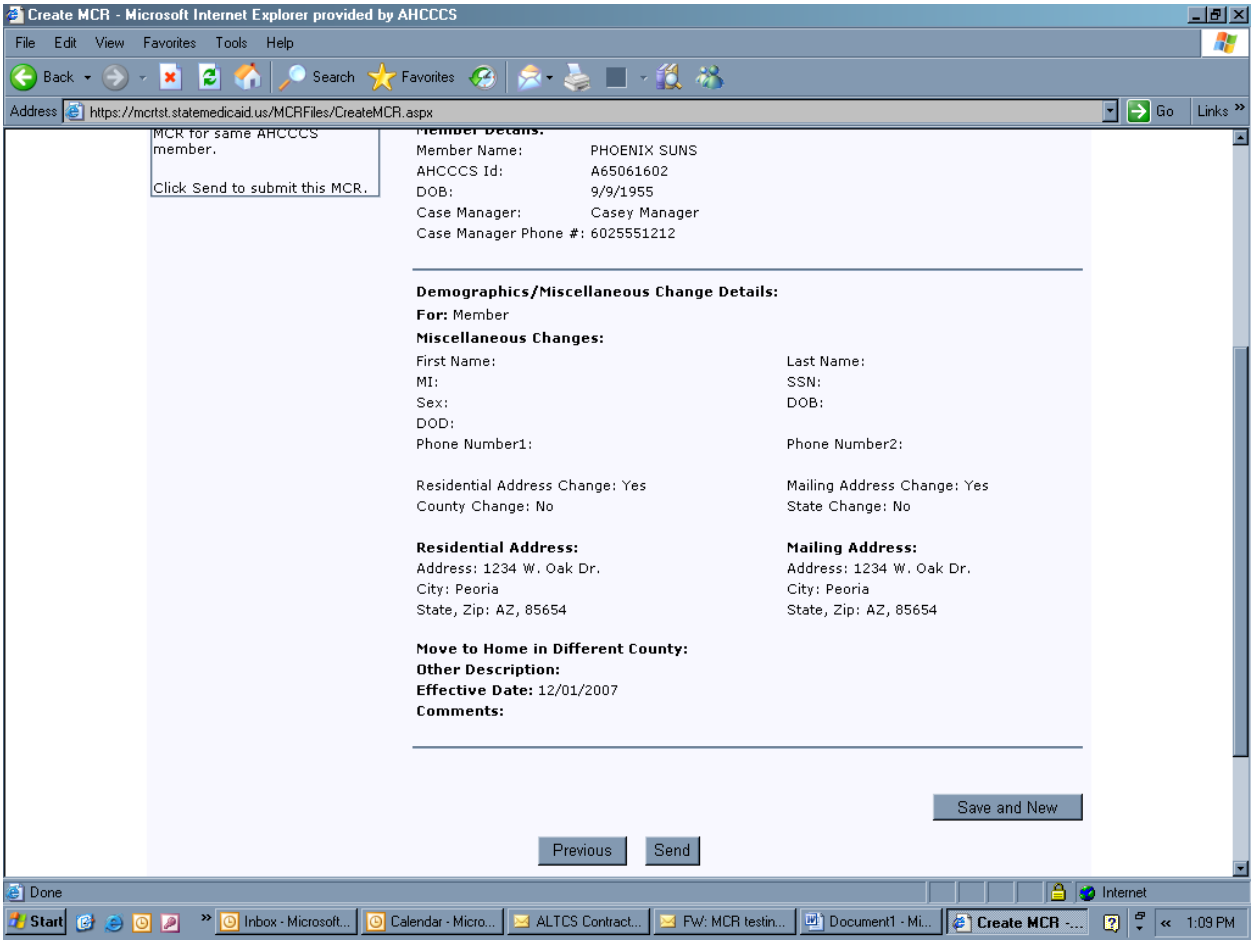


- This page and the following one display all the change data that was filled in on the prior screens by the user. It should be reviewed to ensure accuracy before sending the MCR to AHCCCS, including the location where the MCR will be sent (shown above the title of the MCR Change Type as "Sent To:").

- A review screen similar to the one shown above will appear after the data entry and Select Location screens for **all** Change types.

Review and Submit MCR – cont'd

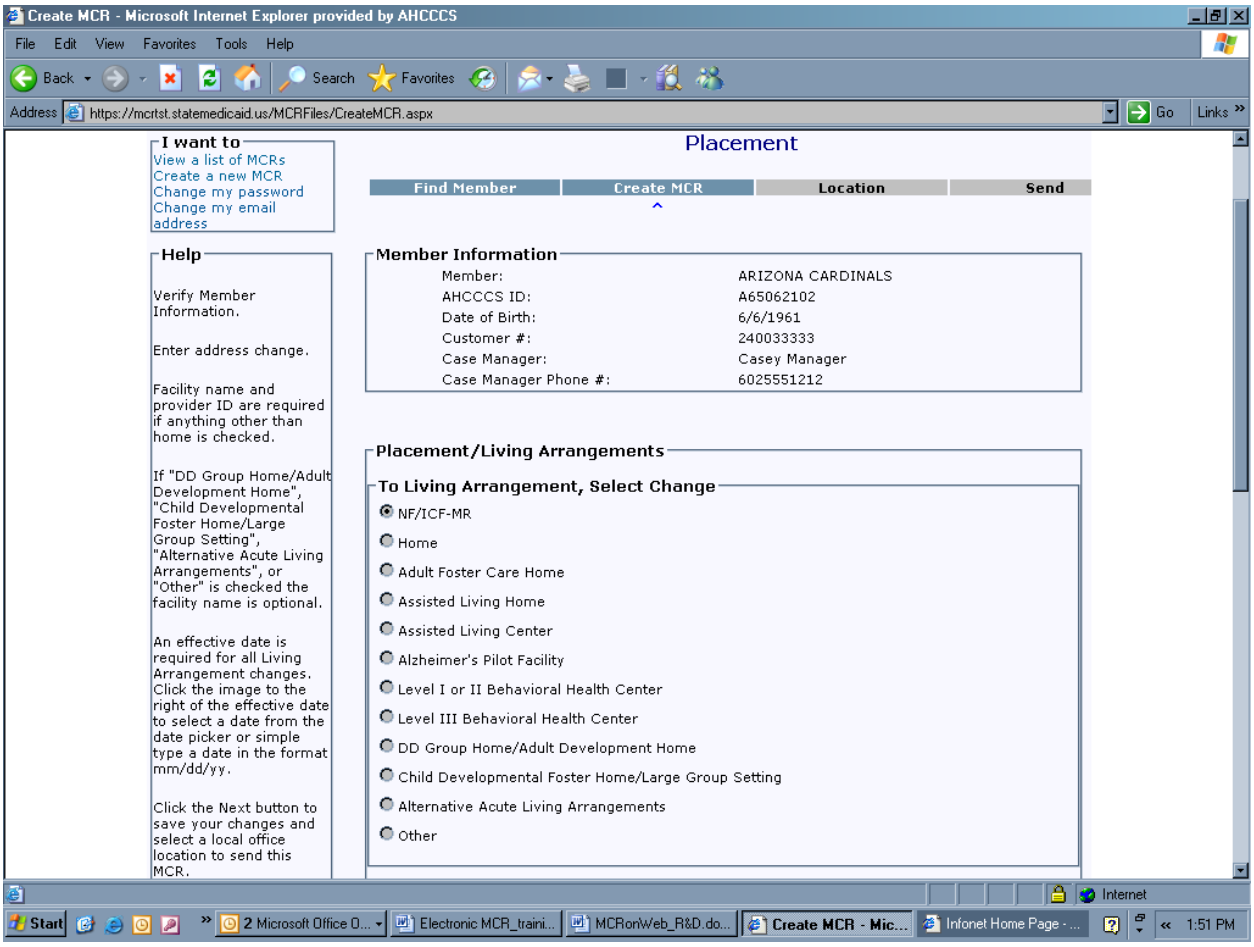
This screen is the same for all types of MCR changes



- Clicking the "Send" button submits the MCR to selected AHCCCS location and then returns the user to the Contractor's "home" page. The just created MCR will appear on that page in the Contractor's MCR list with Status "New".
- The "Save and New" button saves the change information already entered and allows the user to create another MCR for a different change type for the same member. For example, if the user just finished reporting an address change for the member and now wants to also report an Income/Resource change. The user is returned to the "Create MCR" page to choose the new change type to be reported (page 13 of this policy).
- When all MCRs for the same member have been created, the user will click "Send" from this screen and all will be sent as designed. Each MCR/change type for the member will be listed separately on the Contractor's "home" page.
- If the user discovers an error in the entered data, clicking the "Previous" button will take the user, screen by screen, back through the previous screens to find the location where the data needs to be changed.

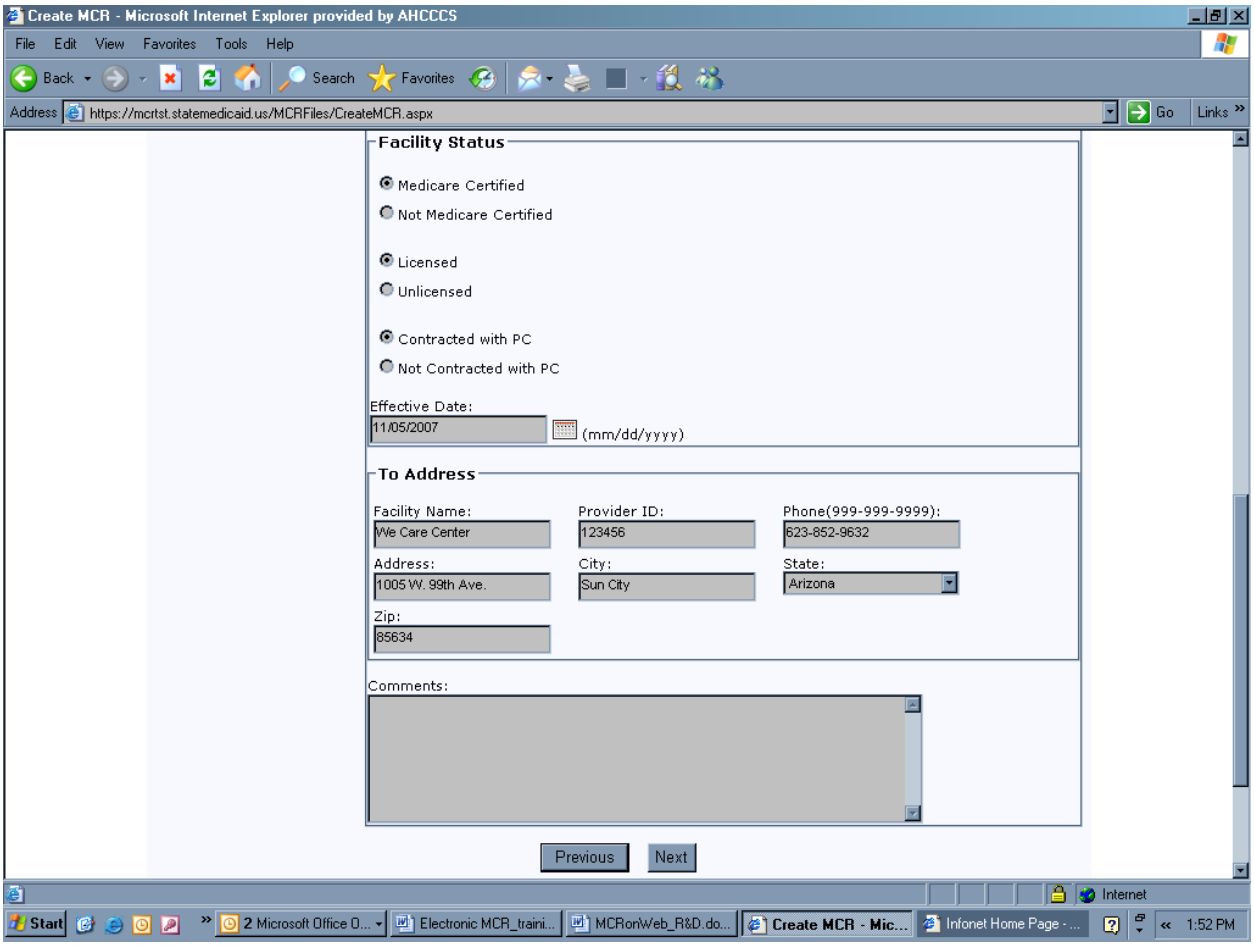
As before, clicking the "Next" button, after making those changes, will bring the user forward again to the "Select Location" screen and then this review screen. On the "Select Location" screen, the AHCCCS location to which the MCR should be sent must be chosen again, it is not saved when the user back-tracks. If, however, an attachment was added electronically (explained on pages 27-29of this policy), that document will be saved.

I. Create a New MCR – Placement/Living Arrangements



- This page and the following page show those fields on the Placement/Living Arrangements screen which need to be completed to report this type of change for the member.
- The box shown on this page lists the placement types to which the member may have moved.
- Note that a member who moves to their "own home" from a residential setting (or vice versa) should have that change reported as a Placement/Living Arrangement change, not a Demographic change (as described on pages 16-17 of this policy). Demographic changes are only used when a member moves from one "own home" address to another "own home" address.
- The "Other" box on this list should be used to report **Loss of Contact** with a member to the eligibility office. Additional information needed for this change type can be found on the following page.

Create a New MCR – Placement/Living Arrangements - cont'd



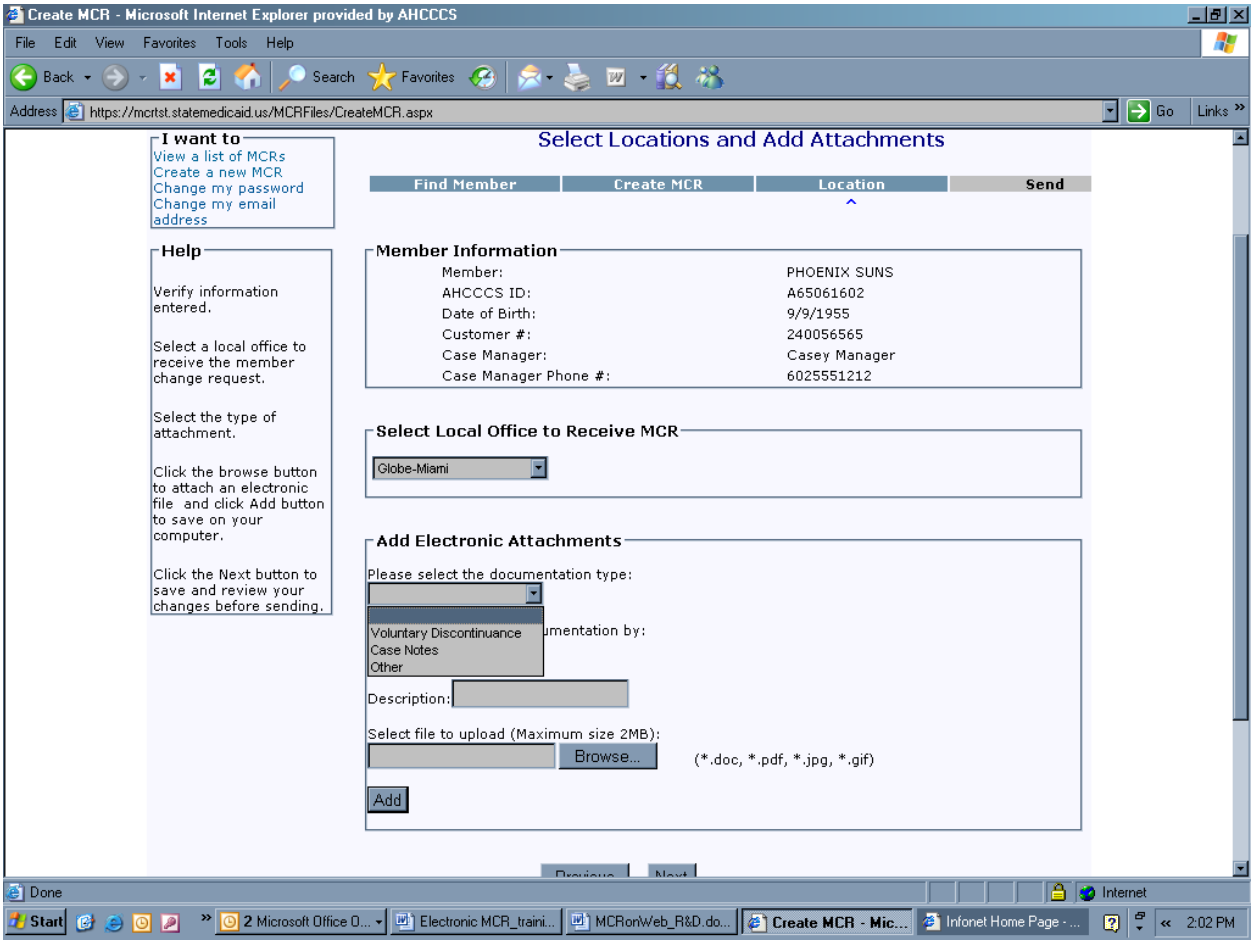
- None of the pairs of choices in the "Facility Status" box are required but, if known, should be marked to provide information to Eligibility.
- An Effective Date of the Placement change is required, in the designated format (mm/dd/yyyy), however, for **all** placement type changes.
- The Facility Name, Provider ID and phone # (in the designated format, with dashes) are required except for the following changes:
  - Home
  - DD Group Home/Adult Developmental Home
  - Child Developmental Foster Home/Large Group Setting
  - Alternative Acute Living Arrangement
  - Other
- The address information, including city, state and zip code, is required for all changes, except "Home".
- For **Loss of Contact** – enter the last known phone number and address information for the member and a comment to explain that the case manager has been unable to contact the

member at these. Eligibility may have updated information that they can send back to the case manager for contact.

- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

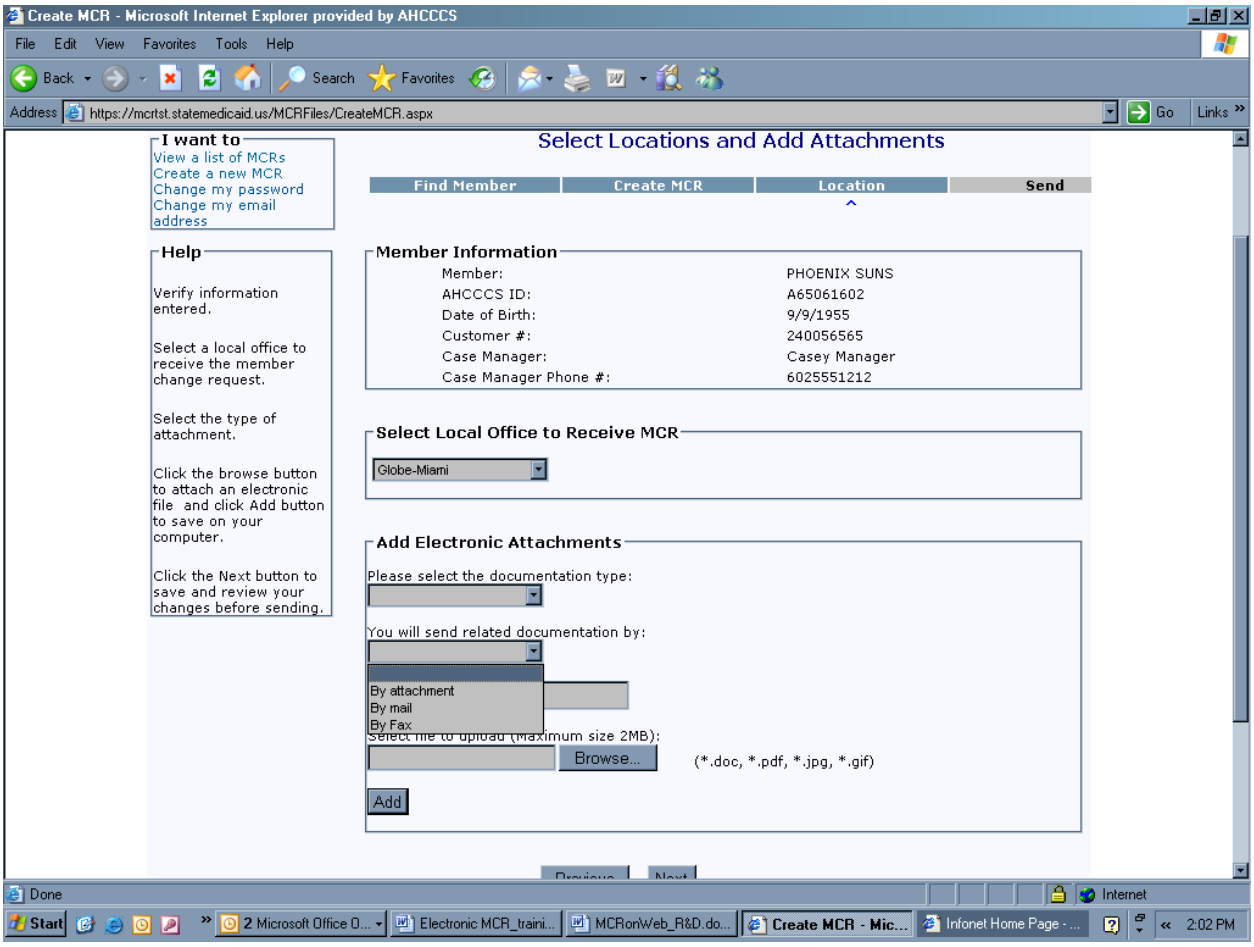
J. Add Attachments

This screen is the same for all types of MCR changes



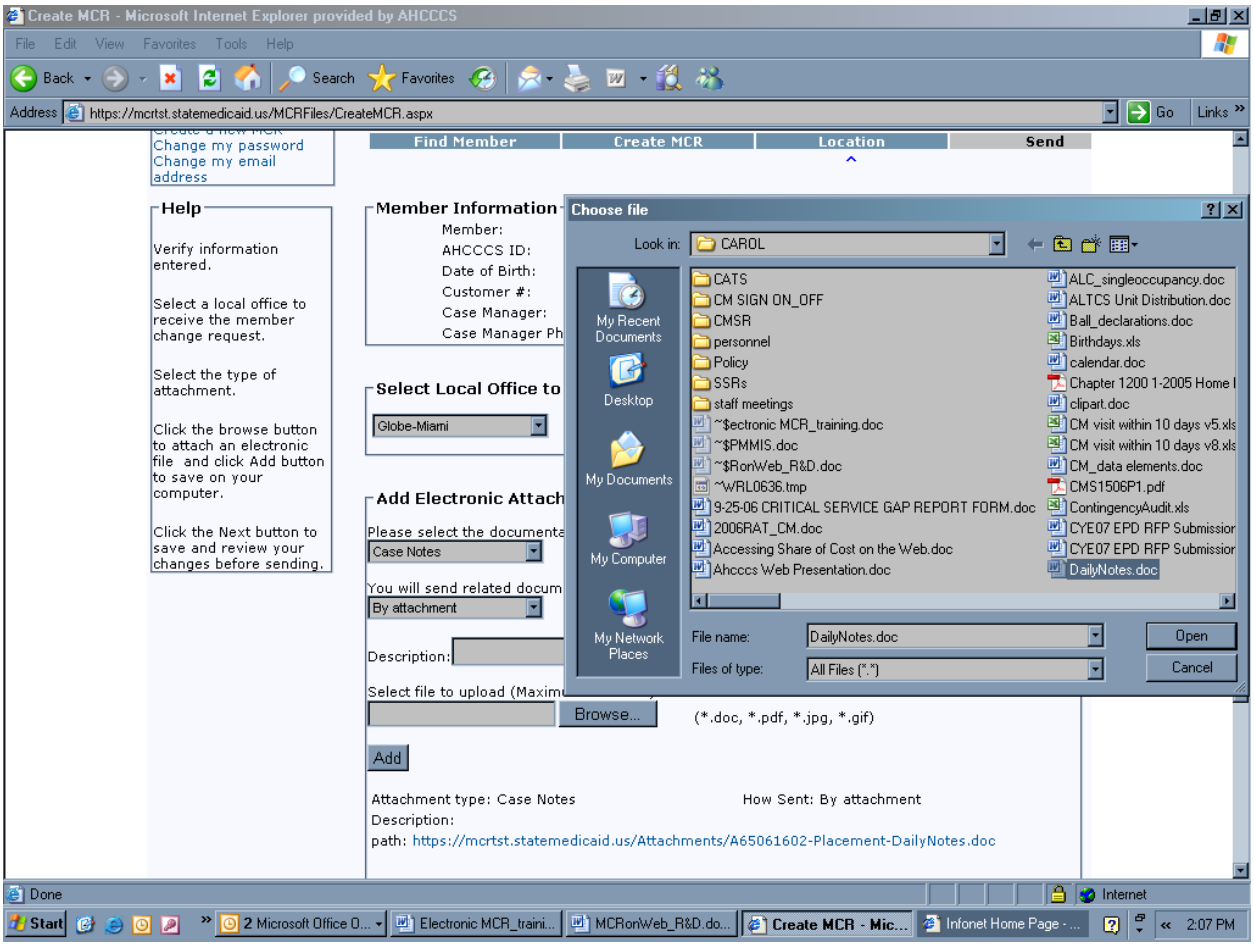
- This is the screen described on page 19 of this policy related to Selecting a Location for the MCR. Adding Attachments will be described here and the next 3 pages that follow.
- The user must first select the "documentation type" from the drop down, as shown above.
- A "Description" can be added to explain the attachment but this is not necessary.

Add Attachments – cont'd



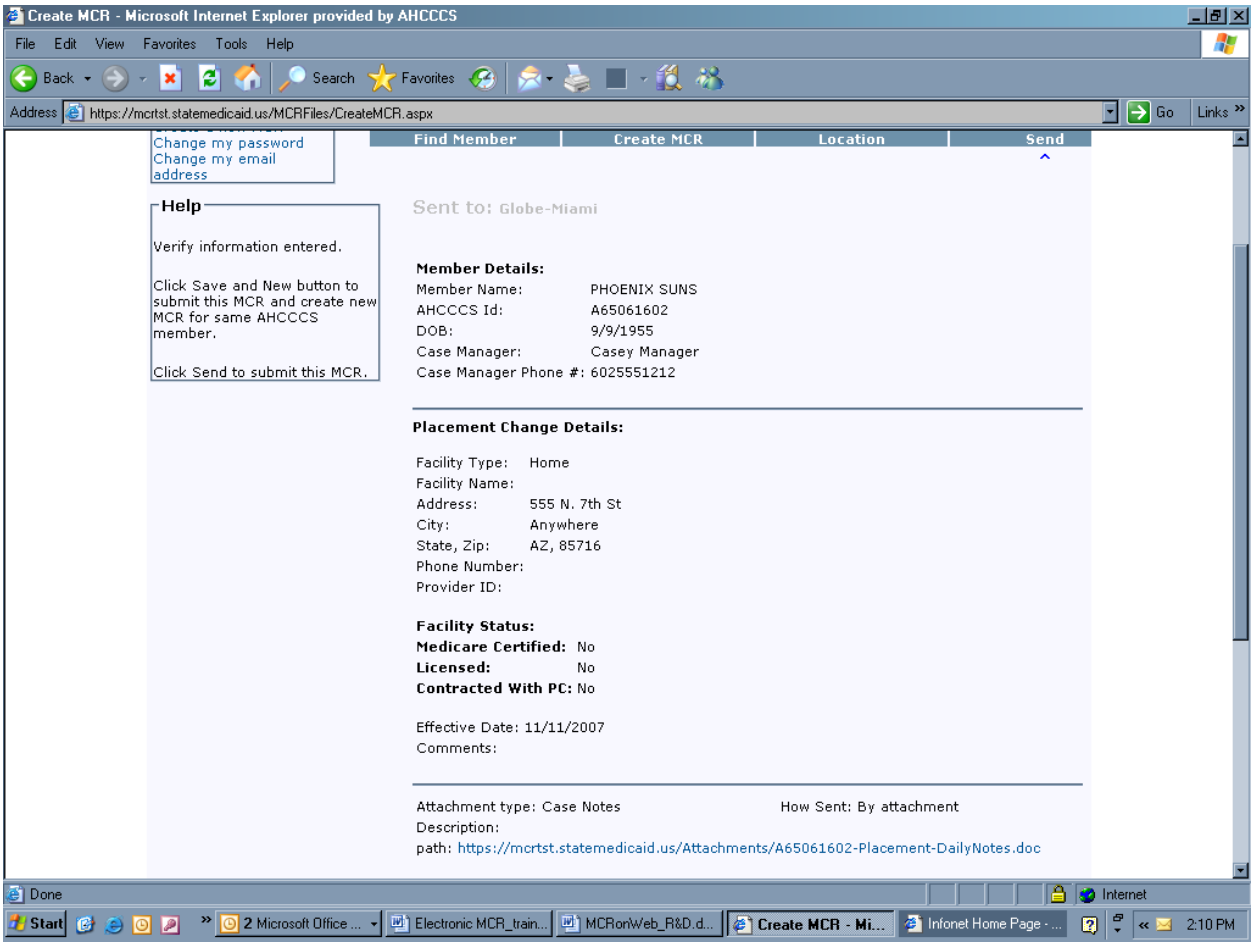
- In this next box, the user will designate how related documents will be attached or sent: by electronic attachment to the MCR, by mail to follow the MCR or by fax to follow the MCR.
- Regardless of the method by which the related documents will be sent, the user should then click the "Add" button. Clicking this button adds a note at the bottom of the Review screen (shown on page 30 of this policy) to alert AHCCCS of the attachment and how it will be sent.
- The user MUST click the "Add" button if "Voluntary Discontinuance" was selected, even when the document will be sent by Mail or by Fax.
- When documents associated with an MCR are faxed or mailed to AHCCCS, the sender should clearly indicate on the document that they are related to an MCR which was submitted electronically so they can be routed and filed correctly.
- If documents will be attached to the MCR electronically, the following 2 pages describe the steps necessary.

Add Attachments – cont'd 2



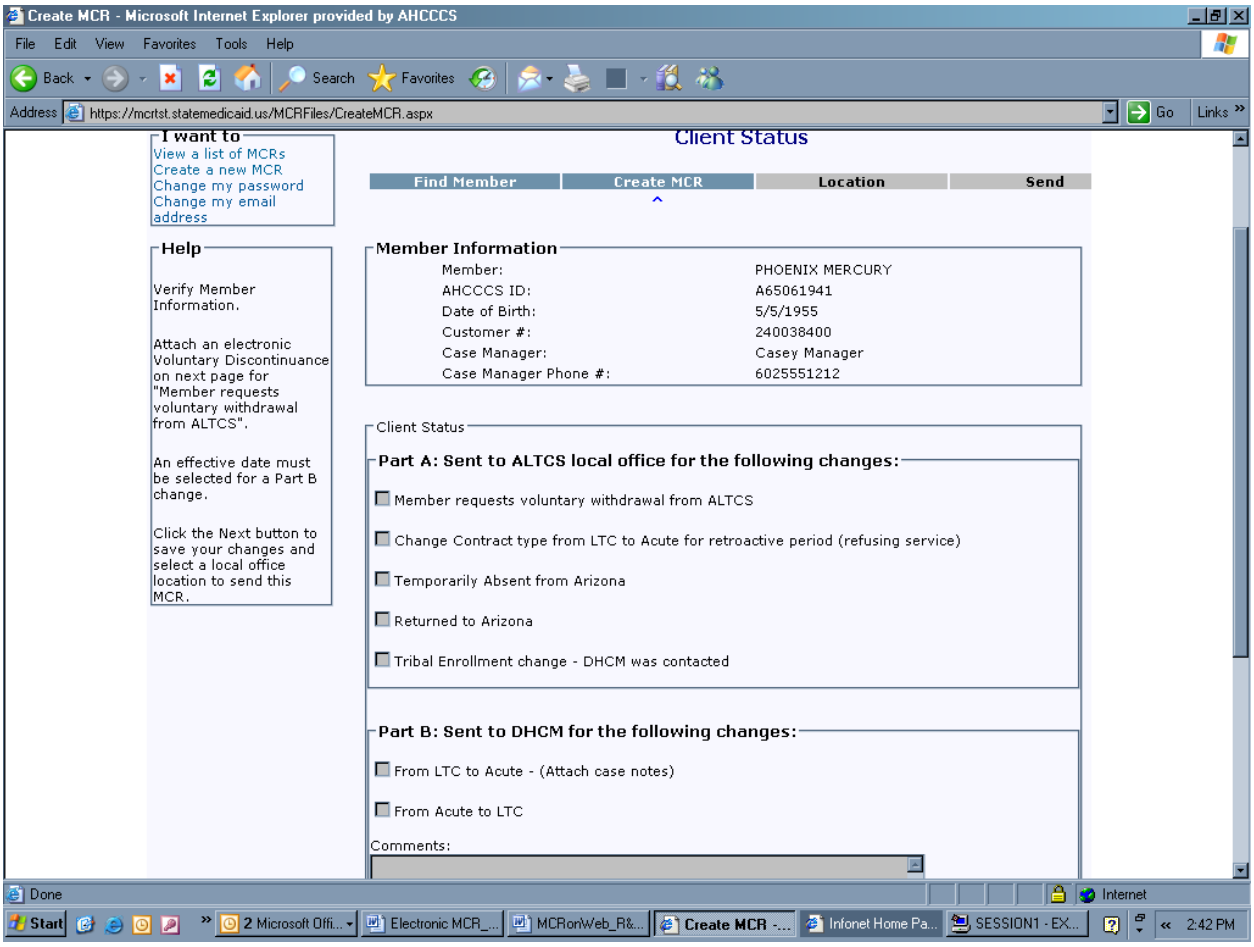
- By clicking the "Browse" button, the user should be able to access available drives within their Contractor's system in order to attach any files or documents saved there that may pertain to the MCR.
- The user should click the "Open" button in the Choose File window after highlighting the file(s) that need to be attached to the MCR.
- **The user must then click the "Add" button on the MCR screen.** If this button is not clicked, the document(s) will not be attached to MCR. When the document is attached, its path will appear at the bottom of the screen (see example above).
- More than one document can be added by repeating the above 3 steps for each document.
- **Once a document is attached in this manner it can not be deleted.**
- If the user back-tracks (using the "Previous" button) to make changes to the data entered on the MCR after adding an attachment, that document will still be attached when the user returns to this screen to re-select the location to send the MCR to.
- Clicking the "Next" button will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

K. Review and Submit MCR – Attachments



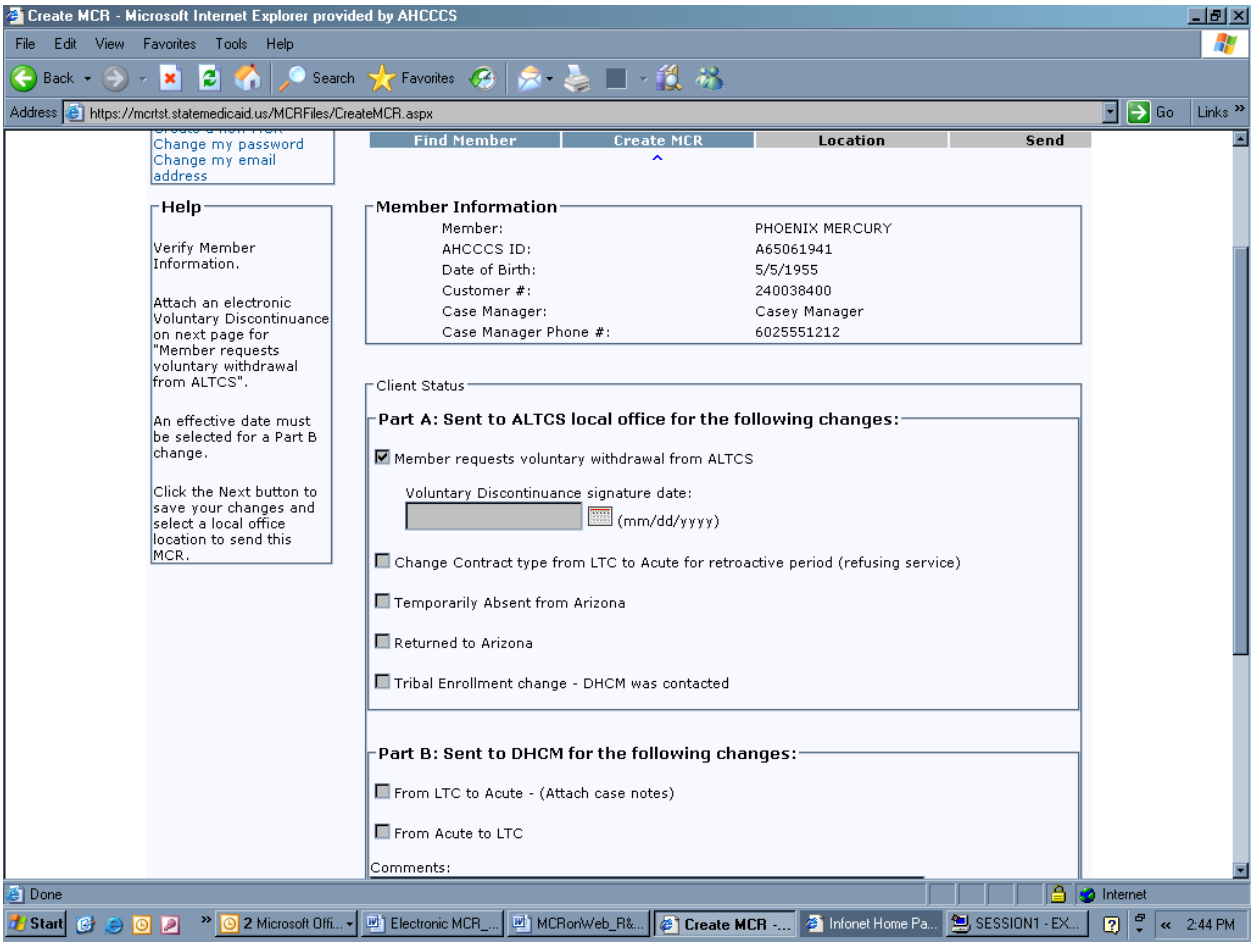
- In the above example, the review screen shows the Attachment Type, How Sent and because a document was attached electronically, the path of that document. When AHCCCS receives this MCR and clicks on the path, the document will appear.
- If more than one document was added, whether by electronic attachment, mail or fax or a combination of these, each should be listed separately as an attachment here.
- If the user intended to attach a document and it does not appear here, the "Add" button may not have been clicked on the prior screen and the user will need to go back and try to add the document again.

L. Create a New MCR – Client Status Changes



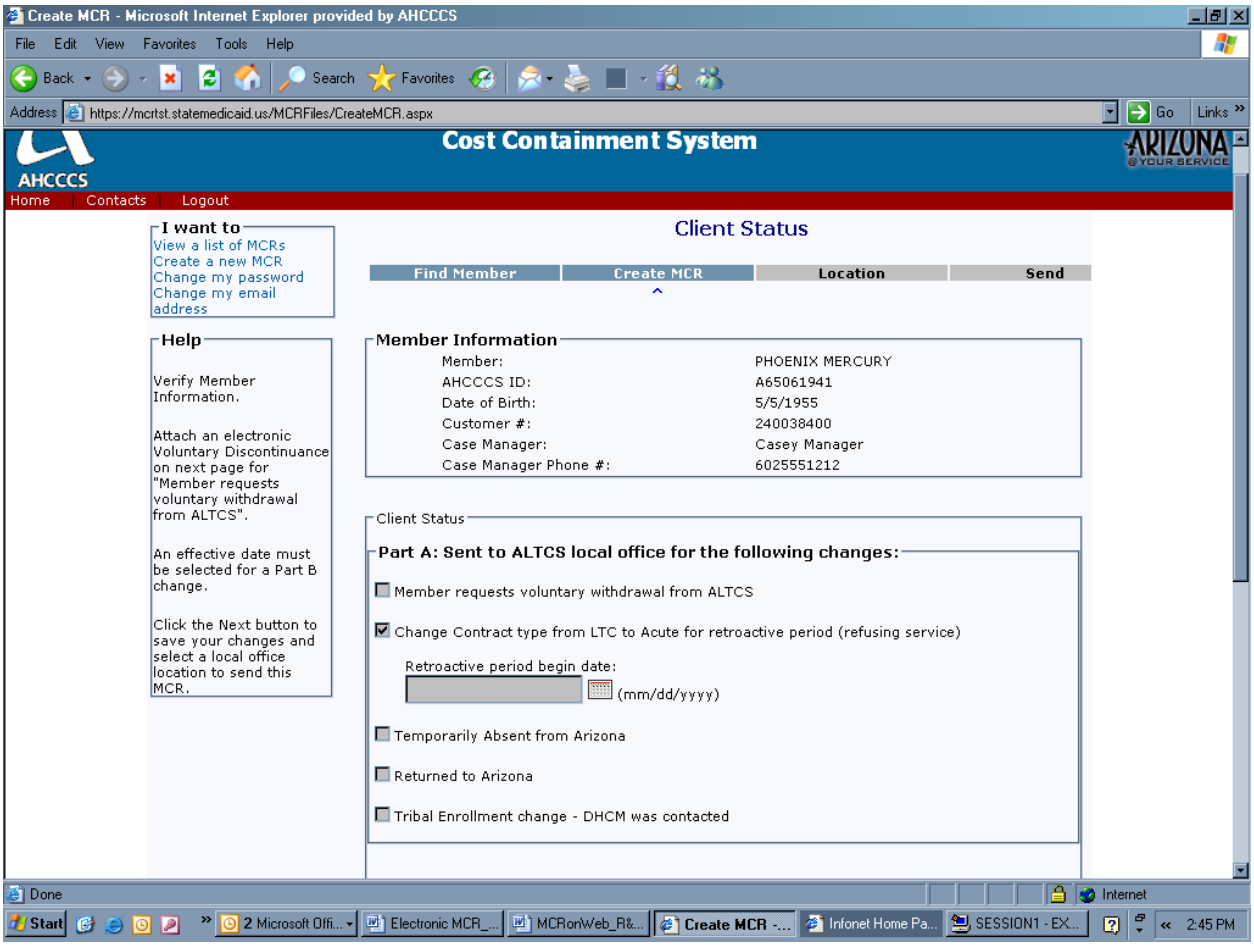
- The change types listed in Part A on this screen are sent to the local eligibility office for processing.
- The change types listed in Part B are sent to the Division of Health Care Management (DHCM) for processing.
- The next several pages of this policy explain how those changes are reported.

4. Client Status Part A Changes - Voluntary Discontinuance



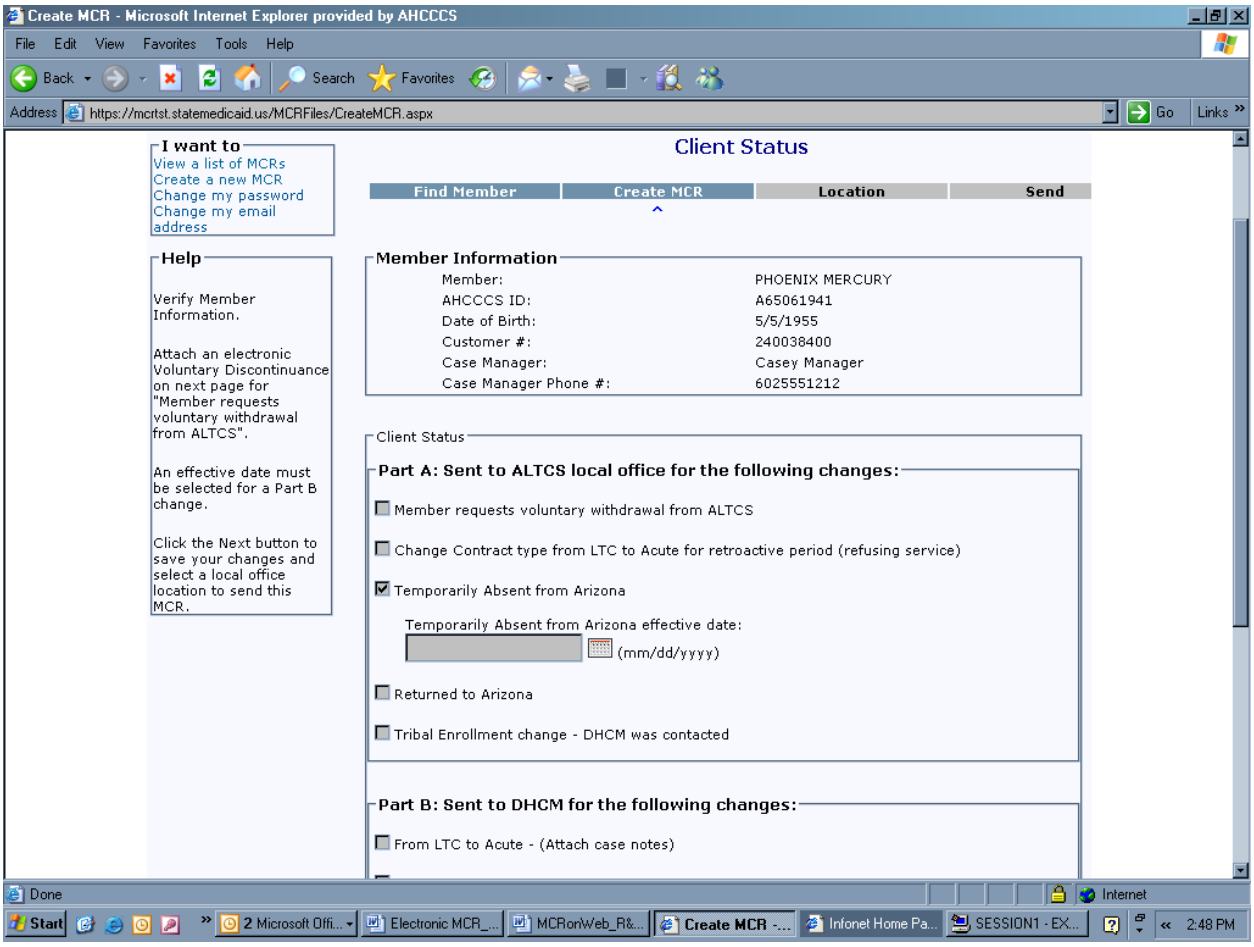
- For Voluntary Discontinuances, the date of the member/representative signature on the Voluntary Discontinuance form is required here, in the designated format (mm/dd/yyyy).
- The Voluntary Discontinuance form is listed on the Add Attachment screen as an option to be sent along with the MCR if signed. The signed form may be attached electronically if a scanned copy is available or it can be sent by mail or fax to the local eligibility office.
- When documents associated with an MCR are faxed or mailed to AHCCCS, the sender should clearly indicate on the document that they are related to an MCR which was submitted electronically so they can be routed and filed correctly.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

4. Client Status Part A Changes – Retro Contract Type Change



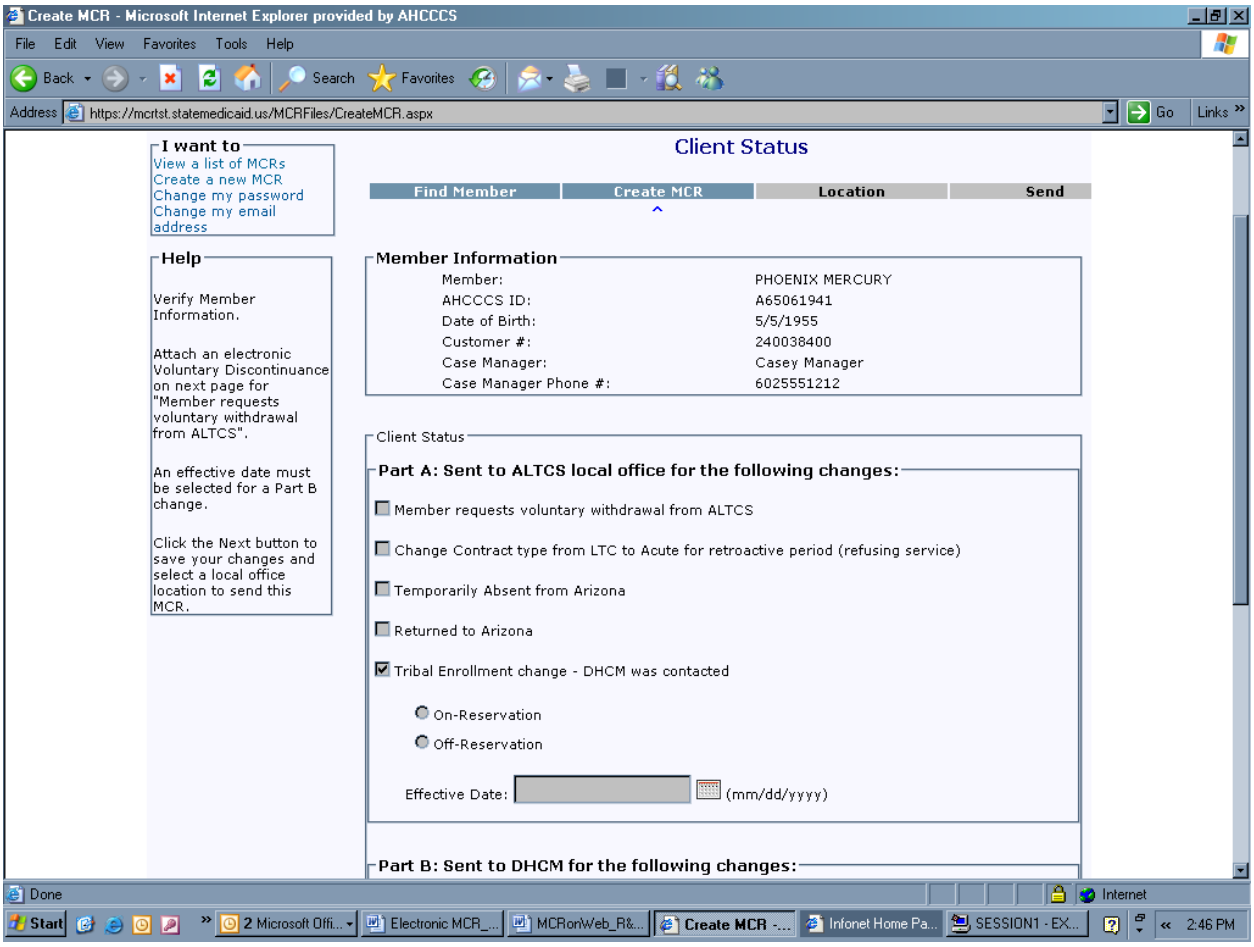
- The Retro Contract Type change option is used, in conjunction with the Voluntary Discontinuance, when the member, who is disenrolling from ALTCS, has a retro period of time for which the member's status should be changed to Acute Care Only (ACO) because the member was not receiving LTC services prior to disenrollment.
- See instructions beginning on page 36 of this policy for cases in which the member's status needs to be changed to ACO retroactively but the member has **not** requested discontinuance from the ALTCS program.
- A begin date for the retroactive ACO period is required in the designated format (mm/dd/yyyy) on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

4. Client Status Part A Changes – Temporary Absence from AZ and Returned to AZ



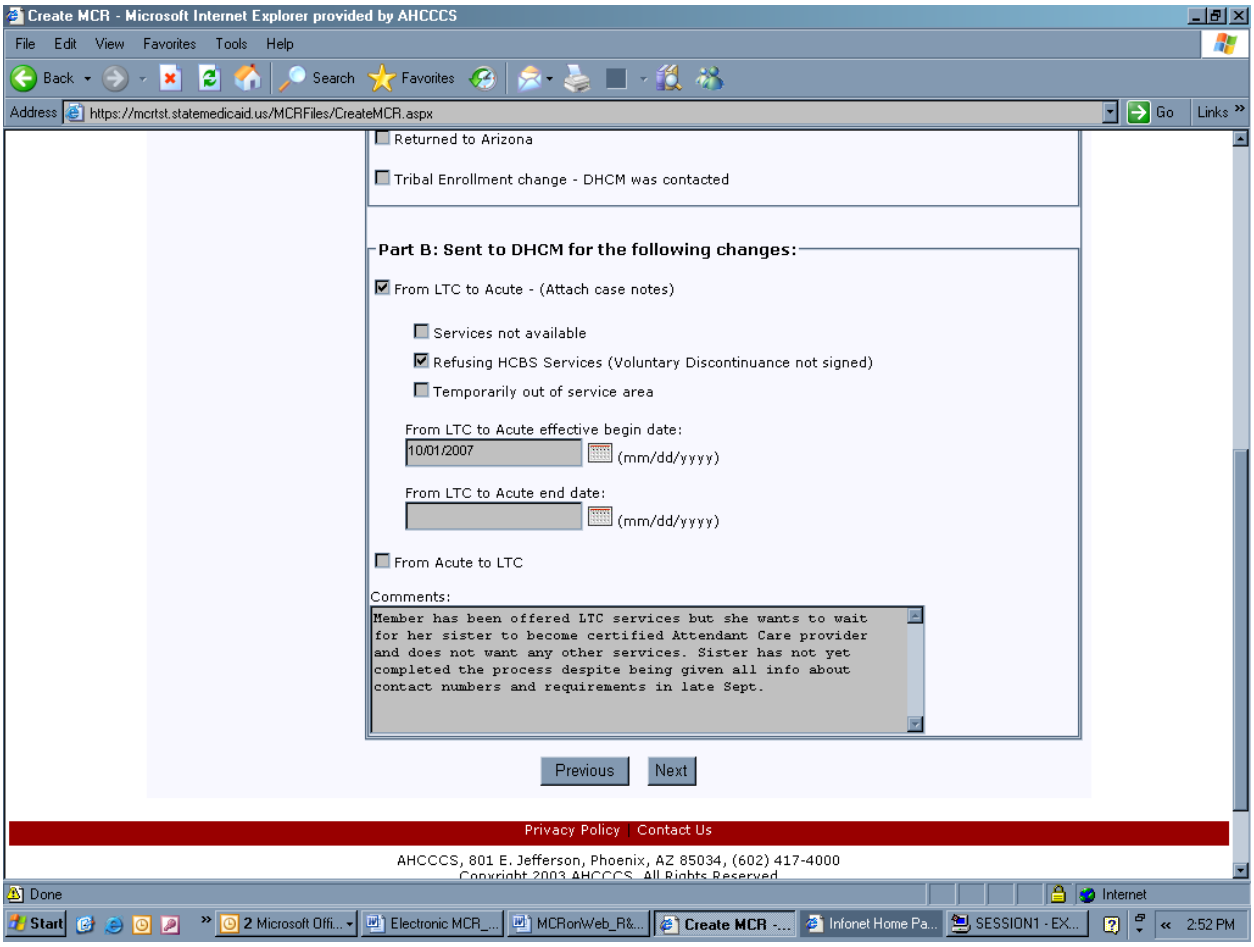
- "Temporary Absence from Arizona" can NOT be reported on the same MCR as "Returned to Arizona".
- A box for the effective date of the change will appear for both of these options when either is checked. The effective date of the change in the designated format (mm/dd/yyyy) will be required on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.
- If the member did or will not get any LTC services for a full calendar month while absent from the state, an MCR to request a change of contract type from LTC to Acute Care Only for that period of time will also be needed. See instructions for Client Status Part B changes beginning on page 36 of this policy.

4. Client Status Part A Changes –Tribal Enrollment Change



- This option is used to report when a Native American member either moves on or off a reservation to an "own home" placement and an enrollment change to or from a Tribal Contractor will be required.
  This type of enrollment change, processed via MCR, will be effective the first of the following month. If the enrollment change needs to be effective sooner than the first of the following month, a Program Contractor Change Request (PCCR) form should be used instead.
- The AHCCCS Division of Health Care Management (DHCM)/Case Management Unit should have been contacted, prior to the creation of this MCR, to assist with this type of transition between Program and Tribal Contractors.
- The effective date of the move, in the designated format (mm/dd/yyyy), will be required on this screen.
- Clicking the "Next" button at the bottom of this screen will take the user to a screen where the local office location to which the MCR will be sent is selected.

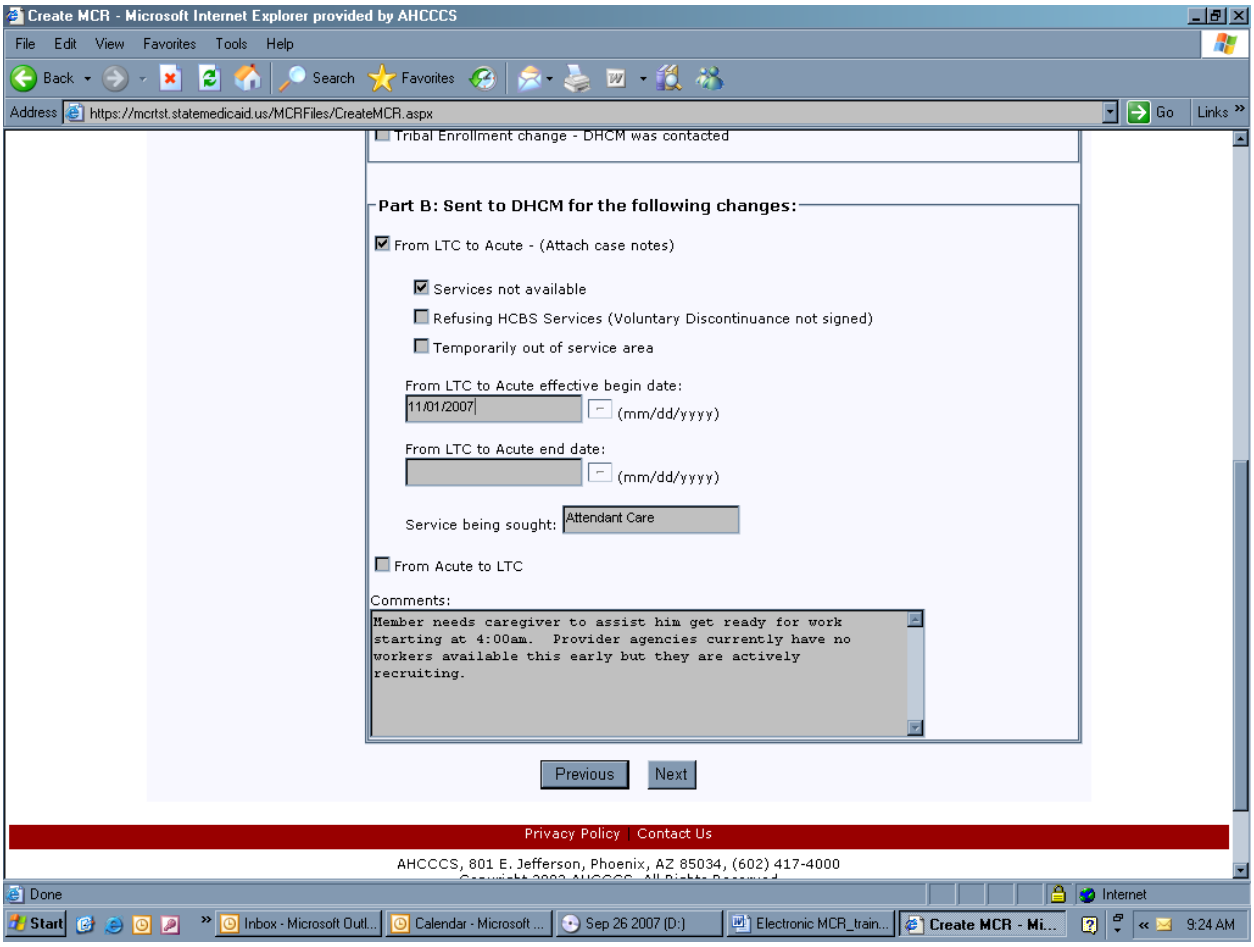
M. Client Status Part B Changes – LTC to Acute Care Only (ACO)



- When LTC to Acute is checked as above, the 3 reasons/options will appear:
  - Services not available – member requests a service(s) that the Contractor can not provide. If this reason/option is chosen, a box will appear to enter the service being sought (see next page).
  - Refusing HCBS services – member will not accept a service(s) that the Contractor has available and has been offered
  - Temporarily out of service area – member is temporarily out of the Contractor's service area (but is expected to return) and is not receiving any LTC services during that time. A separate MCR should be sent to the local eligibility office, using the instructions for Temporary Absence from AZ found on page 34 of this policy if the member is still out of state at the time the MCR is being completed.
- The effective begin date of this changed contract status must be entered in the designated format (mm/dd/yyyy). This date must match the begin date of the "D" placement on CA161 for the member.
- The effective end date should only be entered if this date is in the past. The end date of acute care only status should not be predicted.

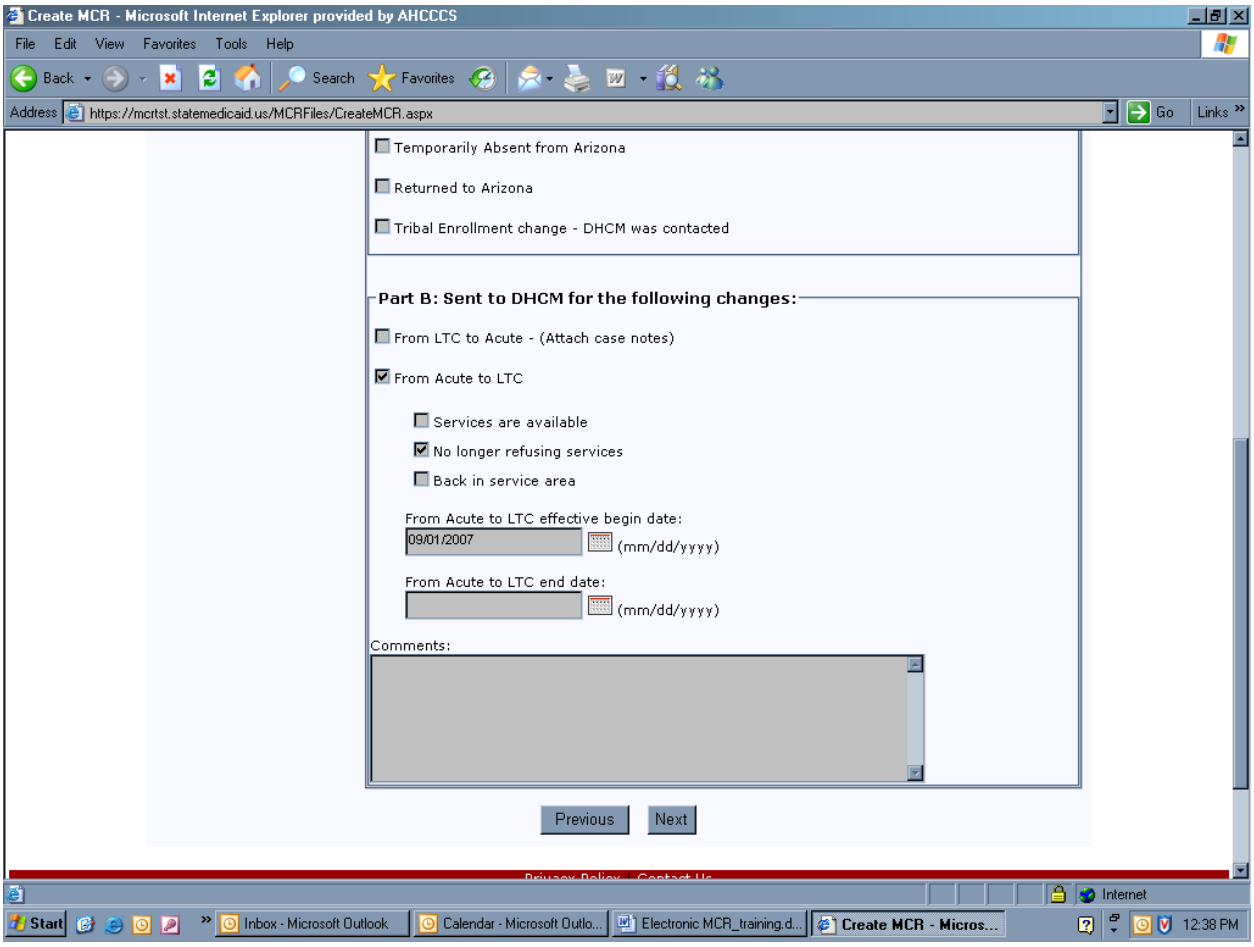
- In lieu of sending case notes, the case manager should write comments here to explain the case. Those comments must support the reason/option chosen and describe the member's situation.
- Case notes can still be sent however, by fax, mail or electronically as an attachment to the MCR.
  - Fax number for DHCM is (602) 417 – 4855
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. DHCM will be the only option for where to send this type of change.
- If a member's contract type needs to be changed for a specific and fixed time period retroactively, one MCR can be used to change both the LTC to ACO and ACO to LTC at the same time instead of sending 2 separate MCRs. An example would be when a member had been refusing services during the previous full calendar month but then began accepting services before another calendar month passed and before the LTC to ACO MCR was sent.

2. Client Status Part B Changes – LTC to ACO – Services not Available



- If the "Services not available" reason/option is chosen, a box will appear, as shown above, in which the case manager should indicate which service is being sought that is currently unavailable.
- Comments need to be entered to explain why services are not available as well as what actions are being taken to resolve this issue.
- If alternative services are provided to the member as a substitution for the requested service, a Client Status change MCR is not needed since the member is receiving LTC services.
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. DHCM will be the only option for where to send this type of change.

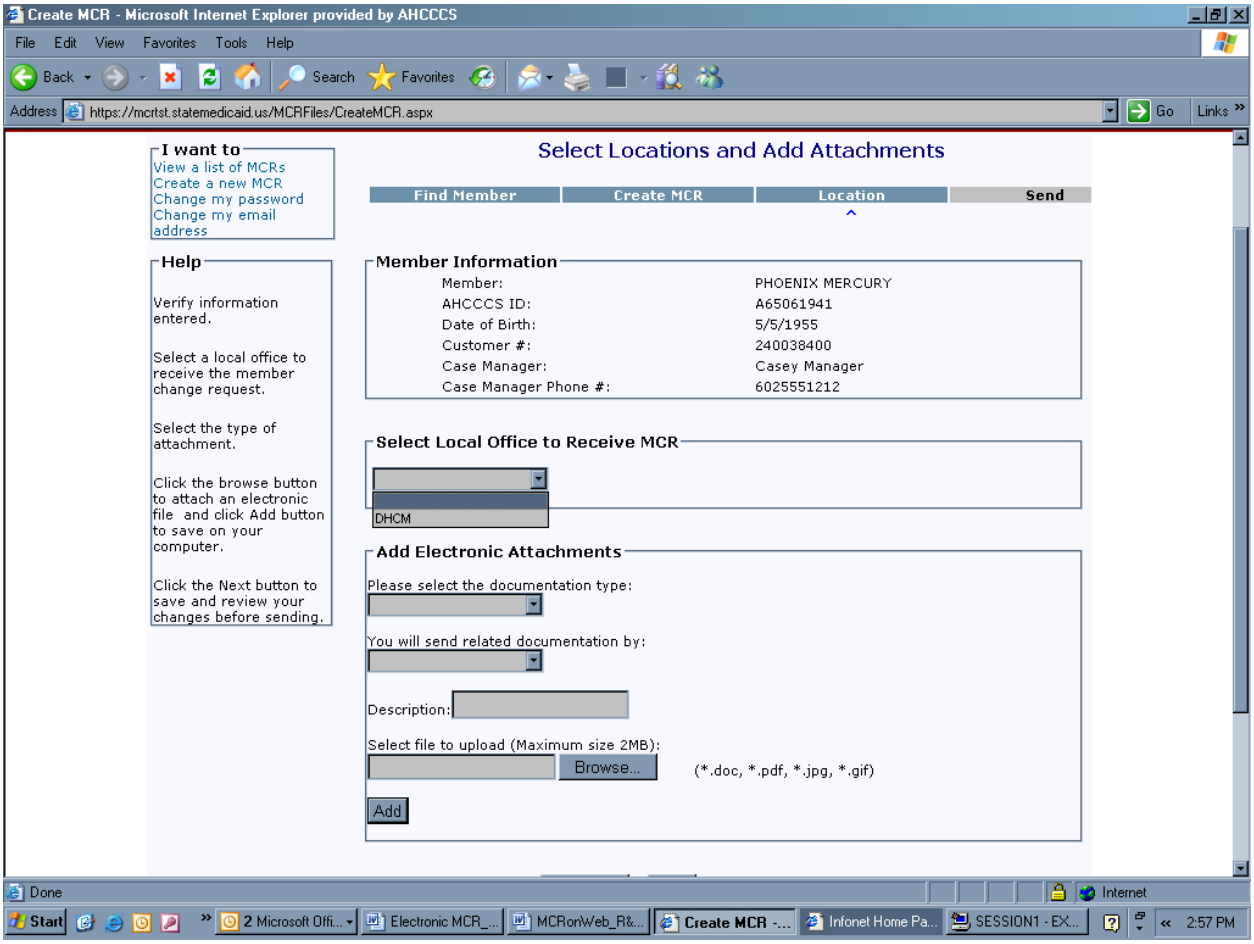
N. Client Status Part B Changes – Acute to LTC



- When Acute to LTC is checked as above, the 3 reasons/options will appear:
  - Services are available – service member requested is now available and being provided.
  - No longer refusing services – member is now accepting LTC services from the Contractor
  - Back in service area – member is back in the Contractor's service area and receiving LTC services.
- The reason/option checked should correspond to the reason/option that was indicated on the prior MCR that changed the member's status from LTC to Acute. For example, if "Services not available" was checked before, "Services are available" must be checked now.
- A date, in the designated format (mm/dd/yyyy), is required only in the Effective Begin date field on this screen. The date the member's status needs to be changed back to LTC should be reported as the Effective Begin date here. No end date is needed for this type of change. This date must match the begin date of the "H" or "Q" placement on CA161 for the member.

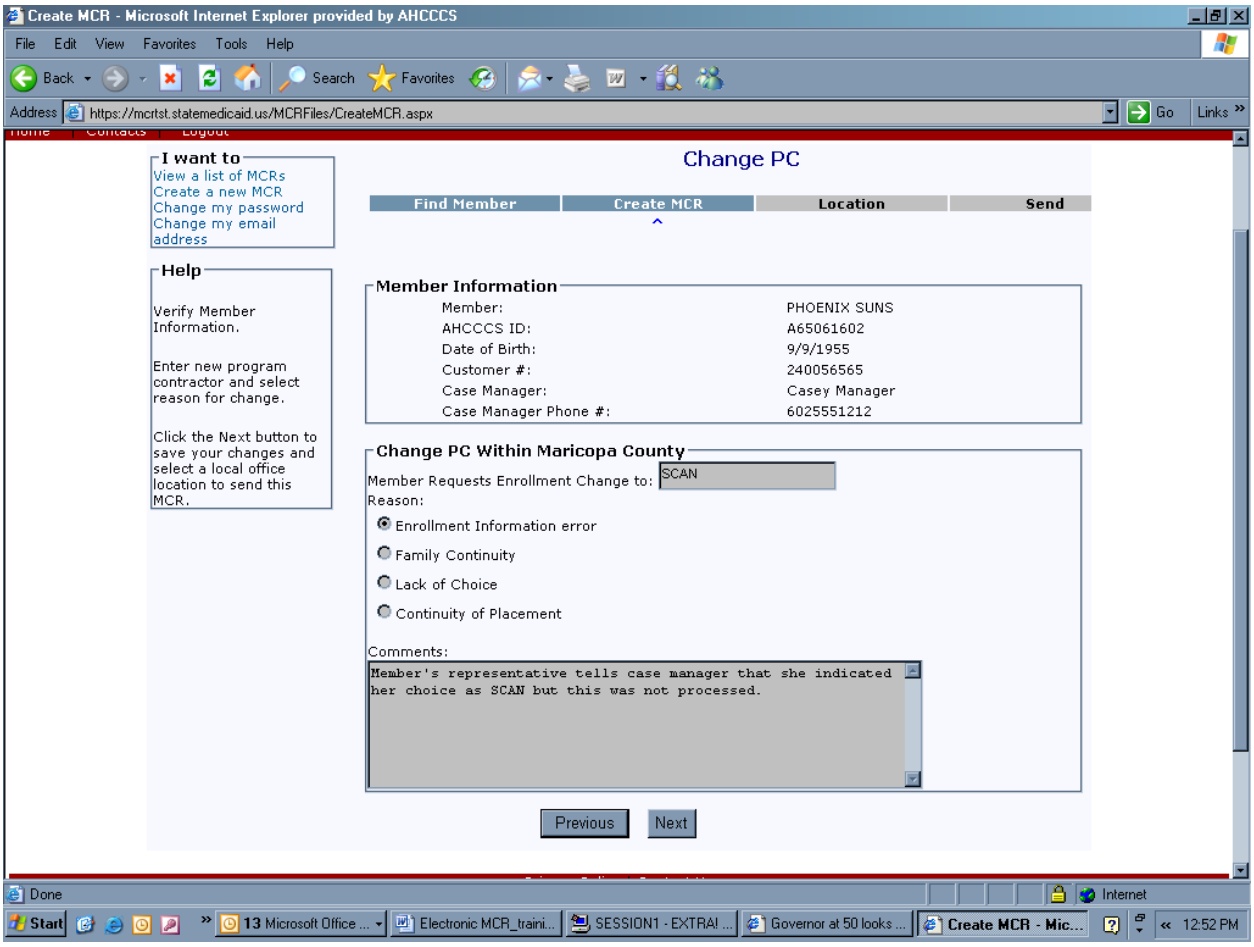
- Comments are not necessary but may be used to explain the circumstances of the case as needed.
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR created will be sent is selected. DHCM will be the only option for where to send this type of change.

O. LTC to ACO and ACO to LTC - Select Location and Add Attachments



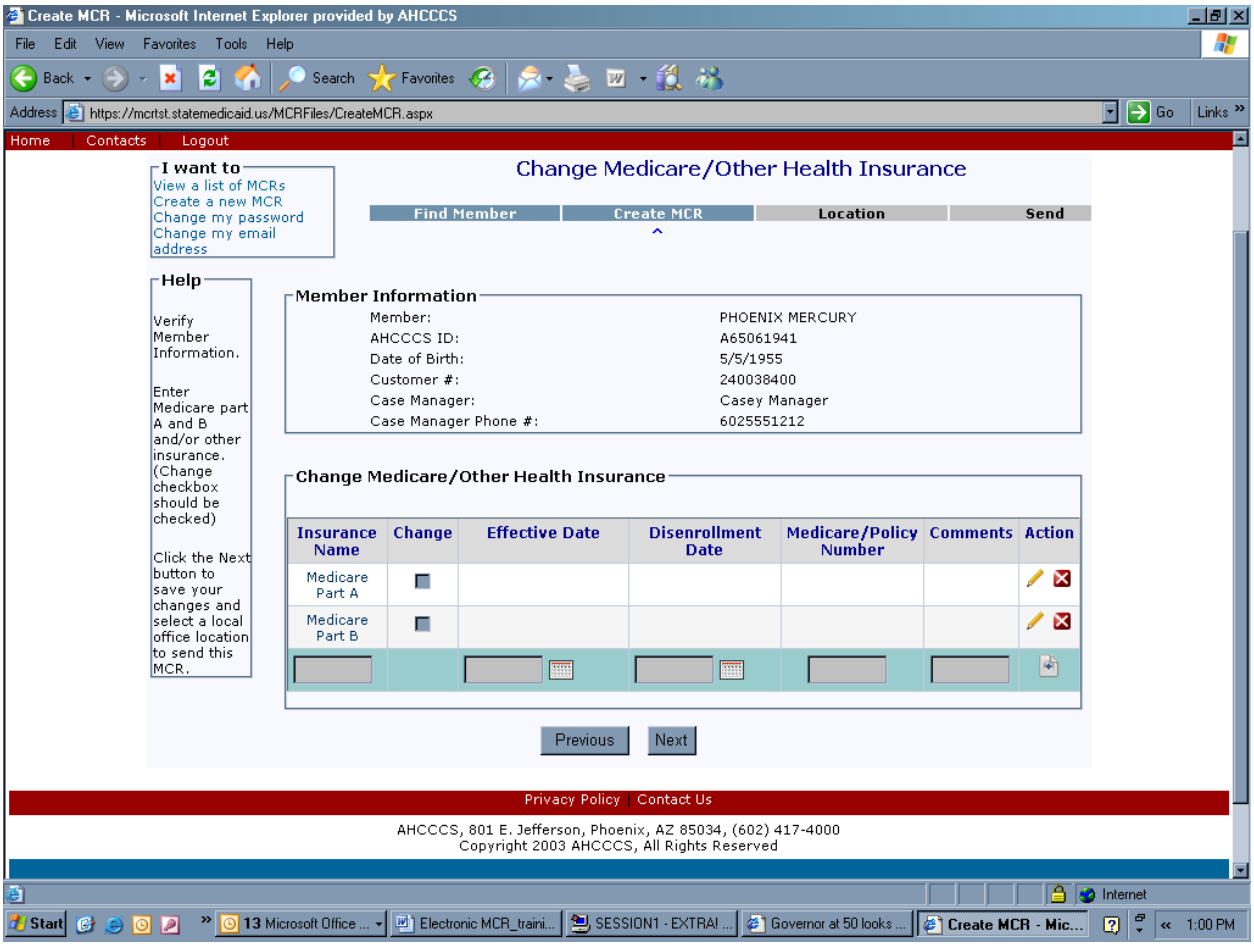
- On this screen for selecting the location for where to send the MCR, DHCM is the only option when Part B type changes (LTC to ACO and ACO to LTC) are being reported.
- As described on pages 27-29 of this policy, attachments may be added here as needed, prior to sending the MCR.
- Clicking the "Next" button at the bottom of the screen (not visible in the picture above) will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

P. Program Contractor Change within Maricopa (or Pima) County



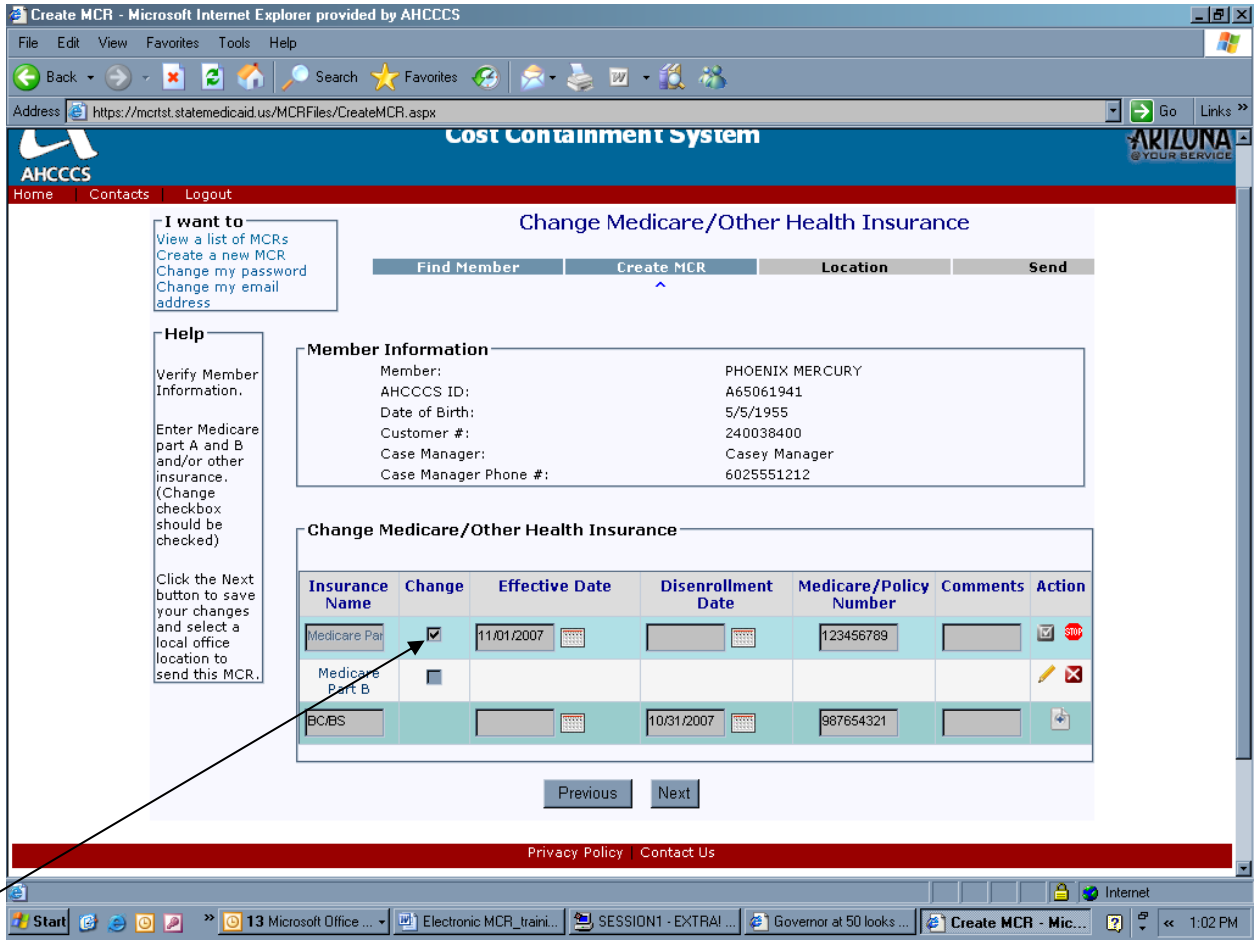
- Enter the name of the Program Contractor that the member is requesting his/her enrollment to be changed to, as indicated in the example above.
- One of the 4 reasons shown above must also be checked to indicate why the member's enrollment needs to be changed outside the Annual Enrollment Choice process. See Policy 403 of this manual and/or AHCCCS Eligibility Policy Manual, Section 1106.02 for more information about these reasons.
- Comments are not required on this screen but are strongly encouraged to explain the member's circumstances as best understood by the case manager in order to assist the Eligibility Specialist in determining whether the change is valid or not.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

Q. Medicare/Other Health Insurance



- On this screen changes to Medicare Part A and Part B information are initiated by clicking on the icon in the Action column on the far right.
- For other health insurance changes, the type of insurance should be entered in the blank "Insurance Name" box which follows the Medicare rows.
- More than one insurance change can be reported on a single MCR but each insurance change must be entered separately on this screen.
- The following page of this policy shows how the screen view changes after the icon is clicked for a Medicare change.

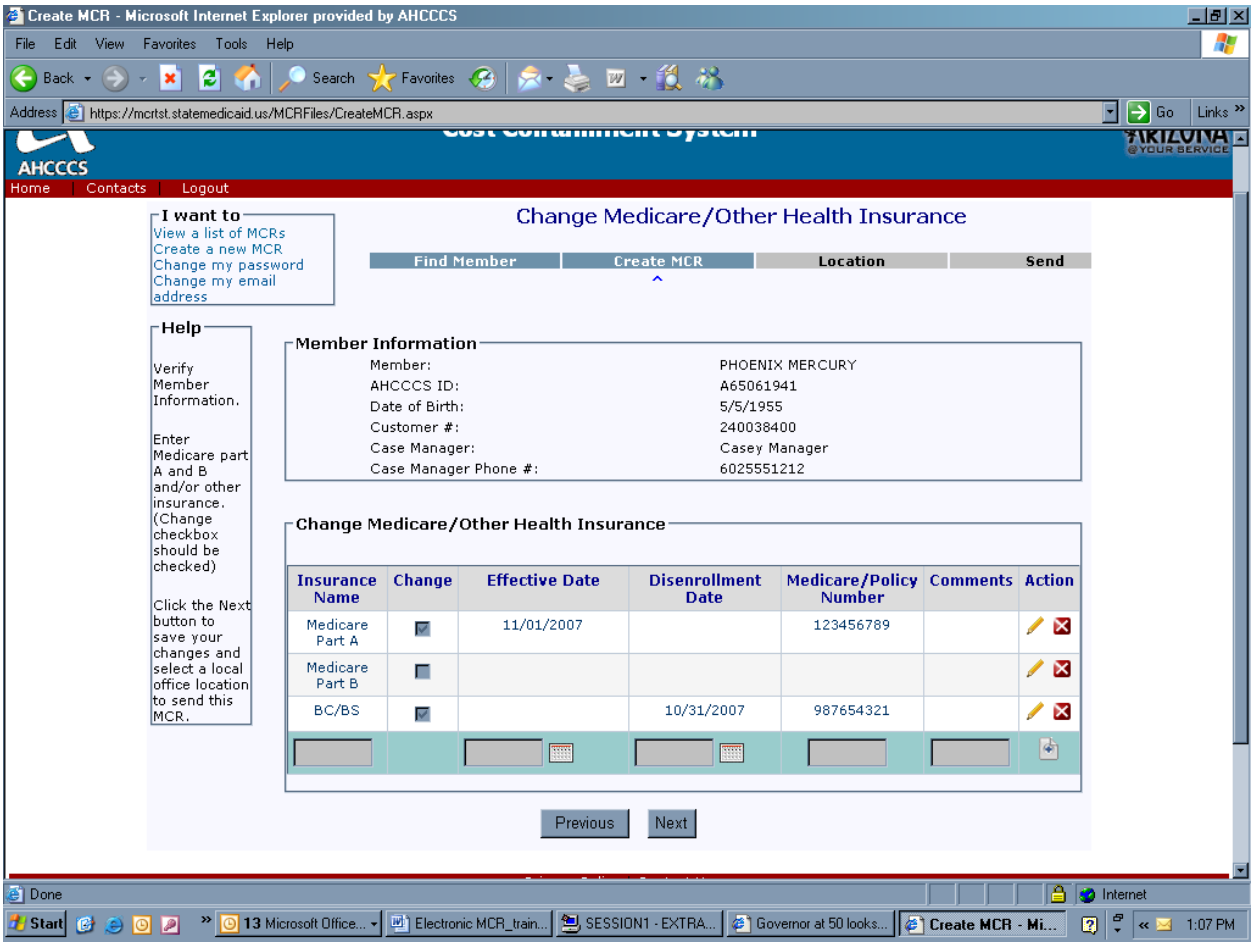
Medicare/Other Health Insurance – cont'd



- In the example above, the user had clicked on the icon for a change to Medicare Part A on the previous screen.
- On this screen, the user must click on the box in the "Change" column so that a check mark appears (as shown above) next to the Medicare Part for which a change is being reported.
- An Effective Date or Disenrollment Date must be entered to indicate whether the change is the begin or end of this type of insurance coverage.
- A Policy Number will be required for all reported changes.
- Comments are not required but may be added if needed.
- Medicare changes are saved/added to the MCR by clicking on the icon in the Action column. **This step must be done before additional insurance changes can be entered on the MCR.**
- Other insurance changes (shown in the example above as BC/BS) are saved/added to the MCR by clicking on the icon in the Action column.

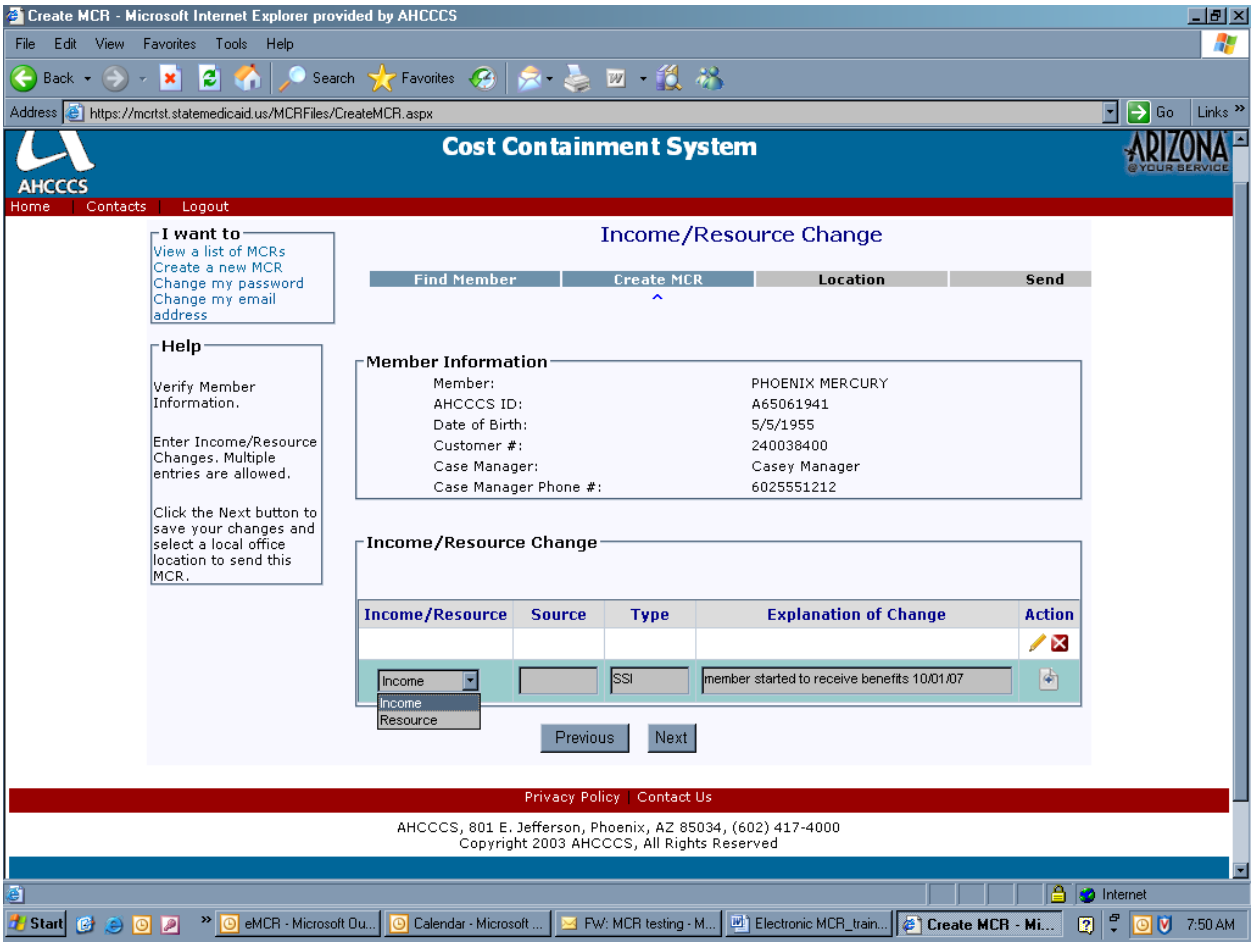
- Clicking on the  icon in the Action column (for Medicare changes only) will cancel the action being entered before it is added.
- Clicking the "Next" button will show the user a screen that indicates the changes that were added (see following page).

Medicare/Other Health Insurance – cont'd, 2



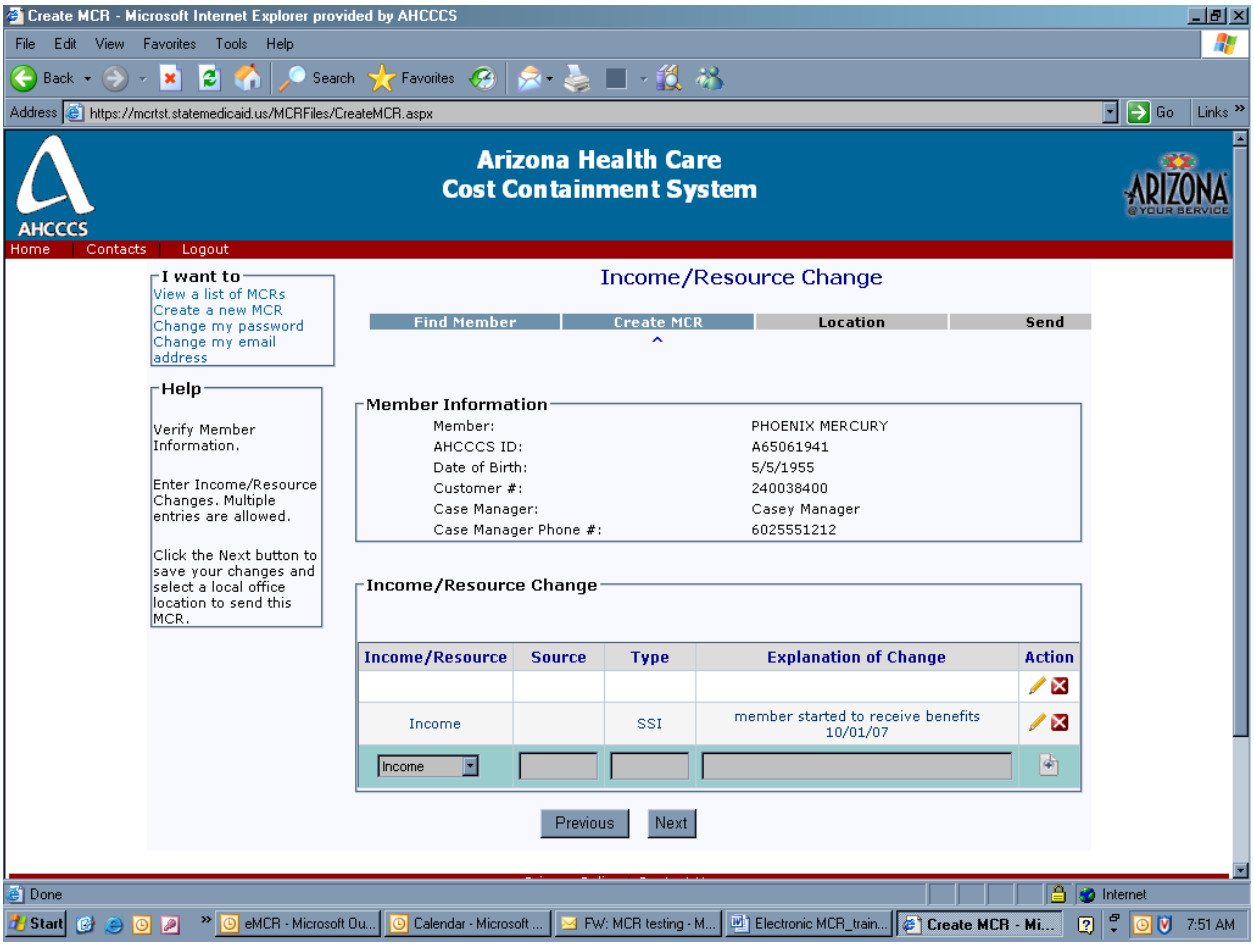
- This screen is like a preview screen that shows the insurance changes that have been added.
- If changes to entered information are needed, the user should click on icon in the Action column for the type needing a change. In the example above, clicking on icon in the Medicare Part B row will also allow changes to be entered now even though nothing was entered previously.
- Clicking on the icon in the Action column will delete the change entered for that row after it has been added/saved. A message box asking if the user is sure they want to delete the entry should appear. Click "OK" when this appears.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

R. Income/Resources Change



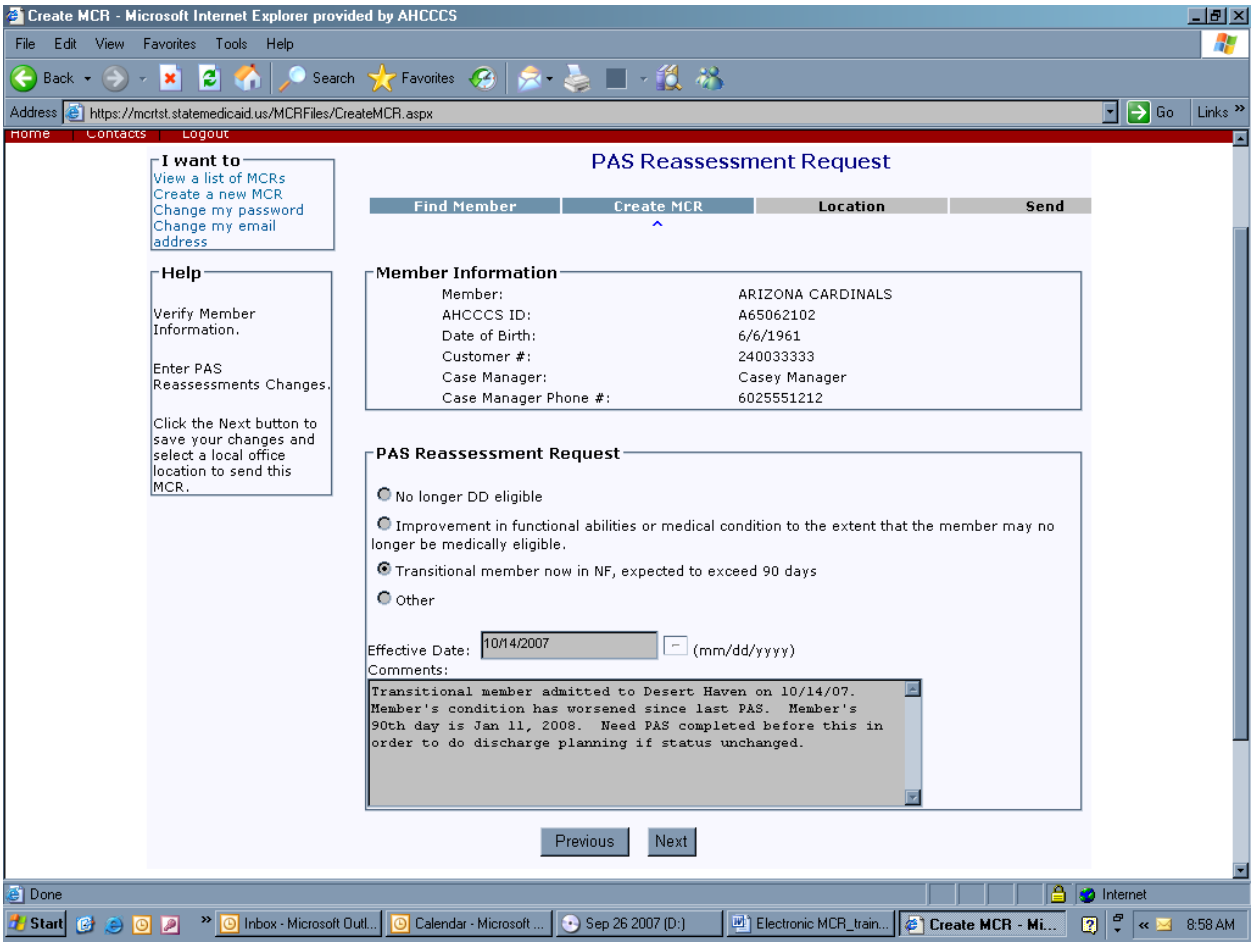
- An Income or Resource change can be reported by choosing the type from the drop down box as shown above.
- If a second Income or Resource change needs to be reported at the same time, the user may click on the icon in the Action column. Another drop down box will appear for the user to choose the type in the same way as shown above.
- The "Source" and "Type" of the income or resource are not required fields but should be used to provide information about where the income/resource is coming from, if known. Examples: Social Security, SSI, VA income, Pension, Wages and Retirement benefits.
- Comments are not required but should be entered if information is available that would assist the Eligibility Specialist in processing the change.
- **Comments should be used to alert AHCCCS about the change in household income status when/if the member's spouse becomes the paid caregiver.**
- Clicking on the icon in the Action column will add the change entered on that line.

Income/Resources Change – cont'd



- This screen is like a preview screen that shows the income/resource changes that have been added.
- If changes to entered information are needed, the user should click on the icon in the Action column for the income/resource needing a change.
- Clicking on the icon in the Action column will delete the change entered for that row.
- Clicking the "Next" button will take the user to a screen where the local office location to which the MCR will be sent is selected.

S. PAS Reassessment Request

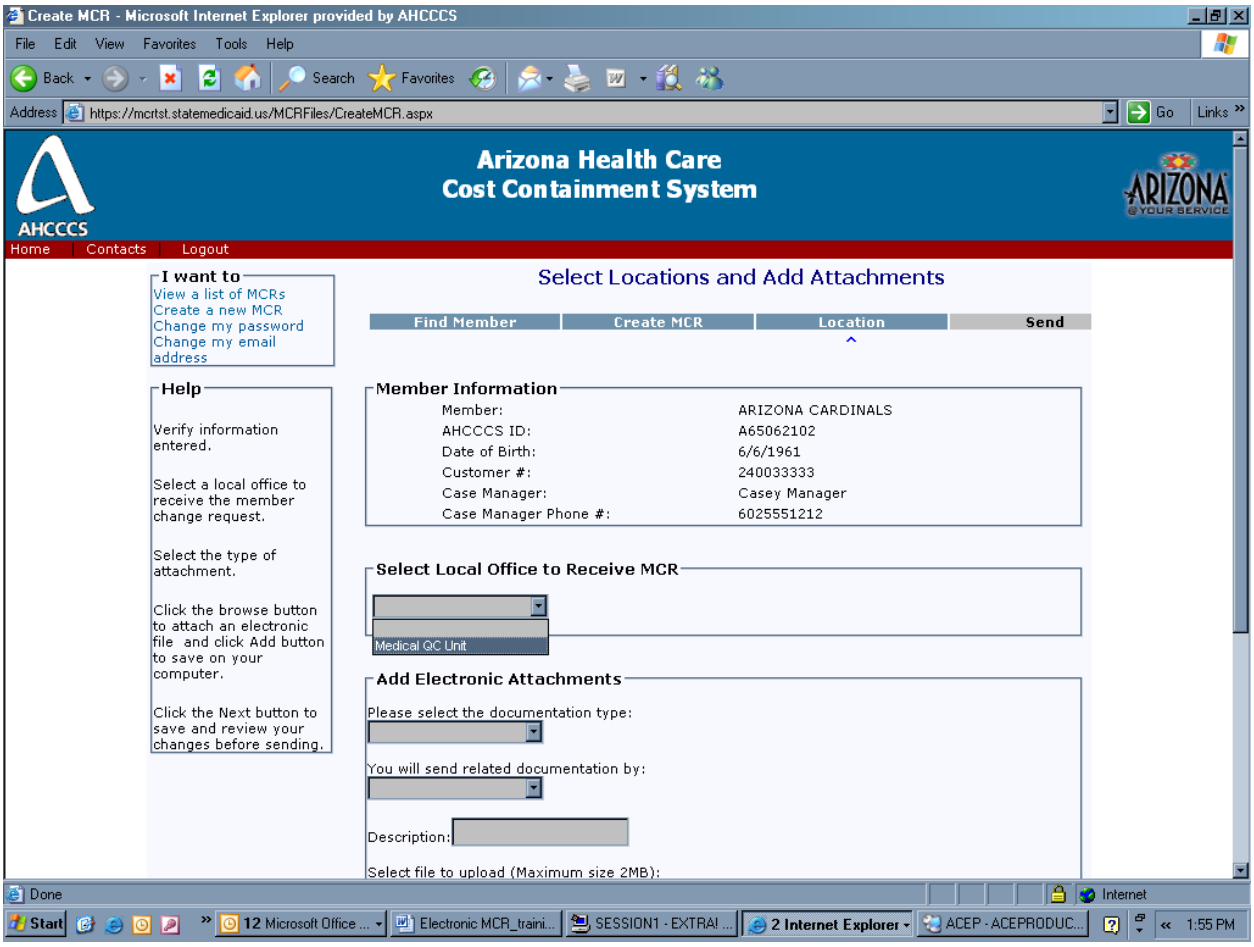


- A reason for the PAS Reassessment must be indicated by choosing one of the choices shown on this screen.
- The "No longer DD eligible" option is used, by DES/DDD only, to indicate that a PAS needs to be completed on a member who no longer meets DDD criteria in order to determine if the individual will continue to be ALTCS eligible as an E/PD member.
- An Effective Date is only required when "No longer DD" is checked. The date entered should reflect the effective date of DD ineligibility.
- An Effective date can be entered for other options even though they are not required. In the example above, the user entered the effective date of a Transitional member's admission to a NF.
- Comments are required when:
  - a PAS is requested due to improvement in the member's status – these comments should include the type and extent of the member's improvement and/or what makes the case manager think the member may no longer be medically eligible
  - for a Transitional member admitted to a NF - these comments should include the name of the NF, admission date and information about the timeframe when a PAS needed

- Other – should explain "other" circumstances which indicate a PAS is needed

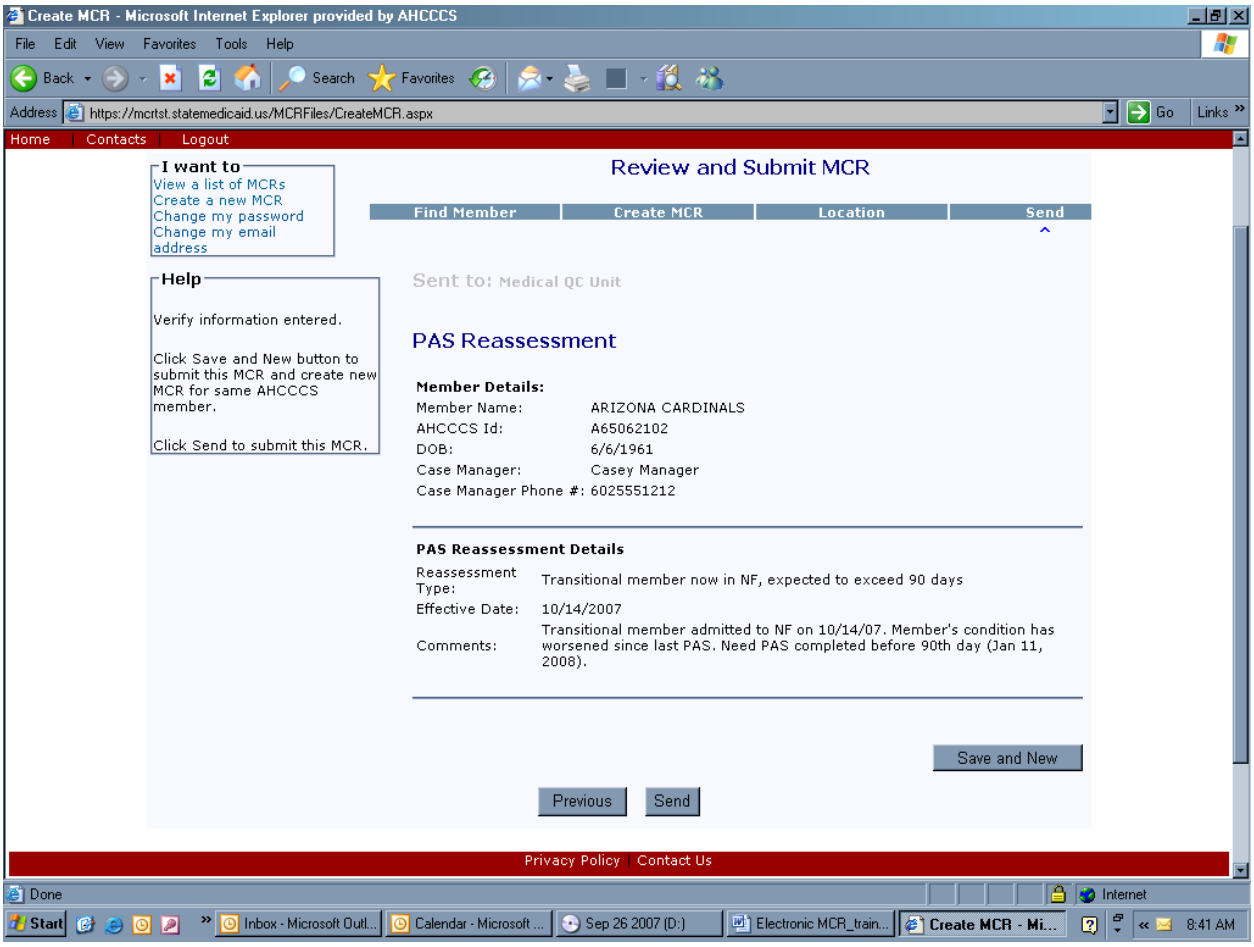
- Clicking the "Next" button will take the user to a screen where the AHCCCS location to which the MCR will be sent is selected. The Medical QC unit in the AHCCCS Central office will be the only option for where to send this type of change.

2. PAS Request - Select Location and Add Attachment



- On this screen for selecting the location for where to send the MCR, Medical QC is the only option when a PAS reassessment is being requested.
- As described on pages 27-29 of this policy, attachments may be added here as needed, prior to sending the MCR.
- Clicking the "Next" button at the bottom of the screen (not visible in the picture above) will take the user to a screen where the details of the MCR just created can be reviewed prior to sending it to AHCCCS.

2. PAS Request - Review and Submit MCR



- Clicking the "Send" button submits the MCR to the selected AHCCCS location and then returns the user to the Contractor's "home" page. The just-created MCR will appear on that page in the Contractor's MCR list with Status "New".
- The "Save and New" button saves the change information already entered and allows the user to create another MCR for the same member. The user is returned to the "Create MCR" page to choose the type of change to be reported (page 14 of this policy).

Note - Currently, if the Effective Date was left blank on the screen where the PAS Reassessment MCR was created (page 48 of this policy), a default date of 01/01/1900 appears in the field here.

IV. References

- AHCCCS Medical Policy Manual, Chapter 1200
- AHCCCS Medical Policy Manual, Chapter 1600

431 – COPAYMENT

Effective Date: 04/01/12, 09/01/12, 06/01/13
Revision Date: 09/15/12, 10/11/12, 05/29/13

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute, Behavioral Health Services (BHS), Arizona Long Term Care Elderly and Physically Disabled System (ALTCS/EPD), Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors.

II. Scope (Overview/General Information)

To outline the copayment requirements described in A.A.C. R9-22-711, including mandatory and optional copayment amounts for certain populations, and provide clarification on services and populations which are exempt from copayments.

The copayments referenced in this policy are only those copayments charged under AHCCCS, and does not apply to other copayments such as Medicare copayments.

III. Definitions

Copayments A monetary amount that a member may be required to pay directly to a provider at the time a covered service is rendered. AHCCCS has two types of copayments:

a. *Mandatory* (also known as "hard"): Providers can deny services to members who do not pay the copayment.
b. *Optional* (also known as "nominal"): Providers are prohibited from denying the service when the member is unable to pay the copayment.

Copayment Levels Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to optional (nominal) copayments, or subject to mandatory (hard) copayments.

Taxi A vehicle that has been issued a taxi special license plate pursuant to A.R.S. §28-2515.

Visit All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.

IV. Policy

A. Mandatory Copayments

Individuals eligible for AHCCCS through the Transitional Medical Assistance (TMA) and Childless Adults/TWG (AHCCCS Care) programs are subject to mandatory copayments for the services listed below (see tables):

For individuals eligible for AHCCCS through the Transitional Medical Assistance (TMA) see also Section F, *Copayment Limits* of this Policy.

TMA Copayments

Service	Copayment
Prescriptions (per drug)	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures	$3.00

AHCCCS Care/TWG Copayments

Service	Copayment
Generic prescriptions and brand name prescriptions when no generic is available (per drug)	$4.00
Brand name prescriptions when there is a generic that can be used (per drug)	$10.00
Non-emergency use of an emergency room	$30.00
Doctor or other provider outpatient office visits for evaluation and management	$5.00
Taxi transportation (members residing in Maricopa and Pima Counties Only). ** The $2.00 copayment will be charged each time a taxi is called. If a taxi waits for a member, e.g., while the member picks up a prescription, then a $2.00 copay cannot be charged for the continuation of the one-way trip.*	*$2.00 each trip

B. Optional Copayments

Individuals eligible for AHCCCS through the following programs are subject to Optional Copayments:

1. AHCCCS for Families with Children (1931)
2. Young Adult Transitional Insurance (YATI) for young adults who were in foster care
3. State Adoption Assistance for Special Needs Children
4. Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled
5. SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled
6. Freedom to Work (FTW)
7. Breast and Cervical Cancer Treatment Program (BCCTP) for Women
8. Members receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E

Optional Copayments for members enrolled in the programs listed above are as follows:

Service	Copayment
Prescriptions (per drug)	$2.30
Physical, Occupational and Speech therapies	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$3.40

C. Members and Services Exempted from Copayments

Some populations and services are never subject to copays as outlined below:

1. Copayments are **never charged** to the following persons:
   a. Children under age 19
   b. People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
   c. Individuals through age 20 eligible to receive services from the CRS program
   d. People who are acute care members and who are placed in nursing homes or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year.
   e. People who are enrolled in the Arizona Long Term Care System
   f. People who are eligible for Medicare Savings Programs only
   g. People who receive hospice care

h. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
i. Other short term exceptions as identified by AHCCCS, such as members residing in a split Maricopa/Pima County Zip Code (transportation copay exemption)

2. When an Acute Care member meets the criteria for copay exemption as described in Section C. 1. d., g. and i. of this Policy, Contractors must notify Member Data Management Administration (MDMA). The Contractor must fax a completed copy of Attachment A, *AHCCCS Notification to Set Member's Copay Flag to Exempt* to AHCCCS MDMA within five days of admission or services being provided.

3. Copayments are **never charged** for the following services:
   a. Hospitalizations
   b. Emergency services
   c. Family Planning services and supplies
   d. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
   e. Services paid on a fee-for-service basis

D. Copayment Collection

Providers are responsible for billing members for the copayment amount at the time of service. This applies to members with optional copayments as well as members with mandatory copays.

1. Mandatory copayments permit providers to deny services to members who do not pay the copayment. Payments to providers will be reduced by the amount of a member's copayment obligation regardless of whether or not the provider successfully collects the mandatory copayment.

2. Optional copayments apply to AHCCCS members who are not required to make the mandatory copayments. When a member has an optional copayment, providers are prohibited from denying the service when the member is unable to pay the copayment. The provider's reimbursement cannot be reduced by the amount of the copayment for members with optional copayments if the member is unable to pay.

E. Encounter Submissions

Refer to the *AHCCCS Encounter Manual*, Chapter 6 for more information on the reporting of copayments on encounter submissions.

F. Copayment Limits

1. A member receiving TMA will not be required to pay additional copayments once the total amount of copayments made is more than 5% of the gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.)

   The AHCCCS Administration will track each member's specific copayment levels by service type to identify those TMA members who have reached the 5% copayment limit.

2. With the exception of prescription drugs (where a copay is charged for each drug received), only **one** copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

G. Copayment Information

For more information regarding copays, refer to the AHCCCS Copayments page on the AHCCCS website and ACOM Policy 201.

V. References

- A.A.C. R9-22-711
- A.R.S. §28-2515
- Acute Care Contract
- ALTCS/DDD Contract
- ALTCS/EPD Contract
- BHS Contract
- CRS Contract
- CMDP Contract
- DDD Contract
- AHCCCS Encounter Manual
- ACOM Policy 201, Medicare Cost Sharing for Members Covered by Medicare and Medicaid
- ACOM Policy 431, Attachment A, AHCCCS Notification to Set Members Copay Flag to Exempt

Attachment A

AHCCCS NOTIFICATION TO SET MEMBERS COPAY FLAG TO EXEMPT

Fax to AHCCCS MDMA 602-253-4807

The circumstances listed below require that a member's copay status be manually set to exempt status. Therefore, please complete and fax this form to AHCCCS MDMA within five days of admission or services being provided.

- Members in nursing facilities and residential facilities such as assisted living in lieu hospitalization. This exemption is limited to 90 days in a contract year. The exemption does not apply to members residing in their own homes receiving home and community based services
- Members receiving hospice services
- Members residing in Maricopa and Pima County split zip codes (Taxi copays only)

Member's Name:_____ AHCCCS ID:_____DOB:_____

Mark one that applies:

☐ Nursing home
☐ Residential facility such as assisted living
☐ Hospice
☐ Split Maricopa and Pima County Zip Codes for Taxi Transportation copays only

Provider Name:_____
Provider Address/Phone Number:_____
Provider Number:_____
Admission Date:_____

Please fill out the below information and refax this notification when the member is discharged or meets 90 day maximum in nursing and residential facilities.

Discharge date or 90 day maximum:_____
Comments:_____
_____
Health plan name:_____
Contact person:_____
Phone number:_____
Date submitted:_____

432 - BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES PROVIDED TO MEMBERS ENROLLED IN THE ACUTE CARE SERVICES PROGRAM

Original Date:
Effective Date: 07/01/12*,
Revision Date: 10/11/12 – Note: The effect date of this clarification is retroactive to 7/01/12.

Staff Responsible for policy: Behavioral Health

I. Purpose

This Policy applies to AHCCCS Acute Care Contractors and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) for the purposes of benefit coordination and delineating financial responsibility for AHCCCS covered behavioral health services provided to AHCCCS members who are enrolled with Acute Care Contractors. For dates of service on and after October 1, 2010, Acute Care Contractors are no longer responsible for payment of behavioral health services provided to their enrolled members, including behavioral health services received during the prior period and emergency inpatient behavioral health services received during the initial seventy-two hours of an emergency inpatient stay, except as otherwise stated in this policy.

This policy specifies that financial responsibility is determined by the primary diagnosis appearing on a claim (defined as the principal diagnosis on a UB claim from a facility or the first-listed diagnosis on a CMS 1500 claim) even if a combination of both medical and behavioral services are listed on the claim.

II. Scope (Overview/General Information)

ADHS/DBHS is responsible for payment of all behavioral health services received by members enrolled in the AHCCCS Acute Care Program, except as described in Section B. AHCCCS assigns all Acute Care enrolled members into a Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (TRBHA) based on the member's zip code in which s/he resides (with the exception of CMDP) at the time of enrollment. This information is included on member identification cards issued on and after October 1, 2010.

*This policy applies to dates of service on or after 10/1/2010 with the exception of Section B2 and C5, which are effective 07/01/2012.

III. Definitions

Acute Care Member	An eligible person who is enrolled in an AHCCCS acute care health plan.
Acute Care Hospital	A general hospital that provides surgical services and emergency services and registered as an AHCCCS provider Type 02.
ADHS/DBHS	Arizona Department of Health Services/ Division of Behavioral Health Services, the state agency responsible for the provision of all medically necessary covered behavioral health services to AHCCCS TXIX and TXXI acute care members. ADHS/DBHS contracts with T/RBHAs (Tribal/Regional Behavioral Health Authorities) to administer covered behavioral health services in geographically specific areas of the state. ADHS/DBHS is responsible for ensuring that T/RBHAs comply with the requirements of this policy and for timely addressing any deficiencies and compliance issues attributable to the T/RBHAs.
AIHP	American Indian Health Program
Assignment	The process of designating a T/RBHA for a member based on the member's zip code in which s/he resides. Assignment does not confirm a member has or is actively receiving behavioral health care services. Members enrolled with the Children's Medical/Dental Plan (CMDP) are assigned to a T/RBHA based on the zip code of the court of jurisdiction.
Behavioral Health Recipient	A member who is receiving or has received behavioral health services from the member's respective T/RBHA during any time as an AHCCCS acute care member.
Behavioral Health Diagnosis	Behavioral health diagnoses can be located on the ADHS/DBHS website at http://www.azdhs.gov/bhs/covserv.htm and can also be located in PMMIS by entity type of MHS on reference table RF 724.

*This policy applies to dates of service on or after 10/1/2010 with the exception of Section B2 and C5, which are effective 07/01/2012.

Child	A TXIX/TXXI member under the age of 18 years old as per R9-20-101. For purposes of this policy, the designation of "Child" in the AHCCCS PMMIS does not apply the Early and Periodic Screening, Diagnosis and Treatment for persons under 21 years of age, as described in AHCCCS Rules R9-22, Article 2.
Disenrollment	The discontinuance by AHCCCS of a member's ability to receive covered services through a Contractor.
Eligibility	The process of determining, through a written application and required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI.
Enrollment	The process by which an eligible person becomes a member of a Contractor's plan.
GMH/SA	General Mental Health/Substance Abuse
PCP	Primary Care Provider/Physician
Primary Diagnosis	The condition established after study to be chiefly responsible for occasioning the admission or care for the member, (as indicated by the principal diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim).
Prior Period	The period of time, prior to the member's enrollment with an acute care contractor, or if the member is Fee for Service, prior to the date of AHCCCS eligibility determination, during which a member is eligible for covered services. The prior period time frame begins with the first day of the month in which eligibility for Title XIX benefits begin to the date of Title XIX prospective enrollment, or the date of eligibility determination for Fee-for-Service members, whichever is applicable.
SMI	Seriously Mentally Ill; a person 18 years of age or older who is seriously mentally ill as defined in A.R.S. §36-550.

T/RBHA	Tribal/Regional Behavioral Health Authority- an organization under contract with ADHS/DBHS that administers covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members.

III. Policy

A. General

Effective October 1, 2010, AHCCCS assigns all Acute Care enrolled members into a Regional Behavioral Health Authority (RBHA) or Tribal Regional Behavioral Health Authority (T/RBHA) based on the zip code in which the members resides. The T/RBHA will be identified on the member's AHCCCS ID card, the AHCCCS website and 270-271 transactions on and after October 1, 2010.

Although members are assigned to their geographically assigned T/RBHA, members must still contact their respective T/RBHA to initiate services. Members are notified of their behavioral health enrollment and how to access behavioral health services by AHCCCS and ADHS/DBHS through their member handbook in addition to their membership card.

Acute care members will always be enrolled in their assigned T/RBHA whether or not they are actively receiving behavioral health services. Therefore, members will never be disenrolled from the T/RBHA even when treatment is successfully completed or members choose to terminate behavioral health services.

B. Acute Care Contractor Responsibilities/Roles in serving behavioral health recipients

1. Acute Care Contractors are responsible for assisting members in obtaining behavioral health services if requested. The Acute Care Contractor's Behavioral Health Coordinator can facilitate the member's appointment for behavioral health services.
2. Acute Care Contractors are responsible for transportation for the member to the initial T/RBHA scheduled appointment and to the emergency department of an acute care hospital when the transport is emergent.
3. Acute Care Contractors are responsible for non-behavioral health professional

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fees related to co-morbid conditions such as treatment for diabetes, asthma, hypertension etc.

4. Acute Care Contractors are responsible for claims with behavioral health primary diagnoses that are related to communication disorders usually diagnosed in infancy, childhood or adolescence. The claim must be accompanied by procedure codes ranging from 92506-92508 and 92550-92597. These behavioral health conditions require provider types such as speech therapists or other physical health providers, not considered behavioral health providers.
5. Acute care contractors are *not* responsible for reimbursement of inpatient facility and professional behavioral health services to hospitalized members with primary behavioral health diagnoses. Reimbursement is unrelated to the bed or floor where the member is placed.
6. Acute Care Contractors are responsible for the following when provided in an emergency department and there is no admission to the facility:

    a) Reimbursement of all facility covered services, including triage and diagnostic tests, regardless of primary diagnosis.

    b) Reimbursement of non behavioral health *professional* claims, regardless of the presenting problem or diagnosis.

    Acute Care Contractors are not responsible for payment of claims for behavioral health professional services provided in the emergency department. For example, if a behavioral health professional evaluates a member in the emergency room, the T/RBHA is responsible for payment, and the behavioral health professional must bill the T/RBHA for the evaluation.

    In the event of an admission from the emergency department, the responsible payor is determined by the primary diagnosis appearing on the claim for the inpatient stay.

7. Acute Care Contractors are responsible for reimbursement of primary care provider visits, prescriptions, laboratory and other diagnostic tests necessary for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder.

    a) Acute Care Contractors may implement step therapy for behavioral health medications used for these disorders except when the ADHS/DBHS Referral Form 4.3.1 indicates that 1) step therapy has occurred or 2) the treating T/RBHA provider recommends that the member remain on the current prescribed medication for psychiatric

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stability.

b) Members may continue to receive medication management from their primary care providers (which are the fiscal responsibility of the acute care contractor) while simultaneously receiving counseling and other medically necessary rehabilitative services from the T/RBHA.

8. Acute Care Contractors are responsible for ensuring that the member's supply of psychotropic medications, including antipsychotic medication, is adequate to last through the date of the member's first appointment with a T/RBHA prescriber even if the first appointment is delayed. Acute Care Contractors are responsible for forwarding all relevant member medical information to the T/RBHA prescriber so that it is received prior to the first appointment.
8. Acute Care Contractors are responsible for contacting the T/RBHA for problem resolution regarding access to/delivery of behavioral health services. In the event the T/RBHA is unable to timely resolve the issue, the Acute Care Contractor must notify ADHS/DBHS Member Services (and Quality Management regarding quality of care issues) for assistance in resolving the issue.

C. ADHS/DBHS Roles/Responsibilities for behavioral health services for acute care members

1. The T/RBHA is responsible for accepting and acting upon referrals for behavioral health services, including emergency referrals, in accordance with contractual timelines. A referral is any oral, written, faxed, or electronic request for services made by the member, Acute Care Contractor and or the PCP.
2. The T/RBHA is responsible for ensuring that the final disposition of all referrals for behavioral health services, including emergency referrals from PCPs and Acute Care Contractors is communicated to the referral source and Acute Care Contractor Behavioral Health Coordinator no later than 30 days from the date of the member's initial assessment. If the member declines behavioral health services the final disposition must be communicated back to the referral source and Acute Care Contractor Behavioral Health Coordinator, when applicable, within 30 days from the date of the referral. The T/RBHA is responsible for notifying the Acute Care Contractor if the member does not show up for a scheduled initial appointment and the date of the next scheduled appointment in order for the Acute Care Contractor to assure that the member's psychiatric medications are not interrupted.
3. The T/RBHA is responsible for ensuring a timely response to all appointment requests and shall schedule emergency, urgent and routine evaluations

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consistent with the member's needs and within contractual appointment standards.

4. The T/RBHA is not responsible for claims with behavioral health primary diagnoses that are related to communication disorders usually diagnosed in infancy, childhood or adolescence. Denied claims must include procedure codes ranging from 92506-92508 and 92550-92597. These behavioral health conditions require provider types such as speech therapists or other physical health care providers, which are not considered behavioral health providers.
5. The T/RBHA is responsible for reimbursement of detoxification services provided to a member who is medically stable regardless of setting or bed type.
6. The T/RBHA is *not* responsible for transportation for the member to the initial T/RBHA scheduled appointment or to the emergency department of an acute care hospital when the transport is emergent.
7. The T/RBHA is responsible for reimbursement of both the inpatient facility services and the professional behavioral health services for hospitalized members with primary behavioral health diagnoses unrelated to the bed or floor where the member is placed. Reimbursement of professional behavioral health services, including consultations, is unrelated to the bed or floor where the member is placed even if the member has or is being treated for other co-morbid physical conditions such as diabetes, asthma, hypertension etc. T/RBHAs are not responsible for non-behavioral health professional fees related to the co-morbid conditions.
8. In the event of an admission from the emergency department, the responsible payor is determined by the primary diagnosis appearing on the claim for the inpatient stay.
9. The T/RBHA is responsible for payment of medically necessary professional psychiatric consultations provided to acute care members in either emergency room or inpatient settings, when the primary diagnosis on the professional claim is behavioral health (regardless of primary diagnosis on the facility claim for the inpatient stay). This includes but is not limited to surgeries, procedures or therapies for which behavioral health support for a member is indicated to determine if there are any behavioral health contraindications.
10. The T/RBHA is responsible for reimbursement of ambulance transportation and/or other medically necessary transportation provided to a member who requires behavioral services after s/he has been medically stabilized. For example, the T/RBHA is responsible for transporting a medically stabilized member from the emergency room to another level of care or setting when behavioral health services are medically necessary.
11. The T/RBHA is not responsible for ambulance transportation and/or other medically necessary transportation when the member is enrolled in the AIHP and the primary diagnosis is not behavioral health (unspecified diagnosis code is not considered a behavioral health diagnosis code).

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12. The T/RBHA is responsible for ensuring that the member's supply of psychotropic medications for the treatment of depression, anxiety and attention deficit/hyperactive disorder is adequate to last through the date of the member's first appointment with the PCP, when the T/RBHA has confirmed acceptance of transferring the member to back to the PCP with the PCP. The T/RBHA is responsible for forwarding all relevant member medical information to the PCP that it is received prior to the first/next appointment.
13. The T/RBHA is responsible for reimbursement of laboratory and other diagnostic tests necessary for the initial and ongoing treatment of behavioral health conditions. The primary diagnosis must be a behavioral health diagnosis.
14. The T/RBHA is responsible for submitting the ADHS/DBHS Referral Form 4.3.1 to member's Primary Care Providers (PCPs) for all members referred by the PCP. In such instances the T/RBHA must notify the PCP of the members' diagnosis, the critical laboratory values as defined by the laboratory, and the prescribed medications, including notification of changes in class of medications. For all other members receiving behavioral health services, the above information must be provided by the T/RBHA to the PCP no later than 10 days from the date of the request.
15. Payment of pre-petition screening and court ordered evaluation services are the fiscal responsibility of a county. For payment responsibility for other court ordered services refer to the AHCCCS Contractors Operational Manual Policy 423.
16. The T/RBHA and/or ADHS/DBHS are responsible for contacting and responding to Acute Care Contractors in a timely manner whenever problems with accessing behavioral health services are identified.

D. AHCCCS Responsibilities/Roles

1. AHCCCS assigns each acute care member to his/her respective T/RBHA based on the zip code in which s/he resides with the exception of CMDP children who are enrolled based on the zip code of the court of jurisdiction.
2. AHCCCS sends daily/monthly electronic 834 files to ADHS/DBHS of all enrolled acute care members.
3. AHCCCS identifies each acute care member as "Seriously Mentally Ill" (SMI), "General Mental Health/Substance Abuse" (GMH/SA) or "Child" in the AHCCCS PMMIS system based on ADHS/DBHS submitted designation of each member.
4. AHCCCS designates each acute care member as either TXIX or TXXI as determined by the member's eligibility category.

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5. AHCCCS identifies acute care members who are actively receiving behavioral health services in the AHCCCS PMMIS system based on ADHS/DBHS submitted designation of each member.
6. AHCCCS is responsible for payment of medically necessary transportation (emergent and non-emergent) for TRBHA enrolled AIHP members and the diagnosis code on the claims is unspecified (799.9).

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Matrix of Financial Responsibility

Setting/Service Type	*Facility Fee*	*Behavioral Health Professional Fee (as defined by a primary diagnosis on the professional claim)*	*Non Behavioral Health Professional Fee (as defined by a primary diagnosis on the professional claim)*	
Inpatient Acute Hospital non psychiatric bed when psychiatric bed unavailable and primary diagnosis is psychiatric	T/RBHA	T/RBHA	Acute Care Contractor	
Inpatient Acute Hospital (psychiatric bed)	T/RBHA	T/RBHA	Acute Care Contractor	
Inpatient Acute Hospital (detox bed)	T/RBHA	T/RBHA	Acute Care Contractor	
Residential Treatment Center or any other BH Facility Charges	T/RBHA	T/RBHA	Acute Care Contractor	
Emergency Department (not resulting in an Inpatient admission regardless of primary diagnosis)	Acute Care Contractor	T/RBHA	Acute Care Contractor	
Behavioral health consultation in a hospital setting with a primary medical diagnosis.	**Acute Care Contractor**	**Acute Care Contractor**		
Behavioral health consultation in a hospital setting with primary behavioral health diagnosis. Claim must include a behavioral health diagnosis.	**Acute Care Contractor**	**T/RBHA**		

Service Type	***Initial BH Appointment***	***Transfer from an Inpatient Acute Hospital to a BH setting***	***For other BH related services***	
Non Emergency Transportation	Acute Care Contractor	T/RBHA	T/RBHA	
Service Type	***From BH Facility to Hospital ER***	***From the community to Hospital ER***	***From the community to Psychiatric Hospital***	***From the Hospital ER to Psychiatric Hospital***
Emergency Transportation	Acute Care Contractor	Acute Care Contractor	T/RBHA	T/RBHA
Situation/Service Type	***Prescriptions***	***Primary Care Visit***		***Other BH Services***
Treatment of depression, anxiety and/or attention deficit hyperactive disorder *by the primary care physician*	Acute Care Contractor	Acute Care Contractor		T/RBHA (as defined by the primary diagnosis)
	Prior to initial appointment with Prescriber	***Ongoing (including transition to PCP for depression, anxiety and/or attention deficit hyperactive disorder)***		

Psychotropic Medications	Acute Care Contractor	T/RBHA		
Situation/Service Type				
Behavioral health primary diagnosis with procedure codes 92506-92508 and 92550-92597.	Acute Care Contractor	Acute Care Contractor		

433 – MEMBER IDENTIFICATION CARDS

Effective Date: 11/01/12
Revision Date: 10/11/12

Staff responsible for policy: DHCM Operations

I. Purpose

This policy establishes the responsibilities, guidelines and restrictions for producing and distributing Member Identification Cards for AHCCCS Arizona Long Term Care services Contractors.

II. Definitions

834 Enrollment Transaction File	A nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly-enrolled members and changes to existing members.
Business Day	For the purposes of this policy, a business day is considered to extend from 7:00 am in the morning to 7:00 am the following morning. If the next day is a weekend or a holiday, then the ending timeframe is extended to 7:00 am in the morning of the day following the weekend or holiday.
Card Holder	A printed sheet enclosing the Member Identification Card used during the mailing to the member.
Geographic Service Area (GSA)	An area designated by AHCCCS 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 9 A.A.C. 22, Article 1.
Member Identification Card	A Contractor-specific identification card that meets the formatting requirements outlined in this policy and issued by the Contractor to each member. The card is used by the member when presenting for services.

III. Policy

A. General

The Contractor must produce and distribute Member Identification cards to all members assigned to the Contractor. Moreover, the Contractor must produce and distribute cards to newly-enrolled members, and have a process for producing and distributing replacement Member Identification Cards to all of the Contractors' enrolled members. The cards must meet the formatting, timeliness and prior approval guidelines outlined in this policy.

B. Format of ID Cards

Member Identification cards must meet the following formatting standards.

1. The front of the card must contain an AHCCCS logo, and be no smaller than .56" by .44"

2. The front of the card must include the following text in the Arial font no smaller than 11 points:

   Arizona Health Care
   Cost Containment System

3. The front of the card must include the following text in the Arial font no smaller than 9 points:

   Member Identification Card

4. The front of the card must also include the following minimum identification information in the Arial font no smaller than 8 points:

   Member Name: Paul S Patient
   AHCCCS ID # A12345678 001

5. The front of the card must include the follow text in the Arial font no smaller than 8 points:

   Health Plan Name: <Insert Health Plan Name>
   <Plan short name> Phone: <Plan phone number>

6. The back of the card must include the following text in the Arial font no smaller than 7 points:

Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit <insert appropriate website address>.

7. The remaining back of the card may include additional information identified as appropriate by your plan, subject to AHCCCS approval. Possible items could include your logo, contact information for contracted hospitals, or after hours clinics.

8. The card holder or an insert included in the card's mailing to the member if a card holder is not used, must contain the following text:

   To help protect your identity and prevent fraud, AHCCCS is adding pictures to its on-line verification tool that providers use to verify your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

C. Card Distribution Timeliness

1. Contractors must identify new members needing Member Identification Cards through the daily 834 Transaction Files provided each night by AHCCCS.

2. Members newly enrolled with the Contractor must receive their Member Identification cards in a timely fashion. Each Contractor has two business days starting from the business day following AHCCCS making the 834 Transaction File available to the Contractor to produce and mail a new Member Identification Card.

3. Contractors must have a process where members can contact the Contractor for a replacement Member Identification Card.

4. In the case where a member contacts a plan asking for a replacement card, the plan shall have 3 business days to produce and mail the card.

5. Contractors must also provide new Member Identification cards for each member assigned to the Contractor prior to initiating services in a GSA.

6. The Contractor must provide each assigned member with their new Member Identification Card at least two weeks prior to the commencement of services within the GSA.

D. Approval of Member Identification Cards and Other Compliance Requirements

A Member Identification Card, the card holder, and any letters or information mailed to the member with the card are considered member information as defined in the ACOM Policy 404, Member Information. As such, these materials, including any subsequent changes to these materials, must be submitted to the AHCCCS Administration for approval at least 30 days prior to dissemination. See ACOM Policy 404, Member Information for details on the approval process.

The Contractor must monitor the timeliness standards identified in this policy and ensure they are met, whether the Member Identification Cards are produced by the Contractor or by a third party.

If the Contractor employs a third party to produce or distribute Member Identification Cards, the subcontract qualifies as a Management Services Subcontract and must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report. Moreover, any changes to the subcontractor must be reported to AHCCCS as a material change to the Contractors' operations.

IV. References

- ALTCS Contract, Section D, Paragraph 3, Enrollment and Disenrollment
- ALTCS Contract, Section D, Paragraph 17, Member Handbook and Member Communications
- ALTCS Contract, Section D, Paragraph 29, Network Management
- ACOM Policy 404, Member Information