301 – RESERVED

301A – PROSPECTIVE TITLE XIX WAIVER GROUP NON-MED RECONCILIATION

EFFECTIVE DATE: 10/01/11, 01/01/13, 01/01/2014

REVISION DATE: 08/27/2010, 04/17/12, 12/05/13, 11/21/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care Contractors for the Title XIX Waiver Group (TWG) non-Medical Expense Deduction (non-MED) prospective population reconciliation (TWG non-MED Reconciliation) through CYE 13 (October 2012 to September 2013).

The TWG non-MED reconciliation is based upon prospective net capitation and prospective medical expense 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 expense, and paid reinsurance amounts.

II. DEFINITIONS

HEALTH INSURER FEE CAPITATION ADJUSTMENT — An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

NET TWG NON-MED CAPITATION — Non-MED Prospective Risk Adjusted Capitation plus Delivery Supplemental payments, less the administrative component, premium tax, and the health insurer fee capitation adjustment. The administrative component will be equivalent to the percentage listed in section V. This Per Member Per Month (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.

PREMIUM TAX — The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

REINSURANCE — Reinsurance will be based on the actual reinsurance revenue paid to the Contractor for the dates being reconciled.

III. POLICY

A. GENERAL

1. The prospective TWG non-MED reconciliation shall relate to medical expense during the prospective period being reconciled (including subcapitated expense) net of reinsurance. The amount of the reimbursement to be reconciled against will be capitation and delivery supplemental payments net of the administrative component, premium tax, and the health insurer fee capitation adjustment included in the capitation rate (see Definitions and Attachment A for calculation). The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense to capitation and reinsurance:

   Net TWG Non-MED Capitation (see Attachment A for calculation)

   Less: Total medical expense (net of reinsurance)

   Equals: Profit/Loss to be reconciled

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expense reported by the Contractor to determine the actual medical expense. AHCCCS may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense 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. The 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 AHCCCS Financial Reporting Guide for Acute Care Contractors.

2. The 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 by the initial reconciliation due date provided. 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. The Contractor shall submit data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

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

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) . 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. NOTE

Administration:

- CYE ’11 – Contractor CYE ’09 Bid Administration PMPM less 5.88%
- CYE ’12 – Contractor CYE ’09 Bid Administration PMPM less 5.88%
- CYE ‘13 – Contractor CYE ’09 Bid Administration PMPM less 5.88%

V. REFERENCES

- Acute Care Contract, Section D
- Attachment A, Prospective Title XIX Waiver Group non-MED Reconciliation - Example
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905

ATTACHMENT A, PROSPECTIVE TITLE XIX WAIVER GROUP NON-MED RECONCILIATION – EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

302 CYE 11-13 - PRIOR PERIOD COVERAGE RECONCILIATION: ACUTE CARE AND CMDP CONTRACTORS

EFFECTIVE DATE: 10/01/10, 01/01/13, 01/01/2014

REVISION DATE: 03/15/08, 12/09/09, 8/25/10, 4/17/12, 11/07/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care and DES/CMDP (CMDP) Contractors. For Acute Care Contractors, this policy applies to CYE 2011 through 2013. For CMDP, this policy applies to the periods October 1, 2010 through September 30, 2011, October 1, 2011 through September 30, 2012 and October 1, 2012 through September 30, 2013.

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 through CYE 13, AHCCCS will reconcile the PPC period for all risk groups, except Title XXI members, SOBRA Family Planning, and State Only Transplants. Additionally, effective beginning CYE 12, the Title XIX Waiver Group MED population will no longer be reconciled, as the program terminated September 30, 2011.

II. DEFINITIONS

HEALTH INSURER FEE CAPITATION ADJUSTMENT	An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.
PPC CAPITATION	Capitation payment for the period of time from the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.
PPC MEDICAL EXPENSE	Total expenses covered under the contract for services provided during the PPC time period.
PPC NET CAPITATION	PPC capitation less the administrative component, premium tax, and the health insurer fee capitation adjustment.
PPC PERIOD	The period from the effective date of eligibility to the day a member is enrolled with a Contractor.

PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.
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 and will not be reconciled beginning with CYE 12.

III. POLICY

A. GENERAL

1. For CYE 11 the reconciliation shall relate solely to aggregate adjudicated PPC medical expense 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 CYE 13 the reconciliation shall relate solely to aggregate adjudicated PPC medical expense 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. For CYE 13, the enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation. Additionally, payments related to the health insurer fee capitation adjustment will be excluded.

3. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's PPC net 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. The Contractor shall submit encounters for PPC medical expense 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 expense 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 AHCCCS Financial Reporting Guide for Acute Care Contractors or AHCCCS Financial Reporting Guide for the CMDP Contractor.

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 by the initial reconciliation 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. The Contractor shall submit any data as requested by AHCCCS for reconciliation purposes.

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 Net Capitation
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. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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

IV. NOTE

Acute Care and CMDP Contractor Administration percentage by contract year:

- CYE 11 – 8.0%
- CYE 12 – 8.0%
- CYE 13 – 8.0%

V. REFERENCES

- Acute Care Contract, Section D
- DES/CMDP Contract, Section D
- Attachment A, Health Plan Prior Period Coverage Reconciliation – Example
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- AHCCCS Financial Reporting Guide for the CMDP Contractor
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905

ATTACHMENT A, HEALTH PLAN PRIOR PERIOD COVERAGE RECONCILIATION – EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

302 CYE 14 AND FORWARD - PRIOR PERIOD COVERAGE RECONCILIATION: ACUTE CARE AND CMDP CONTRACTORS

EFFECTIVE DATE: 10/01/13, 01/01/2014

REVISION DATE: 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care and DCS/CMDP (CMDP) Contractors. Due to the uncertainty regarding actual utilization and medical cost experience during the Prior Period Coverage (PPC) period, AHCCCS intends to limit the financial risk to its Contractors. The PPC Reconciliation applies to dates of service effective on and after October 1, 2013 and is based upon prior period expenses and prior period 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. All profit/loss sharing is based on adjudicated encounter data and subcapitated expense reports. For **Acute Care Contractors**, this reconciliation is performed annually on a contract year basis which is October 1 to September 30. For **CMDP**, this reconciliation is also performed annually subject to the reconciliation periods indicated under Section III.B.7.

II. DEFINITIONS

ADMINISTRATIVE COMPONENT	The administrative component will be equivalent to the amount of administrative expense built into the capitation rate for the year being reconciled. Beginning with Contract Year Ending (CYE) 2014, the administrative component is equal to the administrative Per Member Per Month (PMPM) built into the capitation rates multiplied by the actual PPC member months for the contract year being reconciled.
HEALTH INSURER FEE CAPITATION ADJUSTMENT	An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.
PPC CAPITATION	Capitation payment for the period of time from the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.

PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the Contractor only on a prospective basis.
PPC MEDICAL EXPENSE	Total expenses covered under the Acute Care or CMDP contract for services provided during the PPC time period.
PPC NET CAPITATION	PPC capitation less the administrative component, premium tax, and the health insurer fee capitation adjustment.
PPC RECONCILIATION RISK GROUPS	Populations subject to this reconciliation include all PPC risk groups except State Only Transplants and Adult Group above 106% FPL (Adults > 106%) (formerly known as Newly Eligible Adults or NEAD) (Acute Care Contractors Only).
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

III. POLICY

A. GENERAL

1. The reconciliation shall relate solely to fully adjudicated PPC medical expense for all PPC reconciliation risk groups. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

2. The reconciliation will limit the Contractor's profits and losses to 2% of the Contractor's PPC net capitation for all PPC reconciliation 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. The reconciliation will be calculated as follows:

PPC Net Capitation
Less: PPC Medical Expense
Equals: Profit/Loss to be reconciled

AHCCCS may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

PPC capitation and medical expense to be included in the reconciliation are based on the **date of service** for the contract year being reconciled.

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

3. AHCCCS will provide the Contractor with 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 performed 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 the Contractor with 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 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 reconciliation will be paid or recouped through a future monthly capitation payment.

6. **For CYE 14 reconciliation only (Acute Contractors)**: All new Acute Contractors, including incumbent Acute Contractors in a new GSA, will be paid the CYE 13 PPC capitation rates for PPC enrollment dates prior to October 1, 2013. PPC medical expense incurred for dates of service prior to October 1, 2013 will be included in the CYE 14 reconciliation, along with the CYE 13 PPC revenue.

7. **For CMDP only**: All revenue and expenses for the time period October 1, 2013 to September 30, 2014 will be reconciled together as the CYE 14 reconciliation. All revenue and expenses for the time period October 1, 2014 to June 30, 2015 will be

reconciled together as the CYE 15 reconciliation. Subsequent to CYE 15, all revenue and expenses for the time period July 1 to June 30 will be reconciled together on a contract year basis.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit encounters for PPC medical expense and those encounters must reach a 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 AHCCCS Financial Reporting Guide for Acute Care Contractors and the AHCCCS Financial Reporting Guide for the CMDP Contractor.

3. The Contractor shall monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financial 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 by the initial reconciliation due date. 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. The Contractor shall submit any additional data as requested by AHCCCS for reconciliation purposes (e.g. encounter detail file, etc.).

6. If the Contractor performs recoupments/refunds/recoveries on PPC claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. 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
- DCS /CMDP Contract, Section D
- ACOM Policy 412
- Attachment A, Health Plan Prior Period Coverage Reconciliation – Example
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- AHCCCS Financial Reporting Guide for the CMDP Contractor
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905
- 9 A.A.C. 22 Article 1

ATTACHMENT A, HEALTH PLAN PRIOR PERIOD COVERAGE RECONCILIATION - EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

302A CYE 11 AND FORWARD - PRIOR PERIOD COVERAGE RECONCILIATION: ALTCS/EPD CONTRACTORS

EFFECTIVE DATE: 10/01/06, 10/01/10, 01/01/13, 01/01/2014

REVISION DATE: 08/15/09, 08/18/10, 6/22/12, 11/21/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to ALTCS/EPD Contractors for Contract Year Ending (CYE) 11 and forward.

Contractors are paid capitation for all Prior Period Coverage (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 PPC Net Capitation paid to Contractors to the actual PPC Medical Expense as determined by fully adjudicated encounter data. Any profits or losses in excess of the stated percentages will be recouped from or reimbursed to the Contractor, respectively.

II. DEFINITIONS

HEALTH INSURER FEE CAPITATION ADJUSTMENT	An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.
PPC MEDICAL EXPENSE	Total covered medical expenses for services provided during the PPC time period.
PPC NET CAPITATION	PPC capitation less the administrative component, premium tax, and the health insurer fee capitation adjustment.
PPC CAPITATION	Capitation payment for the period of time from the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.

PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the Contractor only on a prospective basis.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

III. POLICY

A. GENERAL

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

For CYE 11, the reconciliation will limit the Contractor's profits and losses to 10% of the Contractor's PPC Net Capitation. Any profits in excess of 10% will be recouped from the Contractor and, likewise, any losses in excess of 10% will be reimbursed.

For CYE 12 and forward, the reconciliation will limit the Contractor's profits and losses to 5% of the Contractor's PPC Net Capitation. Any profits in excess of 5% will be recouped from the Contractor and, likewise, any losses in excess of 5% will be reimbursed. Starting with CYE 13 the enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

B. AHCCCS RESPONSIBILITIES

1. For CYE 11, approximately 15 months after the end of the contract year to be reconciled, AHCCCS shall perform a reconciliation of PPC medical expense to PPC Net Capitation.

   For CYE 12 and forward, approximately 12 months after the end of the contract year to be reconciled, AHCCCS shall perform a reconciliation of PPC medical expense to PPC Net Capitation:

   PPC Net Capitation
   Less: PPC Medical Expense
   Equals: Profit/Loss to be reconciled

PPC capitation and medical expense to be included in the reconciliation are based on the date of service for the contract year being reconciled.

2. AHCCCS will utilize fully adjudicated encounters and subcapitated expenses reported by the Contractor to determine the actual PPC medical expense. Starting with CYE 13 the enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 Contractor. Upon completion of the review period, AHCCCS will evaluate the Contractor's 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. CONTRACTOR RESPONSIBILITIES

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

2. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments before the reconciliation 15 or 12 month timeframe. It is also the responsibility of the Contractor to have any encounter data issues identified, corrected and fully adjudicated within 15 months (CYE 11) or 12 months (CYE 12 and forward) of the end of the contract year being reconciled for the encounters to be included in the reconciliation

IV. NOTE

Administration percentage by contract year

- CYE 11 – 7.5%
- CYE 12 – 6.0%
- CYE 13 – 6.0%
- CYE 14 – 6.0%
- CYE 15 - 6.0%

V. REFERENCES

- ALTCS/EPD Contract, Section D
- Attachment A, Sample PPC Reconciliation CYE 11
- Attachment B, Sample PPC Reconciliation CYE 12 and forward
- AHCCCS Financial Reporting Guide for ALTCS Program Contractors
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905
- 9 A.A.C. 22 Article 1

ATTACHMENT A, SAMPLE PPC RECONCILIATION CYE 11

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, SAMPLE PPC RECONCILIATION CYE 12 AND FORWARD

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

303 - HOME AND COMMUNITY BASED SERVICES RECONCILIATION: ALTCS

EFFECTIVE DATE: 10/01/11, 10/01/13

REVISION DATE: 11/21/13, 11/01/14

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to ALTCS/EPD Contractors for Contract Year End (CYE) 12 (October 1, 2011 – September 30, 2012) and forward. This Policy establishes guidelines regarding reconciliation of the assumed Home and Community Based Services (HCBS) member month mix percentage used for capitation rate development against actual HCBS placement.

II. DEFINITIONS

HOME AND COMMUNITY BASED SERVICES (HCBS) Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.

III. POLICY

A. PLACEMENT

HCBS PLACEMENT

CYE 12 AND CYE 13	CYE 14 AND AFTER
Adult Foster Care	Adult Foster Care
Assisted Living Center	Assisted Living Center
Assisted Living Home	Assisted Living Home
Adult Therapeutic Foster Care	*Removed*
Adult Development Home	Adult Development Home
Adult Behavioral Health Therapeutic Home	Adult Behavioral Health Therapeutic Home
Behavioral Health Level II	Behavioral Health Residential Facility
Behavioral Health Level III	
Behavioral Health Services Center	*Removed*
Child Developmental Foster Home	Child Developmental Foster Home
Group Home for Developmentally Disabled	Group Home for Developmentally Disabled
Home	Home
Traumatic Brain Injury Treatment Facility	Traumatic Brain Injury Treatment Facility
Rural Substance Abuse Transitional Agency	Substance Abuse Transitional Facility

INSTITUTIONAL PLACEMENT

CYE 12 AND CYE 13	CYE 14 AND AFTER
Institution	Institution
Level I Behavioral Health Center Residential Treatment Center	Residential Treatment Center
Psychiatric Hospital/Institute for Mental Disease	Psychiatric Hospital/Institute for Mental Disease

B. 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 below.

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
0-1%	0% of capitation over/under payment
>1%	50% of capitation over/under payment

C. AHCCCS RESPONSIBILITIES

1. AHCCCS shall run monthly placement reports by member by month to be used for the development of the schedule of HCBS and Institutional placement mix.

2. Approximately four 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 HCBS placed 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 (recoupment) to the Contractor's future capitation payments after the Contractor has agreed to the reconciliation amount by the AHCCCS stated deadline.

D. CONTRACTOR RESPONSIBILITIES

1. Contractors shall review monthly placement information supplied through the ALTCS Monthly Enrollment Reports and any other enrollment or capitation paid data and make corrections to placement during the contract year.

2. It is the Contractor's responsibility to identify to AHCCCS any placement data issues and make necessary adjustments either directly via the Client and Tracking System (CATS) or electronic Member Change Report (MCR) submitted to the Division of Health Care Management when contract type changes are necessary. See the ALTCS Member Change Report User Guide on the process for reporting to AHCCCS via the electronic MCR.

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

IV. REFERENCES

- ALTCS/EPD Contract, Section D
- ALTCS Member Change Report User Guide
- A.R.S. §36-2931
- A.R.S. §36-2939

304 - PREMIUM TAX REPORTING

EFFECTIVE DATE: 10/01/11, 10/01/13, 10/01/15

REVISION DATE: 10/01/08, 10/01/10, 04/25/12, 11/08/12, 10/01/13, 01/22/14, 11/01/14, 07/02/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP) and DES/DDD (DDD) Contractors. This Policy outlines the procedures necessary for Contractors to report and pay Premium Tax to the Arizona Department of Insurance (DOI) on a quarterly basis.

II. DEFINITIONS

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the Health Resources and Services Administration (HRSA) and certified by Centers for Medicare & Medicaid Services (CMS) as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
THIRD-PARTY LIABILITY	Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan A.A.C. R9-22-1001.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

III. POLICY

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 October 1, 2003 and after. Each Contractor will report and pay premium tax to the DOI for all payments received from AHCCCS during the quarter being reported. AHCCCS will report to the DOI the total payments to each Contractor for the calendar year by February 15th of the following year.

A. QUARTERLY SUBMISSION OF PREMIUM TAX TO DOI

The Contractor is required to file a quarterly tax report with the DOI, and pay estimated premium taxes based on estimated payments received for the current quarter. See

Attachment A, Matrix of Managed Care Contracting and Reimbursement for Premium Tax 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. The Contractor is required to periodically monitor the DOI website for updated forms and instructions. The quarterly tax report can be found on the DOI website at AHCCCS Contractor Quarterly Premium Tax Report (E-AHCCCS).

B. PAYMENTS INCLUDE

- Capitation revenue payments,
- Delivery supplemental payments,
- Health insurer fee payments,
- PCP Parity Settlement payments,
- Quality Distributions pursuant to Value-Based Purchasing Initiative ACOM policies and the Payment Reform Initiative ACOM policies effective for CYE 14 and 15,
- Reinsurance payments,
- Reconciliation payments/recoupments,
- Nursing Facility Supplemental Payments,
- Rural Hospital Supplemental Payments, and
- 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

1. All capitation rates effective October 1, 2003 and after include the premium tax in the rate.

2. Reconciling payments/recoupments, supplemental payments, cost settlements, health insurer fee payments, and withheld capitation subsequently paid to Contractors for payment reform/Value-Based Purchasing initiatives will have the premium tax included in the payments/recoupments.

3. Reinsurance payments include the premium tax for all payments/recoupments made after October 1, 2003.

D. PAYMENTS EXCLUDED FROM PREMIUM TAX

Tribal Case Management –Tribal contractors are paid a case management Per Member Per Month (PMPM) rate as determined by a case management model developed by AHCCCS. Tribal contractors are exempt from Arizona state taxes thus these payments are not subject to premium tax.

Federally Qualified Health Centers (FQHC) – FQHCs contract with AHCCCS Contractors to provide services to members. **Direct** payments from AHCCCS to FQHCs through quarterly supplemental payments or annual reconciliation payments are not considered capitation from AHCCCS and thus are not subject to the premium tax.

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.

Overpayments – Recovery of an overpayment made by a Contractor to a provider is considered a contra-expense and is not subject to premium tax.

Fee-For-Service - Payments which are made by the Administration directly to providers are paid on a Fee-For-Service basis and not subject to premium tax.

State Only Transplant Payments – State Only Transplants, as specified in A.R.S. §36-2907.10 and §36-2907.11 are not included within the scope of the legislation.

E. QUARTERLY REPORTING TO AHCCCS

In addition to filing the original Premium Tax Form (E-AHCCCS), and AHCCCS Contractor Quarterly Premium Tax Report to the DOI, each Contractor will submit a copy of the premium tax report(s) filed with the DOI to DHCM. This copy can be submitted to AHCCCS electronically or in hard copy format. Hard copies should be sent 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 and as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. On a quarterly basis DHCM will compare 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

By February 15th succeeding the end of a calendar (tax) year, DHCM will report the total amount AHCCCS paid to Contractors, by plan, to:

Compliance Section Manager, Financial Affairs Division
Arizona Department of Insurance
2910 N. 44th St., Suite 210
Phoenix, AZ 85018-7269

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. The DOI 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

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.

To pay taxes, fees, related penalty or interest electronically, please use the National Association of Insurance Commissioners (NAIC) OPTins system managed by the DOI. Instructions can be found on the DOI website.

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 found on the DOI website.

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 cannot be reported on the March 15 tax report.

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

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D

- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- Contract, Section F, Attachment F3, Contractor Chart of Deliverables
- A.A.C. R9-22-1001
- A.R.S. §36-2905
- A.R.S. §36-2944.01
- A.R.S. §36-2907.10
- A.R.S. §36-2907.11
- Arizona Department of Insurance website at www.azinsurance.gov
- Attachment A – Matrix of Managed Care Contracting and Reimbursement for Premium Tax

ATTACHMENT A, MATRIX OF MANAGED CARE CONTRACTING AND REIMBURSEMENT FOR PREMIUM TAX

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

305 – PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: 10/01/08, 10/01/13, 10/01/15

REVISION DATE: 10/01/08, 10/24/12, 01/22/14, 02/20/14, 05/21/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, CRS, and ALTCS/EPD Contractors and Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan) Contractors certified by AHCCCS. The purpose of this Policy is to establish standards for Contractors to meet the performance bonding and equity per member 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.
PERFORMANCE BOND	A cash deposit with the State Treasurer or a financial instrument secured by the Contractor in an amount designated by AHCCCS to guarantee payment of Contractor claims.
SURETY BOND	An agreement between AHCCCS, the Contractor and the Surety where the surety provides a financial guarantee to AHCCCS.

III. POLICY

AHCCCS requires the posting of a Performance Bond as long as the Contractor has liabilities of $50,000 or more outstanding, or 15 months following the termination date of their contract, whichever is later, to guarantee payment of the Contractor's obligations to providers and non-contracting providers, and performance by the Contractor of its obligations under this Contract.

AHCCCS will inform the Contractor of the required initial amount of the Performance Bond, as determined by AHCCCS, at the beginning of each contract cycle. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the initial amount required.

After the initial performance bond is satisfied, AHCCCS shall evaluate each Contractor's enrollment statistics and/or monthly capitation payments on a monthly basis and determine if adjustments are necessary in accordance with this Policy.

AHCCCS will confirm the performance bond with the appropriate institution at least annually.

A. PERFORMANCE BOND REQUIREMENTS

1. The Contractor may not change the amount, duration or scope of the performance bond without prior written approval from AHCCCS, Division of Health Care Management. The Contractor shall not leverage the bond for another loan or create other creditors using the bond as security.

2. The Performance Bond amount that must be maintained after the contract term shall be sufficient to cover all outstanding liabilities and will be in the amount and for the term determined by AHCCCS.

3. Any security agreement must be disclosed.

4. **Acute Care and CRS Contractors** - The initial amount of the Performance Bond shall be equal to 100% 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 excludes premium tax. Acute Care capitation is inclusive of delivery supplemental payments. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall review the capitation amount 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 90% of one month's capitation, then the amount of the instrument must be increased to at least 100% of one month's capitation. The Contractor shall have 30 days following notification by AHCCCS to increase the amount of the Performance Bond.

5. **ALTCS/EPD Contractors** - The initial amount of the Performance Bond shall be equal to 80% of the total capitation payment, including acute care only members, expected to be paid to the Contractor in the first month of the contract year, or as determined by AHCCCS. The total capitation amount excludes premium tax. 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 capitation amount 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, the amount of the instrument must be increased to at least 80% of one month's capitation. The Contractor shall have 30 days following notification by AHCCCS to increase the amount of the Performance Bond.

6. **AHCCCS Certified MA Plan Contractors** - AHCCCS requires that the Contractor obtain and maintain a Performance Bond specifically for the purpose of the MA Plan in the amount of $1,050 per MA Dual Eligible Member. AHCCCS, Division of Health Care Management (DHCM) and the Contractor shall work together to project the number of eligibles to establish the initial amount of the Performance Bond. See ACOM Policy 313 for the requirements to gain state certification of a Medicare Advantage Plan and the ongoing requirements to stay certified by AHCCCS.

B. SATISFYING THE PERFORMANCE BOND

The following are options for satisfying the performance bond:

1. Cash Deposits,

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 authorized to do business in Arizona,

4. Certificate of Deposit, or

5. An acceptable substitute in lieu of one of the above agreed to by AHCCCS.

C. CASH DEPOSIT

1. Deposit of Funds
   a. Any funds to be deposited with the State Treasurer shall be sent to DHCM in the form of a check or a wire transfer of funds to the State Treasurer. Reference Attachment A for Instructions for Wire/ACH Transfers of Funds to AHCCCS Via Arizona State Treasurer. Additionally, a letter should be sent to DHCM describing:
      i. The application of funds (Acute Care, CRS, ALTCS/EPD, MA Plan, or any combination), and
      ii. A contact person at the Contractor and contact phone number, for any issues concerning the deposit, and a wire number if the funds were sent via a bank wire. Note the attached wire instructions.
   b. DHCM will “claim” the funds by submitting a copy of the Contractor’s letter and a “Securities Safekeeping” form to the State Treasurer’s Office. After the funds have been claimed, DHCM will send a confirmation that the funds were received and claimed.

2. Withdrawal of Funds
   a. To withdraw principal funds, send a letter to DHCM requesting the withdrawal. The letter must include:
      i. The amount of the withdrawal,
      ii. The program from which the funds are being withdrawn (Acute Care, CRS, ALTCS/EPD or MA Plan),
      iii. The date that the funds should be withdrawn (allow a minimum of 10 working days), and
      iv. The manner the warrant from the State Treasurer's office is to be handled:
         - Mailed by the US Postal Service, or
         - Courier pick-up (please include a phone number of the primary contact so prompt notice can be given), or
         - Wiring instructions.
   b. DHCM will submit to the State Treasurer's Office a copy of the Contractor's letter and a "Securities Safekeeping" form to release the funds. DHCM will forward the warrant to the Contractor in the manner requested in the withdrawal letter.

D. LETTER OF CREDIT

1. Establishment of Letter of Credit
   a. Before a Letter of Credit can be accepted as a performance bond it must be approved by AHCCCS for form and amount. Requirements include:
      i. Be of standard commercial scope and issued by a bank, credit union or savings and loans authorized to do business in the State of Arizona and insured by the appropriate Federal Institution;
      ii. For an amount that meets or exceeds the performance bond dollar requirement;
      iii. For a time period that meets or exceeds the AHCCCS contract term ; The LOC should be payable to AHCCCS for the benefit of covered members, providers and certain third parties;
      iv. DHCM must receive a signed extension 30 days prior to the expiration date;
      v. A statement that the performance bond cannot be changed in the amount, duration or scope, or discontinued without the authorization from DHCM.
   b. Send a copy of the agreement to be executed to DHCM 30 working days prior to the execution date. DHCM will review the agreement and advise of acceptance or that changes are necessary. The DHCM review will only be for issues that are necessary for the AHCCCS performance bond; it will not include review for any other matters.
   c. DHCM will respond in writing that the performance bond is acceptable or changes need to be made for acceptance.
   d. After the agreement is executed, send the original to DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parties.

e. The Contractor shall send notification of a contact person at the financial institution issuing the letter of credit and contact phone number to the DHCM Finance Manager.

2. Return of Letter of Credit original
   a. The original Letter of Credit will be returned to the makers upon:
      i. Termination of the Letter of Credit, or
      ii. Termination of the AHCCCS contract, or
   b. Satisfying the performance bond requirement with another acceptable form as outlined by AHCCCS.

E. SURETY BOND

1. Establishment of Bond
   a. Before a Surety Bond can be accepted as a performance bond it must be approved by AHCCCS for form and amount. Requirements include:
      i. 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,
      ii. For an amount that meets or exceeds the performance bond dollar requirement,
      iii. For a time period that meets or exceeds the AHCCCS contract term,
      iv. DHCM must receive a signed extension 30 days prior to the expiration date, and
      v. A statement that the performance bond cannot be changed in the amount, duration or scope or discontinued without the authorization of DHCM.

2. Send a copy of the agreement to be executed to DHCM 30 working days prior to the execution date. AHCCCS will review the agreement and will advise of acceptance or that changes are necessary. The AHCCCS review will only be for issues necessary for the AHCCCS performance bond; it will not include review for any other matters.

3. DHCM will respond in writing whether the performance bond is acceptable or changes need to be made for acceptance.

4. After the agreement is executed, the Contractor shall send the original to DHCM. The original will be held in safe keeping until the agreement ends or is terminated by the parities.

5. The Contractor shall send notification of a contact person at the financial institution issuing the surety bond and contact phone number to the DHCM Finance Manager.

6. Return of Surety Bond original
   a. The original Surety Bond will be returned to the makers upon:
      i. Termination of the Surety bond, or
      ii. Termination of the AHCCCS contract, or

iii. Satisfying the performance bond requirement with another acceptable form as outlined by AHCCCS, or
iv. Statutory Notice of Release

F. CERTIFICATE OF DEPOSITS

1. Types of Certificate of Deposits
   a. Only Certificates of Deposit from banks,
   b. Savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the performance bond.

2. Assignment to Arizona State Treasurer

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

4. 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 DHCM. A letter should accompany the Certificate of Deposit describing the contract or line of business the Certificate of Deposit is satisfying (Acute Care, CRS, ALTCS/EPD, or MA) and a contact person.
   b. After the Certificate of Deposit has been sent to the State Treasurer, DHCM will send a 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, the Contractor must monitor the maturity date. No notification should be expected from the State Treasurer's office or DHCM. Evidence of the renewal of each CD must be sent to DHCM within five days of the renewal date.
   d. The Contractor shall send notification of a contact person at Contractor and contact phone number to the DHCM Finance Manager.

5. Withdrawal of a Certificate of Deposit
   a. Send a letter to DHCM requesting the release of a specific Certificate of Deposit giving:
      The institution of the Certificate of Deposit,
      i. The certificate number,
      ii. The amount of the Certificate of Deposit,
      iii. The program the Certificate of Deposit is being withdrawn from,
      iv. The manner the Certificate of Deposit is to be returned to the Plan, and
      v. A contact person.

   DHCM will submit to the State Treasurer's Office a copy of the Contractor's letter

and a "Securities Safekeeping" form to release the funds. DHCM will forward the warrant to the Contractor in the manner requested in the withdrawal letter.

G. EQUITY PER MEMBER REQUIREMENTS

1. **Formula**

   Unrestricted equity, less on-balance sheet Performance Bond, divided by the number of members enrolled at the end of the period.

2. **Acute Care Requirement**

   Contractors with 0-99,999 members: $170
   Contractors with 100,000+ members: $115

3. **CRS Requirement**

   At least $260 per member for CYE 2014
   At least $320 per member for CYE 2015
   At least $370 per member for CYE 2016 and thereafter

4. **ALTCS/EPD Requirement**

   All Contractors $2,000

5. **AHCCCS Certified Medicare Advantage Plan Requirement:**

   $50 per member upon commencement of the plan. One year after the MA Plan is established, AHCCCS will require that the equity per member amount increase to $350 per MA Plan Dual Eligible Member.

H. REMEDIATION WHEN A CONTRACTOR FAILS TO MEET THE EQUITY PER MEMBER REQUIREMENT

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

1. Submission of corrective action plan to increase equity,

2. Monthly financial reporting, if not already required,

3. Increase the amount of the Performance Bond,

4. Capital infusion to bring equity into compliance,

5. Enrollment Cap.

If the Contractor fails to comply with the above requirements, AHCCCS may apply sanctions as delineated in ACOM Policy 408.

I. 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.

J. 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 100% of one month's capitation to cover the amount of the equity necessary to meet the requirements.

K. 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 DHCM 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.

IV. REFERENCES

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- A.R.S. §35-155
- 42 CFR 438.116
- ACOM Policy 408
- ACOM Policy 313
- SFAS No. 141, Business Combinations
- EITF 88-16, Basis in Leverage Buyout Transactions
- Attachment A, Instructions for Wire/ACH Transfers of Funds to AHCCCS via Arizona State Treasurer

ATTACHMENT A, INSTRUCTIONS FOR WIRE/ACH TRANSFERS OF FUNDS TO AHCCCS VIA ARIZONA STATE TREASURER

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

306 – RESERVED

307 - RESERVED

308 – RESERVED

309 – RESERVED

310 - DELIVERY SUPPLEMENTAL PAYMENT

EFFECTIVE DATE: 10/01/08, 12/01/12, 10/01/13, 03/01/15, 06/01/15

REVISION DATE: 11/16/09, 11/15/12, 11/21/13, 02/12/15, 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to the payment of the delivery supplemental payment for 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 postpartum care when billed using the global obstetrical package. The delivery supplement is also paid when the infant is stillborn. 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.
PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis.

III. POLICY

A. GENERAL

1. When a member delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to members who deliver in a PPC time period.

2. All live births must be reported within one year of birth in order for the Contractor to receive a delivery supplemental payment.

3. All live births must be reported by the member's Contractor through the AHCCCS Online Provider website. Births reported by any State Agency will not be eligible for a delivery supplemental payment.

4. All stillbirths must be reported in compliance with AMPM Policy 410 in order for the Contractor to receive a delivery supplemental payment.

IV. REFERENCES

- Acute Care Contract, Section D
- AMPM Policy 410
- 9 A.A.C. 22 Article 1

311 CYE 12-13– ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION

EFFECTIVE DATE: 10/01/11, 01/01/2014

REVISION DATE: 11/08/12, 12/19/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care Contractors, excluding Children's Rehabilitative 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 medical expense 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 Per Member Per Month (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.

HEALTH INSURER FEE CAPITATION ADJUSTMENT

An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

NON-CAPPED NEWBORN EXPENSES

In accordance with the Acute Care contract, the Contractor must notify AHCCCS of a newborn born to an AHCCCS mother. 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 notification are considered non-capped expense and are excluded from reconciliations. However, expenses for those newborns where AHCCCS is notified within one day of the date of birth will be included in the reconciliation.

PREMIUM TAX

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

PROSPECTIVE MEDICAL EXPENSE

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 component, premium tax, and the health insurer fee capitation adjustment.

REINSURANCE

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

SUBCAPITATED EXPENSE

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 except for those expenses for newborns where AHCCCS is notified within one day of the date of birth.

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 net capitation including Delivery Supplement payments and will be net of the administrative component, premium tax, and health insurer fee capitation adjustment. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 10 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 Medical Expense – Subcapitated Expense + 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 medical expense supported by fully adjudicated encounters and subcapitated expense reported by the Contractor to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense 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. The 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 AHCCCS Financial Reporting Guide for Acute 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 for reconciliations 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. The Contractor shall report all subcapitated expense in a format requested by AHCCCS. Subcapitated encounters should have a CN 1 code of 05 and a paid amount of $0 for all non-PCP rate parity encounters. All subcapitated encounters that have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures. This includes all subcapitated amounts greater than $0 for PCP Rate Parity that are subject to AHCCCS cost settlement.

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 412. 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
- Attachment A, Health Plan Acute Program Tiered Prospective Reconciliation - Example
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- ACOM Policy 412
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905

ATTACHMENT A, HEALTH PLAN ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION - EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

311 CYE 14 AND FORWARD – ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION

EFFECTIVE DATE: 10/01/13, 01/01/2014

REVISION DATE: 11/08/12, 10/01/13, 11/08/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care Contractors. The Acute Program Tiered Prospective Reconciliation applies to dates of service effective on and after October 1, 2013 and is based upon prospective medical expense 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. This reconciliation is performed annually on a contract year basis.

II. DEFINITIONS

ADMINISTRATIVE COMPONENT

The administrative component will be equivalent to the amount of administrative expense built into the capitation rate for the year being reconciled. Beginning with Contract Year Ending (CYE) 2014, the administrative component is equal to the administrative Per Member Per Month (PMPM) awarded to the Contractor multiplied by the actual prospective member months for the contract year being reconciled. For any rates that are not bid by the Contractor, but are set by AHCCCS, the administrative component is equal to the administrative PMPM built into the capitation rates multiplied by the actual prospective member months for the contract year being reconciled.

HEALTH INSURER FEE CAPITATION ADJUSTMENT

An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

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

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

PROSPECTIVE MEDICAL EXPENSE

Prospective expenses reported through **fully adjudicated encounters** and subcapitated expense incurred by the Contractor for covered services with dates of service during the contract year (excluding expenses incurred during the prior period coverage (PPC) time period).

PROSPECTIVE NET CAPITATION

Prospective capitation, risk adjusted if applicable, plus Delivery Supplemental payments, less the administrative component, premium tax, and the health insurer fee capitation adjustment. For CYE 15 and forward, an amount equal to the Quality Contribution shall be deducted from prospective capitation. Refer to ACOM 315 for the definition and computation of the Quality Contribution.

REINSURANCE

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

SUBCAPITATED EXPENSE

Expenses incurred by the Contractor as payments to a provider under a subcapitated arrangement. The subcapitated expense used in this reconciliation is 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 include all prospective risk groups except State Only Transplants and Adult Group above 106% FPL (formerly known as Newly Eligible Adults or NEAD). Expenses incurred and revenues received for covered services with dates of service during the PPC timeframe 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 net capitation less prospective medical expense plus reinsurance payments. 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. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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%	3%
> 3% and <= 6%	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

LOSS	CONTRACTOR SHARE	STATE SHARE	MAX CONTRACTOR LOSS	CUMULATIVE CONTRACTOR LOSS
<= 3%	100%	0%	3%	3%
> 3%	0%	100%	0%	3%

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 10 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 Medical Expense – Subcapitated Expense + Reinsurance payments.

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

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

2. AHCCCS will utilize only prospective medical expense supported by fully adjudicated encounters and subcapitated expense reported by the Contractor to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense 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.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit encounters for prospective 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 prospective risk group transactions, and shall submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide for Acute Care Contractors.

3. The 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.

4. 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 for reconciliations 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.

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

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

7. If the Contractor performs recoupments/refunds/recoveries on prospective claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. 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
- Attachment A, Health Plan Acute Program Tiered Prospective Reconciliation - Example
- ACOM Policy 412
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905
- 9 A.A.C. 22 Article 1

ATTACHMENT A, ACUTE PROGRAM TIERED PROSPECTIVE RECONCILIATION – EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

312 CYE 13 – CRS PROGRAM TIERED RECONCILIATION

EFFECTIVE DATE: 10/01/12, 01/01/13, 01/01/14

REVISION DATE: 12/05/13, 12/19/13, 01/15/15

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 effective October 1, 2012 through September 30, 2013 and is based upon adjudicated medical expense 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%.
HEALTH INSURER FEE CAPITATION ADJUSTMENT	An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.
MEDICAL EXPENSE	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 component, premium tax, and the health insurer fee capitation adjustment.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

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 EXPENSE 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 expense, net of reinsurance. The expense will be reconciled against net capitation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 10 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 – Medical Expense – Subcapitated Expense + Reinsurance payments.

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

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

2. AHCCCS will utilize only medical expense supported by fully adjudicated encounters and subcapitated expense reported by the Contractor to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense 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.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit encounters for medical expense 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 expense used in the reconciliation.

2. The 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 AHCCCS Financial Reporting Guide for the CRS Contractor.

3. The 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 AHCCCS Financial Reporting Guide for the CRS Contractor.

4. 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 for reconciliations 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.

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

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

7. 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 ACOM 412. 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
- Attachment A, CRS Program Tiered Reconciliation - Example
- ACOM Policy 412
- AHCCCS Financial Reporting Guide for the CRS Contractor
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905

ATTACHMENT A, CRS PROGRAM TIERED RECONCILIATION - EXAMPLE

SEE THE ACOM WEBPAGE PAGE FOR ATTACHMENT A OF THIS POLICY

312 CYE 14 AND FORWARD – CHILDREN'S REHABILITATIVE SERVICES PROGRAM TIERED RECONCILIATION

EFFECTIVE DATE: 10/01/13, 01/01/2014

REVISION DATE: 11/15/12, 10/24/13, 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to the Children's Rehabilitative Services (CRS) Contractor.

The CRS Program Tiered Reconciliation applies to dates of service effective on and after October 1, 2013 and is based upon adjudicated medical expense 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/block purchase expense reports. This reconciliation is performed annually on a contract year basis.

II. DEFINITIONS

ADMINISTRATIVE COMPONENT — The administrative component will be equivalent to the amount of administrative expense built into the capitation rate for the year being reconciled. Beginning with Contract Year Ending (CYE) 2014, the administrative component is equal to the administrative Per Member Per Month (PMPM) awarded to the Contractor multiplied by the actual member months for the contract year being reconciled.

HEALTH INSURER FEE CAPITATION ADJUSTMENT — An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

MEDICAL EXPENSE — Expenses reported through **fully adjudicated encounters** and subcapitated/block purchase expenses incurred by the Contractor for covered services with dates of service during the contract year.

NET CAPITATION	Capitation less the administrative component, premium tax, and the health insurer fee capitation adjustment.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.
PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the Contractor only on a prospective basis.
REINSURANCE	For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the Contractor as the result of medical expense incurred by the Contractor for covered services with dates of service during the contract year being reconciled.
SUBCAPITATED/BLOCK PURCHASE EXPENSES	Expenses incurred by the Contractor as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated/block purchase expenses used in this reconciliation are reported by the Contractor through quarterly financial reports in the format required by AHCCCS.
TIERED RECONCILIATION POPULATION	All CRS members, with the exception of State Only Transplant members, are subject to this tiered reconciliation.

III. POLICY

A. GENERAL

1. The CRS tiered reconciliation shall be based on net capitation less medical expense plus reinsurance payments. 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 the tiered reconciliation population. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be

included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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%	3%
> 3% and <= 6%	50%	50%	1.5%	4.5%
> 6%	0%	100%	0%	4.5%

LOSS	CONTRACTOR SHARE	STATE SHARE	MAX CONTRACTOR LOSS	CUMULATIVE CONTRACTOR LOSS
<= 3%	100%	0%	3%	3%
> 3%	0%	100%	0%	3%

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 10 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 – Medical Expense – Subcapitated Expense/Block Purchase Expenses + Reinsurance payments.

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

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

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

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/block purchase expense information to financial statements and other Contractor submitted files for reasonableness. AHCCCS may perform an audit of self-reported subcapitated or block purchase 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.

   For CYE 14 Only: If a new Contractor is awarded the CRS contract, PPC medical expense for dates of service prior to October 1, 2013 will be separately included in the reconciliation at 100% risk sharing with no risk band. If the incumbent Contractor is awarded the CRS contract, all PPC medical expense that relate to acute care and behavioral health services for dates of service prior to October 1, 2013 will be included in the reconciliation at 100% risk sharing with no risk band. All PPC medical expense that relate to CRS specialty services with dates of service prior to October 1, 2013 will be excluded from the reconciliation.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit encounters for prospective medical expense 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 expense used in the reconciliation.

2. The 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 AHCCCS Financial Reporting Guide for the CRS Contractor.

3. The 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 AHCCCS Financial Reporting Guide for the CRS Contractor.

4. 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 for reconciliations 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.

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

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

7. If the Contractor performs recoupments/refunds/recoveries on the related claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. 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, Section D
- Attachment A, Health Plan CRS Program Tiered Reconciliation - Example
- ACOM Policy 412
- AHCCCS Financial Reporting Guide for the CRS Contractor
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905
- 9 A.A.C. 22 Article 1

ATTACHMENT A, HEALTH PLAN CRS PROGRAM TIERED RECONCILIATION – EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

313 – CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE – AHCCCS MEMBERS

EFFECTIVE DATE: 11/01/12, 06/01/15

REVISION DATE: 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, 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 members. This Policy outlines the steps necessary to gain Medicare Advantage state certification by AHCCCS and the ongoing requirements to stay certified.

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

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.

II. 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 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	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 of one month's capitation or an established amount per enrolled member.

III. POLICY

A. CONTRACTOR RESPONSIBILITIES

Contractors pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Request form to the Division of Health Care Management (DHCM), Medicare Administrator, 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:

1. Timing of start-up,

2. GSA that certification is being requested for,

3. Projected enrollment at start up and at the end of year one by GSA,

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

5. Projected amount, and description of how performance bond requirements will be met initially and ongoing. Refer to ACOM Policy 305 for performance bond requirements,

6. Statement of understanding regarding ongoing monitoring and reporting.

B. AHCCCS RESPONSIBILITIES

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

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

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, the Contractor is required to be in compliance with current financial viability, claims, and administrative standards per the AHCCCS contract.

1. 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.

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

3. Ongoing Monitoring - The Contractor is 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.

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

The Contractor 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

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- ACOM Policy 305
- §1876 of the Social Security Act
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- AHCCCS Financial Reporting Guide for ALTCS Program Contractors
- www.cms.gov

314 – AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: 10/01/13, 11/01/15

REVISION DATE: 10/24/13, 07/30/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care Contractors excluding those with a capped contract. The purpose of this Policy is to describe the factors and methodology used to calculate the auto-assignment algorithm. The auto-assignment algorithm is a mathematical formula used to distribute all members who do not exercise their right to choose a Contractor and do not have family continuity within the prescribed time limits. Assignment to Contractors occurs in a manner consistent with AHCCCS goals.

II. DEFINITIONS

TARGET PERCENTAGES The proportion of members calculated using an AHCCCS defined methodology which is used to distribute members to each Contractor.

III. POLICY

A. COMPONENTS OF THE AUTO-ASSIGNMENT ALGORITHM

1. Overview:

The auto-assignment algorithm uses a combination of pre-determined factors to assign points to Contractors, which are then used to establish target percentages. The target percentages are loaded into a data table and a formula is used to assign cases to Contractors. A case may be a member or a household of members. The algorithm data table consists of all the Geographical Service Areas (GSAs) in the state, all Contractors serving each GSA, and the target percentages established by risk group. The equation used is:

$$(t/T) - P = d$$

t = The total members assigned to the GSA, per risk group category, for the Contractor

T = The total members assigned to the GSA, per risk group category, all Contractors combined

P = The target percentage of members per risk group for the Contractor

d = The difference

All non-capped Contractors, within a given GSA and for each risk group, will have a placement in the algorithm and will receive members accordingly. A Contractor with a more favorable target percentage in the algorithm will receive proportionally more members. Conversely, a Contractor with a lower target percentage in the algorithm will receive proportionally fewer members.

The Contractor furthest from its target percentage within a GSA and risk group, i.e. the largest negative difference, is assigned the next case for that GSA. The algorithm is calculated after each assignment to give a new difference for each Contractor. When multiple Contractors have the same largest negative difference, the Contractor with the lowest Health Plan I.D. Number will be assigned the case.

2. **Factors**:

Target percentages will be developed based on the following factors:

FACTOR		WEIGHTING
1.	The Contractor's awarded capitation rate.	50%
2.	The Contractor's overall score earned on the Acute Care Operational Review (OR) as a percentage of total score available.	25%
3.	The Contractor's twelve month average of monthly total approved encounters per member month (mm).	25%

These are listed as Factor #1, Factor #2 and Factor #3 in the example under "4. Target Percentages" below.

3. **Points**:

Each Contractor will be assigned a number of points for each of the above indicated factors **separately** using the following table:

NUMBER OF AWARDS IN GSA FOR EACH FACTOR	1ST PLACE	2ND PLACE	3RD PLACE	4TH PLACE	5TH PLACE	6TH PLACE	7TH PLACE
2	60	40					
3	44	33	23				
4	35	28	22	15			
5	30	25	20	15	10		
6	27	23	19	15	10	6	
7	24	21	18	14	11	8	4

Points are assigned based on the number of Contractors in each GSA. Points will be weighted as indicated above to determine each Contractor's target percentage by risk group by GSA.

4. **Target Percentages**:

By weighting the points assigned to each factor, the target percentages are determined. For Contractors in all GSAs except Maricopa (GSA 12) and Pima/Santa Cruz (GSA 10), these percentages will be evaluated annually. For Contractors in the Maricopa and Pima GSAs, the target percentages will be evaluated quarterly.

The following example illustrates the relationship of the factors, points and target percentages.

EXAMPLE: TANF 1-13MF

CONTRACTOR	FACTOR #1 (CAP RATE) 50% WEIGHT		FACTOR #2 (OR SCORE %) 25% WEIGHT		FACTOR #3 (12 MONTH AVG. OF TOTAL APPROVED ENCOUNTERS/MM) 25% WEIGHT		TARGET %
	RATE	POINTS	SCORES	POINTS	SCORES	POINTS	
CONTRACTOR A	Lowest (Best)	30.00	2nd Highest	25.00	4th Highest	15.00	25.00%
CONTRACTOR B	3rd Lowest	20.00	Highest (Best)	30.00	3rd Highest	20.00	22.50%
CONTRACTOR C	2nd Lowest	25.00	Lowest (Worst)	10.00	Lowest (Worst)	10.00	17.50%
CONTRACTOR D	Highest (Worst)	10.00	4th Highest	15.00	Highest (Best)	30.00	16.250%
CONTRACTOR E	4th Lowest	15.00	3rd Highest	20.00	2nd Highest	25.00	18.750%
		100.00		100.00		100.00	100.00%

Factor 1 is the Contractor's awarded cap rate and thus the "Lowest" awarded rate (best rate) receives the greatest number of points. The "Highest" awarded rate (worst rate) receives the least number of points.

Factor 2 is the Contractor's overall score earned on the Acute Care Operational Review (OR) as a percentage of total score available to thr specific Contractor. Converting the score to a percentage normalizes the scores over a Contractor-specific denominator. The overall score earned is calculated by adding the total percentage earned for each standard assessed. The total score available per Contractor is calculated by adding the total number of standards assessed for that Contractor from the OR. For CYE 16, the OR results from CYE 14 will be utilized. The "Highest" combined OR score percentage is the best score and receives the greatest number of points. The "Lowest" combined OR score percentage is the worst score and receives the least number of points.

Factor 3 is the Contractor's twelve month average of monthly total approved encounters per member month (mm). The monthly total approved encounters per mm is calculated by adding all encounters approved during the month for both monthly encounter cycles divided by the total number of monthly member months. For CYE 16, the approved encounters during CYE 14 will be utilized. The "Highest" average approved encounter/mm is the best score and receives the greatest number of points. The "Lowest" average approved encounter/mm is the worst score and receives the least number of points.

B. MAXIMUM ENROLLMENT

1. On January 1, April 1, July 1, and October 1, those Contractors in Pima (GSA 10) and Maricopa (GSA 12) that have enrolled membership equal to or greater than 45% of the GSA total will have their target percentages set to zero. The points removed will be redistributed based on the existing distribution to all the remaining Contractors in that GSA that have not reached the 45% maximum enrollment threshold. In GSA 10, only the Pima County membership will be included in the analysis of Contractor enrollment; Santa Cruz members will be excluded from the computations.

2. AHCCCS will use a standard enrolled membership report run out of the Agency's data warehouse to determine the enrolled membership used in the calculation. This report will be run effective December 1, March 1, June 1, and September 1.

3. Once a Contractor in GSA 10 (using only the Pima County membership) or GSA 12 is determined to reach the 45% threshold, the Contractor will be notified before the auto-assign algorithm is changed.

C. ANNUAL ADJUSTMENTS

1. The auto-assignment algorithm will be reviewed annually by AHCCCS. The target percentages assigned to each Contractor may be recalculated based on the combination of factors used. If new factors are being incorporated into the auto-assignment algorithm, AHCCCS will notify the Contractor no less than three months prior to October 1 or the effective date.

2. Each Contractor will receive from DHCM Finance the updated auto-assignment algorithm with updated target percentages once they are changed.

D. MEDICARE ALIGNMENT

AHCCCS may address assignment of dual eligible members in a unique manner for improved care coordination opportunities.

E. FACTORS FOR CYE 17 AND BEYOND

1. AHCCCS may change the algorithm at any time during the term of the contract in response to Contractor-specific issues (e.g. imposition of an enrollment cap) or in the best interest of the AHCCCS Program and/or the State. AHCCCS may change the algorithm factor methodology for subsequent years to recognize and reward Contractor performance across a variety of factors of importance to AHCCCS.

2. Factors may be based on a combination of capitation rates and one or more of the following types of performance measures:
   a. Clinical performance measures
   b. Encounter submission measures
   c. Claims processing performance measures
   d. Other administrative measures (e.g. measures related to grievances/hearings)
   e. Operational Reviews or other performance assessments

IV. REFERENCES

- Acute Care Contract, Section D

315 – ACUTE PROGRAM PAYMENT REFORM INITIATIVE

EFFECTIVE DATE: 10/01/13

REVISION DATE: 12/19/13

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE AND DHCM CLINICAL QUALITY MANAGEMENT (CQM)

I. PURPOSE

This Policy applies to all Acute Care Contractors excluding Children's Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP), and the Maricopa Integrated RBHA. The AHCCCS Payment Reform Initiative (PRI) applies to all dates of service effective on and after October 1, 2013 and is based on Quality Management Performance Measures (QMPMs) utilized by the AHCCCS Clinical Quality Management Unit as described in this Policy. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health. This PRI payment is performed annually on a contract year basis.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality withhold amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
MEASUREMENT YEAR	The period for which the PRI Policy applies. The first measurement year will be Contract Year Ending (CYE) 2014 (October 1, 2013 - September 30, 2014).
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.

PREMIUM TAX COMPONENT	The premium tax component is equal to the tax imposed pursuant to A.R.S §36-2905 for prospective capitation payments made for the contract year. The rate of tax imposed under A.R.S. §36-2905 is 2 percent as of the effective date of this Policy, October 1, 2013.
PROSPECTIVE GROSS CAPITATION	Prospective capitation payments made to Contractors on a monthly basis which includes medical expense, reinsurance offset, administration, risk/contingency and premium tax, and any subsequent amendments thereof.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY MANAGEMENT PERFORMANCE MEASURES	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the PRI. See highlighted rows in Attachment A.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
QUALITY WITHHOLD	A specified percentage of all Contractors' Prospective Gross Capitation payments that will be withheld to fund the PRI.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.
SHARED-SAVINGS ARRANGEMENT	An arrangement between a Contractor and provider designed to achieve cost savings which may include improved outcome requirements, in defined areas, the savings from which are shared between the Contractor and the provider. Sub-capitated arrangements may qualify as shared-savings arrangements, subject to the limitations identified in C.2. of this Policy.

SOBRA FAMILY PLANNING EXTENSION PROGRAM	A program that provides family planning services only, for a maximum of two consecutive 12-month periods to a SOBRA woman whose pregnancy has ended and who is not otherwise eligible for full Title XIX services. The Family Planning Extension Program is available through December 31, 2013. (Also referred to as Family Planning Services Extension Program).

III. POLICY

A. GENERAL

PRI payments will be made to Contractors based on relative Contractor performance for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see Attachment A). Each QMPM is allocated a percentage of the total quality withhold funds available for distribution; see Attachment B for the percent of withhold by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn payments on any or all of the QMPM.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score); and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment B. The quality distribution formula first determines payments based on the performance measure score. The balance of quality withhold funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality withhold. Due to Federal requirements, the maximum payment across all QMPMs made to any Contractor will be limited to 5 percent of annual Contractor revenues (total payments by AHCCCS for the Acute Care line of business).

AHCCCS reserves the right to eliminate a particular measure from the PRI. In such a case, AHCCCS will return each Contractor's quality withhold amount for that measure. Modifications to PRI payments, the quality distribution formula, and additional methods for determining payments, including payments based on improvement in measures from year-to-year, will be considered in future measurement years.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the PRI based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will return the Contractor's quality withhold amount for that measure, provided that the Contractor has met the minimum payments requirement under Shared Savings Arrangements stipulated in C.2 of this Policy.

Quality distributions to Contractors will be funded by deducting 1 percent from Prospective Gross Capitation (Quality Withhold) exclusive of Delivery Supplemental, SOBRA Family Planning Extension Program, KidsCare and State Only Transplant payments.

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. The first measurement year will be October 1, 2013 - September 30, 2014. Risk adjustment methods will be considered and utilized, if deemed to be appropriate.

B. AHCCCS RESPONSIBILITIES

1. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS Actuaries shall tabulate results of the PRI and authorize payments to Contractors. The full amount of the quality withhold will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment B for an example):

   Q= Quality Withhold
   S = Scaling Factor
   CMeasure = Contractor's QMPM Result
   MinStd = Quality Management Minimum Performance Standard
   A = Adjustment Factor
   R = Rank Factor

   Performance Measure Score:
   If equal to or above MinStd, then Q * S * ((CMeasure – MinStd) /MinStd)
   If below minimum standard, then zero

   Performance Rank Score: A * Q * R

   Quality Distribution: Performance Measure Score + Performance Rank Score

C. CONTRACTOR RESPONSIBILITIES

1. Contractors will adhere to all requirements of the AMPM, Chapter 900, Policy 970.

2. A minimum of five percent of the value of total payments under all contracts executed with health care providers must be governed by shared-savings arrangements for the measurement year. Sub-capitated arrangements that do not also have a shared savings component may account for no more than 2.5 percent of this total value. AHCCCS expects the minimum value threshold to grow each year with the allowance for sub-capitated arrangements that do not also have a shared savings component held flat or eliminated from the shared savings definition.

   The Contractor will certify to AHCCCS that this minimum will be met by submitting the Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment C to the DHCM Finance Manager within 60 days of the start of the measurement year. Failure to attest to the minimum in a particular measurement year will disqualify the Contractor from any quality distributions for that year, and the Contractor's withheld capitation will be included in total quality distributions to all other Contractors. AHCCCS reserves the right to request and audit a look-back report after the

end of the contract year to review the reasonableness of the projected amounts included in Attachment C.

IV. REFERENCES

- Acute Care Contract, Section D
- AMPM Chapter 900
- A.R.S. §36-2905
- Attachment A – Acute Contractor Quality Management Performance Measure Standards
- Attachment B – Payment Reform Initiative (PRI) Quality Distribution Example
- Attachment C – Payment Reform Initiative (PRI) Shared Savings Arrangement Certification

ATTACHMENT A – ACUTE CONTRACTOR QUALITY MANAGEMENT PERFORMANCE MEASURE STANDARDS

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B – PAYMENT REFORM INITIATIVE (PRI) QUALITY DISTRIBUTION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C – PAYMENT REFORM INITIATIVE (PRI) SHARED SAVINGS ARRANGEMENT CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

315 CYE 15 – ACUTE PROGRAM PAYMENT REFORM INITIATIVE

EFFECTIVE DATE: 10/01/14

REVISION DATE: 06/19/14, 11/20/14

Staff responsible for policy: DHCM Finance and DHCM Clinical Quality Management (CQM)

I. PURPOSE

This Policy applies to all Acute Care Contractors excluding Children's Rehabilitation Services (CRS), Department of Child Safety/Comprehensive Medical and Dental Program (DCS/CMDP), and the Maricopa Integrated RBHA. The AHCCCS Payment Reform Initiative (PRI) applies to dates of service effective on and after October 1, 2014 and is based on Quality Management Performance Measures (QMPMs) utilized by the AHCCCS Clinical Quality Management (CQM) Unit as described in this Policy. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health, by aligning the incentives of the Contractor and provider through shared savings payment arrangements.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality contribution amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
MEASUREMENT YEAR	The period for which the PRI Policy applies which shall be 10/1 through 9/30.
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PROSPECTIVE GROSS CAPITATION	Prospective capitation payments made to Contractors on a monthly basis which includes medical expense, reinsurance offset, administration, risk/contingency and premium tax, and any subsequent amendments thereof.
QUALITY CONTRIBUTION	A specified percentage of all Contractors' Prospective Gross Capitation payments that will be assessed through a reconciliation process to fund the PRI.
QUALITY MANAGEMENT PERFORMANCE MEASURES	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the PRI. See highlighted rows in Attachment A.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.
SHARED-SAVINGS ARRANGEMENT	A written contract between a contractor and provider designed to achieve cost savings and quantifiable improved outcomes, which in the event of savings, are shared between the contractor and the provider.

III. POLICY

A. GENERAL

In order to qualify for a quality distribution, the Contractor must meet the minimum shared savings qualifying criteria in C.2. and certify as described in C.3. Failure to meet or certify to this minimum in a particular measurement year will disqualify the Contractor from any quality distributions for that year. However, the Contractor's quality contribution used in the reconciliation described below will still be assessed and included to fund quality distributions to all other Contractors.

Quality distributions will be made to Contractors based on relative Contractor performance for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see Attachment A). Each QMPM is allocated a percentage of the total quality contribution funds available for distribution; see Attachment B for the percent of contribution by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn distributions on any or all of the QMPMs.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score); and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment B. The quality distribution formula first determines payments based on the performance measure score. The balance of quality contribution funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality contributions. Due to Federal requirements, the maximum distribution across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation attributable to the Acute PRI.

Modifications to the quality distribution formula, and additional methods for determining quality distributions, including quality distributions based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular measure from the PRI. In such a case, AHCCCS will remove each Contractor's quality contribution amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the PRI based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's quality contribution amount for that measure, provided that the Contractor has met and certified to the minimum payments requirement under Shared Savings Arrangements stipulated in C.2 and C.3 of this Policy.

Quality distributions to Contractors will be funded by assessing one percent of Prospective Gross Capitation (quality contribution) exclusive of Delivery Supplemental, KidsCare and State Only Transplant payments.

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed to be appropriate.

B. AHCCCS RESPONSIBILITIES

1. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year basis.

2. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate results of the PRI and reconcile the contribution from and distribution to Contractors.

   The quality contribution may be adjusted, if necessary, for the elimination of a particular measure from the PRI or the elimination of a Contractor from a particular measure as indicated above.

   The full amount of the quality contribution will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment B for an example):

   Q= Quality Contribution
   S = Scaling Factor
   CMeasure = Contractor's QMPM Result
   MinStd = Quality Management Minimum Performance Standard
   A = Adjustment Factor
   R = Rank Factor

   Performance Measure Score:
   If equal to or above MinStd, then Q * S * ([CMeasure – MinStd]/MinStd)
   If below minimum standard, then zero

   Performance Rank Score: A * Q * R

   Quality Distribution: Performance Measure Score + Performance Rank Score

3. Through the reconciliation, the total quality distribution will be subtracted from the net quality contribution to establish the amount due to or due from the Contractor. The difference will be adjusted for premium tax. See Attachment D for example.

   AHCCCS will provide the Contractor with the 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 address any issues as warranted.

   Any amount due to or due from the Contractor as a result of the reconciliation will be paid or recouped through a future monthly capitation payment.

C. CONTRACTOR RESPONSIBILITIES

1. Contractors will adhere to all requirements of the AMPM, Chapter 900, Policy 970.

2. A minimum of 10 percent of the value of total prospective payments under all contracts executed with health care providers must be governed by shared-savings arrangements for the measurement year. AHCCCS expects the minimum value threshold to grow each year. Written contracts shall be executed no later than February 1.

3. The Contractor will certify to AHCCCS that this minimum will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. an initial Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment C to the DHCM Finance Manager within 60 days of the start of the measurement year.
   b. a final Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment C to the DHCM Finance Manager due 180 days after the end of the measurement year.

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

AHCCCS reserves the right to request an audit of the Certifications included in Attachment C.

IV. REFERENCES

- Acute Care Contract, Section D
- AMPM Chapter 900
- Attachment A, Acute Contractor Quality Management Performance Measure Standards
- Attachment B, Payment Reform Initiative (PRI) Quality Distribution Example
- Attachment C, Payment Reform Initiative (PRI) Shared Savings Arrangement Certification
- Attachment D, Payment Reform Initiative (PRI) Reconciliation Example
- A.R.S. 36-2905

ATTACHMENT A, ACUTE CONTRACTOR QUALITY MANAGEMENT PERFORMANCE MEASURE STANDARDS

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, PAYMENT REFORM INITIATIVE (PRI) QUALITY DISTRIBUTION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, PAYMENT REFORM INITITATIVE (PRI) SHARED SAVINGS ARRANGEMENT CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, PAYMENT REFORM INITITATIVE (PRI) RECONCILIATION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

315 CYE 16 – ACUTE PROGRAM VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATE: 04/02/15, 06/11/15

Staff responsible for policy: DHCM Finance and DHCM Clinical Quality Management (CQM)

I. PURPOSE

The AHCCCS Value-Based Purchasing (VBP) Initiative applies to Acute Care Contractors The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, and those related to child and adolescent health, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality contribution amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
MEASUREMENT YEAR	The period for which the VBP Initiative Policy applies which shall be 10/1 through 9/30.
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PROSPECTIVE GROSS CAPITATION	Prospective capitation payments, prior to adjustments for Health Insurer Fee payment, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, administration, risk/contingency and premium tax, and any subsequent amendments thereof. For purposes of this policy, Prospective Gross Capitation is exclusive of Delivery Supplemental, KidsCare and State Only Transplant payments.
QUALITY CONTRIBUTION	A specified percentage of Contractors' Prospective Gross Capitation payments that will be assessed through a reconciliation process to fund the VBP Initiative.
QUALITY MANAGEMENT PERFORMANCE MEASURES	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the VBP Initiative.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.
VALUE-BASED PURCHASING PAYMENT PER VALUE-BASED PURCHASING CONTRACT	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the VBP strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

VALUE-BASED PURCHASING STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

This strategy shall not be counted towards the minimum qualifying criteria outlined under C.1.b. in order to be eligible for quality distribution under this policy.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS

Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS

Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS	Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a fee-for-service purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.
SHARED RISK	Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service purchasing system.
CAPITATION + PERFORMANCE-BASED CONTRACTS	Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

1. All Acute Care Contractors

All Acute Care Contractors shall be eligible to qualify for a quality distribution by meeting the VBP strategies qualifying criteria in C.1.b. and certify as described in C.1.c. Failure to meet or certify to meeting the criteria in a particular measurement year

will disqualify the Contractor from any quality distributions for that year. However, the Contractor's quality contribution used in the reconciliation described below will still be assessed and included to fund quality distributions to all other Contractors.

Quality distributions will be made to Contractors based on relative Contractor performance for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see highlighted rows in Attachment B). Each QMPM is allocated a percentage of the total quality contribution funds available for distribution; see Attachment C for the percent of contribution by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn distributions on any or all of the QMPMs.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score); and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment C. The quality distribution formula first determines payments based on the performance measure score. The balance of quality contribution funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality contributions. Due to Federal requirements, the maximum distribution across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation attributable to the Acute VBP Initiative.

Modifications to the quality distribution formula, and additional methods for determining quality distributions, including quality distributions based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular measure from the VBP Initiative. In such a case, AHCCCS will remove each Contractor's quality contribution amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the VBP Initiative based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's quality contribution amount for that measure, provided that the Contractor has met and certified to meeting the qualifying criteria under VBP strategies stipulated in C.1.b. and C.1.c. of this Policy.

Quality distributions to Contractors will be funded by assessing one percent of Prospective Gross Capitation (quality contribution).

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed to be appropriate.

2. Acute Care Contractors Affiliated with a Regional Behavioral Health Authority (RBHA) Contract

   In addition to those requirements outlined above in Section A.1, an Acute Care Contractor affiliated with an entity that holds a RBHA contract must also meet the VBP strategies qualifying criteria in C.2.a. and certify as described in C.2.b. Failure to meet or certify to meeting the criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

   Quality contributions and quality distributions do not apply to this section.

B. AHCCCS RESPONSIBILITIES

1. All Acute Care Contractors

   a. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year basis.

   b. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate results of the VBP Initiative and reconcile the contribution from and distribution to Contractors.

      The quality contribution may be adjusted, if necessary, for the elimination of a particular measure from the VBP Initiative or the elimination of a Contractor from a particular measure as indicated above.

      The full amount of the quality contribution will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment C for an example):

      Q= Quality Contribution
      S = Scaling Factor
      CMeasure = Contractor's QMPM Result
      MinStd = Quality Management Minimum Performance Standard
      A = Adjustment Factor
      R = Rank Factor

      Performance Measure Score:
      If equal to or above MinStd, then Q * S * ([CMeasure – MinStd]/MinStd)
      If below minimum standard, then zero

      Performance Rank Score: A * Q * R
      Quality Distribution: Performance Measure Score + Performance Rank Score

   c. Through the reconciliation, the total quality distribution will be subtracted from the net quality contribution to establish the amount due to or due from the Contractor.

d. The difference computed in B.1.c. shall be adjusted by adding the total of all VBP payments per VBP contracts certified by the Contractor attributed to the period of October 1, 2015 through September 30, 2016, and submitted to AHCCCS in the final Attachment E as prescribed in C.1.c.

AHCCCS shall test the total amount due to/from the Contractor to ensure that the Federal limit of 5% of annual prospective gross capitation is met. Any amount in excess of the limit shall be reduced to bring the final due to/from within the Federal requirement.

The Contractor is not required to meet the VBP strategies qualifying criteria in C.1.b. or C.2.a. in order for the VBP payments to be added to the Contractor's reconciliation results computed in B.1.c.

e. The result computed in B.1.d. will be adjusted for premium tax. See Attachment D for example.

AHCCCS will provide the Contractor with the 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 address any issues as warranted.

Any amount due to or due from the Contractor as a result of the reconciliation will be paid or recouped through a future monthly capitation payment.

2. Acute Care Contractors Affiliated with a Regional Behavioral Health Authority (RBHA) Contract

AHCCCS shall affirm that the Contractor met the VBP strategies qualifying criteria in a particular contract year and will assess sanctions up to a maximum of $250,000 for failure to meet the criteria.

C. CONTRACTOR RESPONSIBILITIES

1. All Acute Care Contractors

a. The Contractor shall adhere to all requirements of the AMPM, Chapter 900, Policy 970.

b. A minimum of 20 percent of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the measurement year. AHCCCS expects the minimum value threshold to grow each year.

Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Fee-For-Service Strategy. Strategies

utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

A minimum of 25 percent of the 20 percent requirement shall be with an organization that includes Primary Care Providers (PCPs).

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

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

The Contractor may use quality measures other than the measures identified in Attachment B as part of its VBP strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts executed no later than February 1 of each measurement year, and shall only be counted for the time period in the measurement year for which contract is in effect.

c. The Contractor shall certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format:
   i. An initial VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager within 60 days of the start of the measurement year.
   ii. A final VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager due 180 days after the end of the measurement year.

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

   AHCCCS reserves the right to request an audit of the Certifications included in Attachment E.

2. Acute Care Contractors Affiliated with a Regional Behavioral Health Authority (RBHA) Contract

   a. In addition to those requirements outlined above in Section C.1, an Acute Care Contractor affiliated with an entity that holds a RBHA contract shall also enter into

at least two VBP contracts with integrated providers, who offer physical and behavioral health clinical integration, for aligned members who are not already integrated under the Acute or RBHA contracts, but who receive their acute care and behavioral health services from affiliated entities, e.g. children, non-dual adults with GMH/SA needs, non-integrated adults with serious mental illness. AHCCCS intends to further extend and refine the scope of this requirement in future years.

The physical health portion of contracts executed under this requirement may be used to fulfill the VBP strategies qualifying criteria under C.1.b.

b. The Contractor shall certify to AHCCCS that this requirement will be met by completing and submitting the comporting section in Attachment E. The Contractor shall submit Attachment E as outlined in Section C.1 above.

Failure to attest to the VBP strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

AHCCCS reserves the right to request an audit of the Certifications included in Attachment E.

IV. REFERENCES

- Acute Care Contract, Section D
- AMPM Chapter 900
- Attachment A, Acute Care Program Value-Based Purchasing (VBP) Strategies
- Attachment B, Acute Care Contractor Quality Management Performance Measure Standards
- Attachment C, Acute Care Program Value-Based Purchasing (VBP) Quality Distribution Example
- Attachment D, Acute Care Program Value-Based Purchasing (VBP) Reconciliation Example
- Attachment E, Acute Care Program Value-Based Purchasing (VBP) Strategies Certification
- A.R.S. §36-2905

ATTACHMENT A, ACUTE CARE PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, ACUTE CARE CONTRACTOR QUALITY MANAGEMENT PERFORMANCE MEASURE STANDARDS

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, ACUTE CARE PROGRAM VALUE-BASED PURCHASING (VBP) QUALITY DISTRIBUTION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, ACUTE CARE PROGRAM VALUE-BASED PURCHASING (VBP) RECONCILIATION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

ATTACHMENT E, ACUTE CARE PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT E OF THIS POLICY

316 CYE 14 AND FORWARD – ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL RECONCILIATION

EFFECTIVE Date: 10/01/13, 01/01/2014

REVISION DATE: 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care Contractors for Contract Year Ending (CYE) 14 and forward.

Beginning January 1, 2014, the State of Arizona will expand Medicaid eligibility to certain adults aged 19-64, without Medicare, with income greater than 106% of the Federal Poverty Level (FPL) through 133% FPL. This population is known as Adult Group above 106% FPL (Adults > 106%) (formerly known as Newly Eligible Adults or NEAD).

Due to the uncertainty regarding actual utilization and medical cost experience of the Adults > 106% population, AHCCCS intends to limit the financial risk to its Contractors. AHCCCS will isolate the Adults > 106% population revenue and expenses and reconcile Contractor prospective and Prior Period Coverage (PPC) profits and losses to 1% for CYE 14 and forward.

The Adults > 106% reconciliation applies to dates of service from January 1, 2014 through September 30, 2014 for CYE 14 and October 1 to September 30 thereafter, and is based upon prospective and PPC net capitation and expenses as described in this Policy. 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 administrative expense built into the capitation rate for the year being reconciled. The administrative component is equal to the administrative Per Member Per Month (PMPM) rate built into the capitation rate multiplied by the actual prospective and PPC member months for the contract year being reconciled.

HEALTH INSURER FEE CAPITATION ADJUSTMENT An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor's liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

PPC CAPITATION	Capitation payment for the period of time from the first day of the month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.
PRIOR PERIOD COVERAGE (PPC)	The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the Contractor only on a prospective basis.
PPC MEDICAL EXPENSE	Total expenses covered under the Acute Care Contract for services provided during the PPC time period.
PPC NET CAPITATION	PPC capitation less the administrative component, premium tax, and the health insurer fee capitation adjustment.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.
PROSPECTIVE MEDICAL EXPENSE	Expenses reported through **fully adjudicated encounters** and subcapitated expense incurred by the Contractor for covered services with dates of service during the contract year (excluding expenses incurred during the PPC time period).
PROSPECTIVE NET CAPITATION	Prospective capitation, risk adjusted if applicable, plus Delivery Supplemental payments, less the administrative component, premium tax and the health insurer fee capitation adjustment. For CYE 15, an amount equal to the Quality Contribution shall be deducted from prospective capitation. Refer to ACOM 315 for the definition and computation of the Quality Contribution.
REINSURANCE	For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the Contractor as the result of prospective medical expense incurred by the Contractor for covered services with dates of service during the contract year being reconciled.

SUBCAPITATED EXPENSE Expenses incurred by the Contractor as payments to a provider under a subcapitated arrangement. The subcapitated expense used in this reconciliation is reported by the Contractor through quarterly financial reports in the format required by AHCCCS.

III. POLICY

A. GENERAL

1. The Adults > 106% reconciliation shall relate solely to fully adjudicated Adults > 106% prospective and PPC medical expenses. The amount due from or due to the Contractor as a result of this reconciliation will be based on aggregated profits and losses across both prospective and PPC risk groups. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

2. The reconciliation will limit the Contractor's profits and losses to 1% (See Attachment A for calculation). Any losses in excess of 1% will be reimbursed to the Contractor, and likewise, profits in excess of 1% will be recouped.

B. AHCCCS RESPONSIBILITIES

1. No less than six months after the contract year to be reconciled, AHCCCS shall perform an initial reconciliation. The reconciliation will be calculated as follows:

   Profit/Loss to be reconciled = Prospective Net Capitation + PPC Net Capitation – Prospective Medical Expense – PPC Medical Expense – Subcapitated Expense + Reinsurance payments

   Attachment A to this Policy provides an example of the Adults > 106% reconciliation calculation.

2. AHCCCS will utilize only expenses supported by fully adjudicated encounters and subcapitated expense reported by the Contractor to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

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 expense included in the reconciliation.

5. 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.

6. A second and final reconciliation will be performed no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. 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.

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 reconciliation will be paid or recouped through a future monthly capitation payment

8. AHCCCS may include adjustments to the initial reconciliation to account for completion factors.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit encounters for Adults > 106% prospective and 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 Adults > 106% prospective and PPC transactions, and shall submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide for Acute Care Contractors.

3. The Contractor shall monitor the estimated Adults > 106% reconciliation receivable/payable and record appropriate accruals on financial statements submitted to AHCCCS on a quarterly basis as specified in the AHCCCS Financial Reporting Guide for Acute Care Contractors.

4. It is the Contractor's responsibility to identify to AHCCCS any encounter data issues or necessary adjustments by the initial reconciliation 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 15 months after the end of the contract year being reconciled. AHCCCS will not consider any data for reconciliations submitted by the Contractor after these timeframes. Reconciliation data

issues identified that are the result of an error by AHCCCS will be corrected prior to the final reconciliation.

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

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

7. If the Contractor performs recoupments/refunds/recoveries on any claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. 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
- Attachment A, Health Plan Adult Group above 106% FPL Reconciliation - Example
- ACOM Policy 412
- AHCCCS Financial Reporting Guide for Acute Care Contractors
- Section 9010 of the Patient Protection and Affordable Care Act
- A.R.S. §36-2905
- 9 A.C.C. 22 Article 1

ATTACHMENT A, HEALTH PLAN ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL RECONCILIATION – EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

317 – CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

EFFECTIVE DATE: 06/01/14, 06/01/15

REVISION DATE: 05/07/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS AND DHCM FINANCE

I. PURPOSE

This Policy applies to the Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes the procedure for approval of Contractor changes in Organizational Structure as defined below, including changes in a Management Service Agreement (MSA) subcontractor.

II. DEFINITIONS

ACQUISITION	One company acquires all of another target company's assets, capital, or stock.
ADMINISTRATIVE SERVICES SUBCONTRACTS	An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following: 1. Claims processing, including pharmacy claims, 2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization). 3. Management Service Agreements; 4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner; 5. DDD acute care and behavioral health subcontractors; 6. ADHS/DBHS subcontracted Tribal/Regional Behavioral 7. Health Authorities and the Integrated Regional 8. Behavioral Health Authority. 9. Providers are not Administrative Services Subcontractors.
ARTICLES OF INCORPORATION	The basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

CHANGE IN ORGANIZATIONAL STRUCTURE

Any of the following:

- Acquisition
- Change in Articles of Incorporation,
- Change in Ownership,
- Change of MSA Subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet AHCCCS contractual requirements).
- Joint Venture,
- Merger,
- Reorganization,
- State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature,
- Other applicable changes which may cause:
  - A change in the Employer Identification Number/Tax Identification Number (EIN/TIN),
  - Changes in critical member information, including the website, member or provider handbook and member ID card, or
  - A change in legal entity name.

CHANGE IN OWNERSHIP

Any change in the possession of equity in the capital, stock, profits, or voting rights with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non-stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

JOINT VENTURE

A business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants' other business.

MANAGEMENT SERVICE AGREEMENT (MSA)

A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.

MERGER Two companies join together to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization, or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

REORGANIZATION An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.

III. POLICY

A. CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

A change in Contractor Organizational Structure shall require prior approval of AHCCCS.

A State Agency reorganization shall require prior notification to AHCCCS.

When submitting for prior approval or upon a State Agency reorganization, AHCCCS will review documentation to ensure the following:

1. Uninterrupted services and ongoing adequate access to care and choice for members;
2. The new entity's ability to maintain and support the contract requirements including the commitments in the proposal submitted to AHCCCS during the procurement process;
3. Major functions of the Contractor's organization, as well as AHCCCS programs, are not adversely affected; and
4. The integrity of a fair, competitive AHCCCS procurement process for managed care contracts, which is one of the core founding principles of the AHCCCS program.

AHCCCS reserves the right to obtain stakeholder input on the proposed ownership change through a public notice and feedback process.

AHCCCS reserves the right to temporarily suspend a Contractor's new member enrollment including, but not limited to, auto-assignment pending AHCCCS review and final determination regarding a Contractor's Change in Organizational Structure.

The Contractor shall submit a written notification to AHCCCS of any proposed merger, acquisition, reorganization or change in ownership 180 days prior to the effective date as specified in Contract, Attachment F3, Contractor Chart of Deliverables. This notification shall include:

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

2. A detailed transition plan as outlined below.

B. TRANSITION PLAN

The transition plan shall be submitted 180 days prior to the effective date, as specified in Contract, Attachment F3, Contractor Chart of Deliverables. Items for which information is not yet available for submission, or is still considered draft, shall be noted and must be submitted or resubmitted no later than 90 days prior to the effective date, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

All transition plan documents are to be submitted electronically via the secured File Transfer Protocol (FTP) server to the designated DHCM Operations Compliance Officer.

The Contractor must submit the following as part of the transition plan, as applicable:

1. A letter of explanation which includes the following information:
   a. The type of entity if a new entity will be formed and/or any changes to existing entity,
   b. Any material change to operations as specified in Section D of the Contract, and
   c. In the case of a State Agency, any state or federal legislation, rule or action that necessitates a change in Organizational Structure.

2. Proof that any performance bond requirements have been met by the new entity, if the original entity is no longer a going-concern. The Performance Bond shall be in a form acceptable to AHCCCS. See ACOM Policy 306. (This may be submitted at the 90 day timeframe noted above).

3. Documents including the following:
   a. The formal name and any proposed logo used by the resulting organization,
   b. The organizational chart of the new resulting organization or proposed changes to the existing organizational chart if a new entity is not being formed,
   c. Current audited financial statements of current Contractor and merging entity, and
   d. Pro-forma financial statements of entity resulting from the change in-organizational structure which shall include at a minimum a balance sheet, statement of revenues and expenses and statement of cash flows for the subsequent three years as well as enrollment projections and footnotes detailing assumptions. The format can be the same as the audit format; however the

AHCCCS lines of business should be detailed separately just as is required in the annual audit report.

4. A description of the following:
   a. An assessment of any potential interruption of services to members, and steps the Contractor is taking to ensure there are no interruptions,
   b. Any changes to the management and staffing of the organization currently overseeing services provided under the contract,
   c. Any changes to existing Administrative Services Subcontracts,
   d. Any changes to the administration of critical components of the organizations, including but not limited to information systems, prior authorization, claims processing or grievances,
   e. The Contractor's plan for communicating the change to members, including a draft notification to be distributed to affected members and providers,
   f. The Contractor's plan for changes to critical member information, including the website, member and provider handbook and member ID card,
   g. Any anticipated changes to the network, and
   h. In the case of a State Agency, any changes in federal or state funding that directly impact the AHCCCS line of business.

5. Upon AHCCCS approval of the Transition Plan, the following documents must be submitted within 120 days of the change, as specified in Contract, Attachment F3, Contractor Chart of Deliverables
   a. The articles of incorporation, if applicable, including copies of all affiliation agreements. An affiliate refers to an entity that directly or indirectly controls, is controlled by, or is under common control with another entity; also, a party with which the entity may deal if one party has the ability to exercise significant influence over the other's operating and financial policies. The affiliation agreement (also referred to as a member agreement) defines and governs the affiliate relationship.
   b. Any proposed change to the Employer Identification Number/Tax Identification Number (EIN/TIN).

   (NOTE: change in the EIN/TIN will automatically trigger a change in the AHCCCS health plan identification number).

6. Any additional information requested by AHCCCS

C. ADDITIONAL SUBMISSION REQUIREMENTS

1. The Contractor shall submit the following to the appropriate AHCCCS division no later than 45 days prior to the effective date of the change in organizational structure and commencement of operations under the new structure, as specified in Contract, Attachment F3, Contractor Chart of Deliverables:
   a. Automatic Clearing House (ACH) Vendor Authorization Form. The ACH form is to be submitted as directed on the form.

b. Information regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime in accordance with the 42 C.F.R. 101 through 106, the Contractual Provisions in Section D, Corporate Compliance and ACOM Policy 103. The information is to be submitted via secured FTP server to the Office of Inspector General (OIG).

2. For a change of MSA Subcontractor, the Contractor is also required to follow the process for the review and approval of the new subcontract as outlined in ACOM Policy 438.

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

D. AHCCCS Disposition of Request

AHCCCS may:

1. Approve the proposal
   a. Without conditions, or
   b. With conditions which may include but are not limited to:
      i. Allowing an open enrollment for plan membership,
      ii. More rigorous oversight for a specified period of time,
      iii. A cap on enrollment.

2. Deny the proposal

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

IV. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- Contract, Section F, Attachment F3, Contractor Chart of Deliverables
- ACOM Policy 103
- ACOM Policy 306
- ACOM Policy 438
- 42 CFR 455.101 through 106
- Automatic Clearing House (ACH) Vendor Authorization Form

318 CYE 15 – ARIZONA LONG TERM CARE SYSTEM ELDERLY AND PHYSICALLY DISABLED PROGRAM PAYMENT REFORM INITIATIVE

EFFECTIVE DATE: 10/01/14

REVISION DATE: 11/20/14

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE AND DHCM CLINICAL QUALITY MANAGEMENT (CQM)

I. PURPOSE

This policy applies to all ALTCS EPD Contractors. The AHCCCS Payment Reform Initiative (PRI) applies to dates of service effective on and after October 1, 2014 and is based on Quality Management Performance Measures (QMPMs) utilized by the AHCCCS Clinical Quality Management (CQM) Unit as described in this policy. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through shared savings payment arrangements.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality contribution amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
MEASUREMENT YEAR	The period for which the PRI policy applies which shall be 10/1 through 9/30.
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PROSPECTIVE GROSS CAPITATION	Prospective capitation payments, prior to adjustments for Nursing Facility enhanced payments, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, share of cost offset, administration, case management, risk/contingency and premium tax, and any subsequent amendments thereof.
QUALITY MANAGEMENT PERFORMANCE MEASURES	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the PRI. See highlighted rows in Attachment A.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY CONTRIBUTION	A specified percentage of all Contractors' Prospective Gross Capitation payments that will be assessed through a reconciliation process to fund the PRI.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.
SHARED-SAVINGS ARRANGEMENT	A written contract between a contractor and provider designed to achieve cost savings and quantifiable improved outcomes, which in the event of savings, are shared between the contractor and the provider.

III. POLICY

A. GENERAL

In order to qualify for a quality distribution, the Contractor must meet the minimum shared savings qualifying criteria for both the EPD contract and the Medicare Advantage Duals Special Needs Plan (MA-DSNP) spend as it pertains to the ALTCS EPD members in C.2., C.3. and certify as described in C.4. Failure to meet or certify to these minimums in a particular measurement year will disqualify the Contractor from any quality distributions for

that year. However, the Contractor's quality contribution used in the reconciliation described below will still be assessed and included to fund quality distributions to all other Contractors.

Quality distributions will be made to Contractors based on relative Contractor performance under the ALTCS EPD Contract for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see Attachment A). Each QMPM is allocated a percentage of the total quality contribution funds available for distribution; see Attachment B for the percent of contribution by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn distributions on any or all of the QMPMs.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score); and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment B. The quality distribution formula first determines payments based on the performance measure score. The balance of quality contribution funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality contribution. Due to Federal requirements, the maximum distribution across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation attributable to the ALTCS/EPD PRI.

Modifications to the quality distribution formula, and additional methods for determining quality distributions, including quality distributions based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular measure from the PRI. In such a case, AHCCCS will remove each Contractor's quality contribution amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the PRI based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's quality contribution amount for that measure, provided that the Contractor has met and certified to the minimum payments requirement under Shared Savings Arrangements stipulated in C.2 and C.3 of this policy.

Quality distributions to Contractors will be funded by assessing one percent of Prospective Gross Capitation (quality contribution) exclusive of Acute Care Only payments.

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed to be appropriate.

B. AHCCCS RESPONSIBILITIES

1. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year basis.

2. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate results of the PRI and reconcile the contribution from and distribution to Contractors. The quality contribution may be adjusted, if necessary, for the elimination of a particular measure from the PRI or the elimination of a Contractor from a particular measure as indicated above.

   The full amount of the quality contribution will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment B for an example):

   Q= Quality Contribution
   S = Scaling Factor
   CMeasure = Contractor's QMPM Result
   MinStd = Quality Management Minimum Performance Standard
   A = Adjustment Factor
   R = Rank Factor

   Performance Measure Score:
   If equal to or above MinStd, then Q * S * ([CMeasure – MinStd]/MinStd)
   If below minimum standard, then zero

   Performance Rank Score: A * Q * R

   Quality Distribution: Performance Measure Score + Performance Rank Score

3. Through the reconciliation, the total quality distribution will be subtracted from the net quality contribution to establish the amount due to or due from the Contractor. The difference will be adjusted for premium tax. See Attachment D for example.

   AHCCCS will provide the Contractor the data used for the 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 address any issues as warranted.

   Any amount due to or due from the Contractor as a result of the reconciliation will be paid or recouped through a future monthly capitation payment.

C. CONTRACTOR RESPONSIBILITIES

1. Contractors will adhere to all requirements of the AMPM, Chapter 900, Policy 970.

2. Contractor requirement to meet minimum shared savings qualifying criteria:
   a. Relative to the EPD contract, a minimum of five percent of the value of total prospective payments under all contracts executed with health care providers must be governed by shared-savings arrangements for the measurement year.
      The five percent requirement must meet the following criteria:
      i. A minimum of two percent of total Acute Care service payments under all contracts executed for such services must be governed by shared-savings arrangements for the measurement year.
      ii. A minimum of two percent of total Long Term Care (LTC) service payments under all contracts executed for such services must be governed by shared-savings arrangements for the measurement year.
      iii. The Contractor must have additional contracts at the Contractor's discretion governed by shared-savings arrangements such that five percent of the total spend under all contracts shall be governed by shared-savings arrangements for the measurement year. AHCCCS expects the minimum value threshold to grow each year.
   b. Relative to the MA-DSNP contract for ALTCS EPD Duals, a minimum of 1.5 percent of the value of total payments under all contracts with health care providers must be governed by shared-savings arrangements for the measurement year.

3. Written contracts shall be executed no later than February 1st.

4. The Contractor will certify to AHCCCS that these minimums will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. an initial Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment C to the DHCM Finance Manager within 60 days of the start of the measurement year.
   b. a final Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment C to the DHCM Finance Manager due 180 days after the end of the measurement year.

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

   AHCCCS reserves the right to require an audit of the Certifications included in Attachment C.

IV. REFERENCES

- ALTCS EPD Contract, Section D
- AMPM Chapter 900
- Attachment A – ALTCS EPD Contractor Quality Management Performance Measure Standards
- Attachment B – Payment Reform Initiative (PRI) Quality Distribution Example
- Attachment C – Payment Reform Initiative (PRI) Shared Savings Arrangement Certification
- Attachment D – Payment Reform Initiative (PRI) Reconciliation Example
- A.R.S. 36-2905

ATTACHMENT A, CONTRACTOR QUALITY MANAGEMENT PERFORMANCE MEASURES

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, DISTRIBUTION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, SHARED SAVINGS ARRANGEMENT CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, ALTCS EPD PAYMENT REFORM INITIATIVE RECONCILIATION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

318 CYE 16 – ARIZONA LONG TERM CARE SYSTEM ELDERLY AND PHYSICAL DISABILITY PROGRAM VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATE: 06/11/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE AND DHCM CLINICAL QUALITY MANAGEMENT (CQM)

I. PURPOSE

This Value-Based Purchasing (VBP) Initiative Policy applies to all Arizona Long Term Care System Elderly and Physical Disability Program Contractors. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

ADJUSTMENT FACTOR	A factor applied in the calculation of the quality distribution that ensures that the total quality contribution amount by QMPM equals the total quality distribution amount by QMPM. This factor is applied to the performance rank score and varies by the different QMPMs and number of Contractors meeting the minimum standards.
MEASUREMENT YEAR	The period for which the VBP Initiative Policy applies which shall be 10/1 through 9/30.
PERFORMANCE MEASURE SCORE	One of the two scores used in calculating the quality distribution. This score is based on the Contractor's performance relative to the minimum performance standards established by CQM.
PERFORMANCE RANK SCORE	One of the two scores used in calculating the quality distribution. This score is based on a pure ranking of the Contractor's performance.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

PROSPECTIVE GROSS CAPITATION	Prospective capitation payments, prior to adjustments for Nursing Facility enhanced payments and Health Insurance Fee payments, made to Contractors on a monthly basis which includes medical expense, reinsurance offset, share of cost offset, administration, case management, risk/contingency and premium tax, and any subsequent amendments thereof. For purposes of this policy, Prospective Gross Capitation is exclusive of Acute Care only payments.
QUALITY MANAGEMENT PERFORMANCE MEASURES	Health care quality measures utilized by CQM. Subsets of these measures were selected for use in the VBP Initiative.
QUALITY MANAGEMENT MEASUREMENT REPORT	The report issued by CQM annually which includes results by Contractor on QMPMs.
QUALITY MANAGEMENT MINIMUM PERFORMANCE STANDARD	The minimum standard established by CQM for each QMPM and used in calculating the performance measure score.
QUALITY CONTRIBUTION	A specified percentage of all Contractors' Prospective Gross Capitation payments that will be assessed through a reconciliation process to fund the VBP Initiative.
QUALITY DISTRIBUTION	Amounts returned to Contractors, by QMPM, based on the results of the performance measure score and the performance rank score.
RANK FACTOR	A factor applied in the calculation of Contractor's quality distribution amount based on the rank of the Contractor for the performance rank score.
SCALING FACTOR	A factor applied in the calculation of Contractor's quality distribution amount for the performance measurement score.
VALUE-BASED PURCHASING PAYMENT PER VALUE-BASED PURCHASING CONTRACT	A payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals/measures in accordance with the VBP strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment will typically occur after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.

VALUE-BASED PURCHASING STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided, by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

This strategy shall not be counted towards the minimum qualifying criteria outlined under C.2. in order to be eligible for quality distribution under this policy.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS

Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS

Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example. Shared savings programs can be based on a fee-for-service purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.

SHARED RISK Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service purchasing system.

CAPITATION + PERFORMANCE-BASED CONTRACTS Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

In order to qualify for a quality distribution, the Contractor must meet the VBP strategies qualifying criteria for both the EPD contract and the Medicare Advantage Duals Special Needs Plan (MA-DSNP) spend as it pertains to the ALTCS/EPD members in C.2., and certify as described in C.3. Failure to meet or certify to meeting the criteria these minimums in a particular measurement year will disqualify the Contractor from any quality

distributions for that year. However, the Contractor's quality contribution used in the reconciliation described below will still be assessed and included to fund quality distributions to all other Contractors.

Quality distributions will be made to Contractors based on relative Contractor performance under the ALTCS EPD Contract for the measurement year, as determined by CQM, on selected Quality Management Performance Measures (QMPMs - see highlighted rows Attachment B). Each QMPM is allocated a percentage of the total quality contribution funds available for distribution; see Attachment C for the percent of contribution by QMPM. Each measure will be considered independently of other measures, such that a Contractor can earn distributions on any or all of the QMPMs.

The quality distribution formula is based on two factors: Contractors' performance relative to minimum performance standards established by CQM (i.e. performance measure score); and Contractors' rankings on QMPMs (i.e. performance rank score), as illustrated in Attachment C. The quality distribution formula first determines payments based on the performance measure score. The balance of quality contribution funds allocated to the QMPM is then distributed based on the performance rank score. The adjustment factor is applied to the performance rank score to ensure that the total quality distributions equal the total quality contribution. Due to Federal requirements, the maximum distribution across all QMPMs made to any Contractor will be limited to five percent of annual prospective gross capitation attributable to the ALTCS/EPD VBP Initiative.

Modifications to the quality distribution formula, and additional methods for determining quality distributions, including quality distributions based on improvement in measures from year-to-year, may be considered in future measurement years.

AHCCCS reserves the right to eliminate a particular measure from the VBP Initiative In such a case, AHCCCS will remove each Contractor's quality contribution amount for that measure.

AHCCCS reserves the right to exclude a particular Contractor from one or more measures of the VBP Initiative based on insufficient population for the denominator of the measure to provide for a credible statistic or other reasons determined by AHCCCS. In such a case, AHCCCS will remove the Contractor's quality contribution amount for that measure, provided that the Contractor has met and certified to meeting the qualifying criteria under VBP strategies stipulated in C.2 and C.3 of this Policy.

Quality distributions to Contractors will be funded by assessing one percent of Prospective Gross Capitation (quality contribution).

The methods and procedures used for data sources, validation and tabulation of results will be described in the AHCCCS QMPM Report for the measurement year. Risk adjustment methods for the QMPMs will be considered and utilized, if deemed to be appropriate.

B. AHCCCS RESPONSIBILITIES

1. Quality contributions and quality distributions will be settled through a reconciliation performed annually on a contract year basis.

2. Between one and three months after the AHCCCS QMPM Report for the measurement year has been issued, AHCCCS shall tabulate results of the VBP Initiative and reconcile the contribution from and distribution to Contractors.

   The quality contribution may be adjusted, if necessary, for the elimination of a particular measure from the VBP Initiative or the elimination of a Contractor from a particular measure as indicated above.

   The full amount of the quality contribution will be distributed among Contractors based on performance on the quality measures, unless otherwise noted in this Policy. The quality distribution by QMPM will be calculated as follows (see Attachment C for an example):

   Q = Quality Contribution
   S = Scaling Factor
   CMeasure = Contractor's QMPM Result
   MinStd = Quality Management Minimum Performance Standard
   A = Adjustment Factor
   R = Rank Factor

   Performance Measure Score:
   If equal to or above MinStd, then Q * S * ([CMeasure – MinStd]/MinStd)
   If below minimum standard, then zero

   Performance Rank Score: A * Q * R

   Quality Distribution: Performance Measure Score + Performance Rank Score

3. Through the reconciliation, the total quality distribution will be subtracted from the net quality contribution to establish the amount due to or due from the Contractor.

4. The difference computed in B.3. shall be adjusted by adding the total of all VBP payments per VBP contracts certified by the Contractor attributed to the period of October 1, 2015 through September 30, 2016, and submitted to AHCCCS in the final Attachment E as prescribed in C.3.

   AHCCCS shall test the total amount due to/from the Contractor to ensure that the Federal limit of 5% of annual prospective gross capitation is met. Any amount in excess of the limit shall be reduced to bring the final due to/from within the Federal requirement.

5. The result computed in B.4 will be adjusted for premium tax. See Attachment D for example.

AHCCCS will provide the Contractor with the 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 address any issues as warranted.

Any amount due to or due from the Contractor as a result of the reconciliation will be paid or recouped through a future monthly capitation payment.

C. CONTRACTOR RESPONSIBILITIES

1. Contractors will adhere to all requirements of the AMPM, Chapter 900, Policy 970.

2. Contractor requirement to meet minimum VBP strategies qualifying criteria:
   a. Relative to the EPD contract, a minimum of 15 percent of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the measurement year. AHCCCS expects the minimum value threshold to grow each year.
   b. Relative to the MA-DSNP contract for ALTCS/EPD Duals, a minimum of 15 percent of the value of total payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the measurement year. AHCCCS expects the minimum value threshold to grow each year.

   Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Fee-For-Service Strategy. Strategies utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

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

   The same dollars shall not be counted under multiple contracts.

   Additionally, one contract shall not be counted under multiple strategies.

   The Contractor may use quality measures other than the measures identified in Attachment B as part of its VBP strategies.

   In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts executed no later than February 1 of each measurement year, and shall

only be counted for the time period in the measurement year for which contract is in effect.

3. The Contractor shall certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. An initial VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager within 60 days of the start of the measurement year.
   b. A final VBP Strategies Certification as provided in Attachment E to the DHCM Finance Manager due 180 days after the end of the measurement year.

   NOTE: Attachment E contains two tabs. Both tabs must be submitted with the executed copy and the electronic copy in accordance with 3.a. and 3.b.

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

   AHCCCS reserves the right to require an audit of the Certifications included in Attachment E.

IV. REFERENCES

- ALTCS/EPD Contract, Section D
- Attachment A, ALTCS/EPD Program Value-Based Purchasing (VBP) Strategies
- Attachment B, ALTCS/EPD Contractor Quality Management Performance Measures
- Attachment C, ALTCS/EPD Program Value-Based Purchasing (VBP) Quality Distribution Example
- Attachment D, ALTCS/EPD Program Value-Based Purchasing (VBP) Reconciliation Example
- Attachment E, ALTCS/EPD Program Value-Based Purchasing (VBP) Strategies Certification
- AMPM Chapter 900
- A.R.S. §36-2905

ATTACHMENT A, ALTCS/EPD PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, ALTCS/EPD CONTRACTOR QUALITY MANAGEMENT PERFORMANCE MEASURES

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, ALTCS/EPD PROGRAM VALUE-BASED PURCHASING (VBP) QUALITY DISTRIBUTION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, ALTCS/EPD PROGRAM VALUE-BASED PURCHASING (VBP) RECONCILIATION EXAMPLE

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

ATTACHMENT E, ALTCS/EPD PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT E OF THIS POLICY

319 CYE 15 – CHILDREN'S REHABILITATIVE SERVICES PROGRAM PAYMENT REFORM INITIATIVE

EFFECTIVE DATE: 10/01/14

REVISION DATE: 11/20/14

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to the Children's Rehabilitative Services (CRS) Contractor. The AHCCCS Payment Reform Initiative (PRI) applies to all dates of service effective on and after October 1, 2014. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through shared savings payment arrangements.

II. DEFINITIONS

SHARED-SAVINGS ARRANGEMENT	A written contract between a contractor and provider designed to achieve cost savings and quantifiable improved outcomes, which in the event of savings, are shared between the contractor and the provider.

III. POLICY

A. GENERAL

The Contractor must meet the minimum shared savings qualifying criteria in B.1., B.2. and certify as described in B.3. Failure to meet the minimum in a particular contract year will result in sanctions up to a maximum of $250,000.

B. CONTRACTOR RESPONSIBILITIES

1. A minimum of five percent of the value of total prospective payments under all contracts executed with health care providers must be governed by shared-savings arrangements for the contract year. AHCCCS expects the minimum value threshold to grow each year.

2. Written contracts shall be executed no later than February 1st.

3. The Contractor will certify to AHCCCS that this minimum will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. An initial Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment A to the DHCM Finance Manager within 60 days of the start of the contract year.

b. A final Payment Reform Initiative Shared Savings Arrangement Certification as provided in Attachment A to the DHCM Finance Manager due 180 days after the end of the contract year.

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

Failure to attest to the minimum in a particular contract year will result in sanctions up to a maximum of $250,000.

AHCCCS reserves the right to request an audit of the Certifications included in Attachment A.

IV. REFERENCES

- CRS Contract, Section D
- Attachment A, Payment Reform Initiative (PRI) Shared Savings Arrangement Certification

ATTACHMENT A, CHILDREN'S REHABILITATIVE SERVICES PROGRAM PAYMENT REFORM INITIATIVE SHARED SAVINGS ARRANGEMENT CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

319 CYE 16 – CHILDREN'S REHABILITATIVE SERVICES VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATE: 06/11/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Value-Based Purchasing (VBP) Initiative Policy applies to the Children's Rehabilitative Services (CRS) Contractor. This Policy applies to dates of service effective on and after October 1, 2015. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

VALUE-BASED PURCHASING STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

This strategy shall not be counted towards the minimum qualifying criteria outlined under B.1.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given contract year, for example. Shared savings programs can be based on a fee-for-service purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.

SHARED RISK Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service purchasing system.

CAPITATION + PERFORMANCE-BASED CONTRACTS Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

The Contractor must meet the VBP strategies qualifying criteria in B.1., and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

B. CONTRACTOR RESPONSIBILITIES

1. A minimum of 20 percent of the value of total prospective payments, VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the contract year. AHCCCS expects the minimum value threshold to grow each year.

   Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Fee-For-Service Strategy. Strategies utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

   A minimum of 25 percent of the 20 percent requirement shall be with an organization that includes Primary Care Providers (PCPs).

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

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts executed no later than February 1 of each contract year, and shall only be counted for the time period in the contract year for which contract is in effect.

2. The Contractor will certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. An initial VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager within 60 days of the start of the contract year.
   b. A final VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager due 180 days after the end of the contract year.

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

   Failure to attest to the VBP strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

   AHCCCS reserves the right to request an audit of the Certifications included in Attachment B.

IV. REFERENCES

- CRS Contract, Section D
- Attachment A, CRS Program Value-Based Purchasing (VBP) Strategies
- Attachment B, CRS Program Value-Based Purchasing (VBP) Strategies Certification

ATTACHMENT A, CRS PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, CRS PROGRAM VALUE-BASED PURCHASING (VBP) STRATEGIES CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

320 – HEALTH INSURER FEE

EFFECTIVE DATE: 01/01/14, 10/01/15

REVISION DATE: 11/06/14, 07/30/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, and DES/DDD (DDD) Contractors subject to the exclusions noted below. According to contract, AHCCCS will provide funding to the Contractors for the Health Insurer Fee and associated taxes. The purpose of this Policy is to define what the Contractors will submit to AHCCCS and the process by which AHCCCS will provide funding to the Contractors for the Health Insurer Fee.

II. DEFINITIONS

AFFORDABLE CARE ACT (ACA)	Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (ACA).
FEE YEAR	The calendar year in which the fee must be paid.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to Contractors for the contract year.

III. POLICY

A. GENERAL

Section 9010 of the Patient Protection and Affordable Care Act (ACA) requires that the Contractor, if applicable, pay a Health Insurer Fee (HIF) annually beginning in calendar year 2014 based on its respective market share of premium revenues from the preceding calendar year. Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance.

Certain entities will be excluded including, but not limited to:

- Government entities, including independent nonprofit county-organized health system entities that contract with state Medicaid agencies; and

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

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

Every health insurer is required to report its national net premiums written to the IRS annually by April 15 of the fee year on Form 8963, "Report of Health Insurance Provider Information". It is the health insurer's responsibility to allocate its national net premiums written to the entities recorded on its Form 8963. The allocation for each fee year is based on the prior calendar year's revenue. The IRS will then send each health insurer a notice of preliminary fee calculation each fee year. The regulations provide that the IRS will send each health insurer its final fee calculation for a fee year no later than August 31 of that fee year, and that the health insurer must pay the fee to the IRS by electronic funds transfer by September 30.

B. AHCCCS RESPONSIBILITIES

1. Subject to receipt and review of documentation from the Contractor as described below, AHCCCS shall make a retroactive capitation rate adjustment consistent with the methodology approved by the Centers for Medicare and Medicaid Services (CMS) (see Attachment A for CMS approved methodology), to approximate the cost associated with the HIF Premium tax.

2. For Fee year 14, subject to receipt and review of documentation from the Contractor as described below, AHCCCS shall make a subsequent retroactive capitation rate adjustment to the Contractor to approximate the federal income tax liability and Arizona state income tax liability the Contractor incurs related to the HIF, if applicable.

3. For Fee year 15 and forward, the retroactive capitation rate adjustment for the Contractor in B.1 above will include the provision to approximate the federal income tax liability and Arizona state income tax liability the Contractor incurs related to the HIF, if applicable.

4. The HIF and associated tax liability will be deducted from revenue on other AHCCCS revenue/expense reconciliations in a manner consistent with how the premium tax is handled.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall submit to the DHCM Finance Manager a copy of its entity's Form 8963, "Report of Health Insurance Provider Information" filed with the IRS to report net premium along with its final fee estimate by September 30 of each fee year, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

2. The Contractor shall complete Attachment B, Health Insurer Fee Liability Reporting Template and submit both an executed copy and an electronic copy in an Excel format to the DHCM Finance Manager by September 30 of each fee year, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. Since the template includes all lines of business, a Contractor with multiple lines of business only needs to make one submission. The Contractor shall include Title XIX and XXI revenue only. The AHCCCS fee liability shall be allocated to line of business based on the allocation of revenue reported in Attachment B. AHCCCS will verify the reasonableness of the data. In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

3. If no fee is due, the Contractor shall submit to the DHCM Finance Manager a written statement indicating no fee is due and the reason for the exemption.

4. The Contractor shall submit to the DHCM Finance Manager a copy of its entity's federal and Arizona state income tax filings by April 30 of the year following the fee year, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall notify the DHCM Finance Manager of the federal and Arizona state income tax rates that apply to the Contractor.

5. If the Contractor requested a tax filing extension, the Contractor shall submit its anticipated federal and Arizona state income tax rates that apply to the Contractor to the DHCM Finance Manager by April 30 of the year following the fee year, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. Once filed, the Contractor shall submit copies of the federal and Arizona state income tax filings within 30 days of filing.

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

IV. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D

- Contract, Section F, Attachment F3, Contractor Chart of Deliverables
- Attachment A, CMS Approved Retroactive Capitation Rate Adjustment Methodology – One Month Method of Payment of Health Insurere Fee (HIF)
- Attachment B, Health Insurer Fee Liability Reporting Template
- A.R.S. §36-2905
- Section 9010 of the Patient Protection and Affordable Care Act

ATTACHMENT A – CMS APPROVED RETROACTIVE CAPITATION RATE ADJUSTMENT METHODOLOGY – ONE MONTH METHOD OF PAYMENT OF HEALTH INSURER FEE (HIF)

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B – HEALTH INSURER FEE LIABILITY REPORTING TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

321 – PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: 10/01/14

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. The purpose of this Policy is to define parameters for the Payment Reform - E-Prescribing Initiative.

II. DEFINITIONS

ELECTRONIC PRESCRIPTION OR E-PRESCRIPTION	Electronic prescriptions or E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.
ORIGIN CODE	The field located in the National Council for Prescription Drug Programs (NCPDP) standardized code set known as the Prescription Origin Code and also referred to as the NCPDP Prescription Origin Code.

III. POLICY

A. GENERAL

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

The following parameters shall apply for the Payment Reform - E-Prescribing Initiative.

1. Only those prescriptions that meet the definition of an E-Prescription shall be included for the purpose of the initiative. The initiative shall not include other electronic methods of transmitting prescriptions including computer-generated paper prescriptions or facsimiles or telephone-generated prescriptions. The initiative also shall not include E-Prescriptions converted to computer-generated facsimile when the E-Prescription is sent via an intermediary that is unable to complete the transaction.

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

3. Controlled substances can be e-prescribed and therefore, may be counted as an E-Prescription if the electronic origination meets the definition of an E-Prescription.

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

AHCCCS may sanction the Contractor for failure to meet the minimum goals.

B. AHCCCS RESPONSIBILITIES

1. AHCCCS shall determine a baseline of original prescriptions generated as E-Prescriptions by line of business for each Contractor based on encounter data with dates of service between January 1 and May 31, 2014 with adjudication dates through August 31, 2014. For ADHS/DBHS, this policy applies to the Integrated RBHA only. AHCCCS shall determine a baseline of original prescriptions generated as E-Prescriptions for the Integrated RBHA based on encounter data with dates of services during a span of multiple months to be determined based on encounter completeness. The single baseline shall include data for all members (integrated and non-integrated) and all services (behavioral and physical). Improvement shall be measured in total. For CRS, AHCCCS shall determine a baseline of original prescriptions generated as an E-Prescription inclusive of all coverage types.

2. AHCCCS shall measure original prescriptions generated as E-Prescriptions by line of business for each Contractor based on encounter data with dates of services between July 1, 2015 and September 30, 2015 extracted no sooner than December 31, 2015 against the baseline to determine the percent of increase.

C. CONTRACTOR RESPONSIBILITIES

1. The Contractor shall increase the percent of prescriptions originating through E-Prescribing by 20% as compared to the baseline identified by AHCCCS for the Contractor.

2. Prescription origination data must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

3. The Prescription Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

4. The Contractor shall submit an Executive Summary identifying the Contractor's strategies to increase E-Prescribing to the DHCM Finance Manager by October 31, 2014. The Executive Summary shall include whether or not the Contractor will utilize any payment incentives or disincentives.

For ADHS/DBHS, the Executive Summary is due within two months from notification of the baseline.

IV. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide

322 CYE 16 – REGIONAL BEHAVIORAL HEALTH AUTHORITY VALUE-BASED PURCHASING INITIATIVE

EFFECTIVE DATE: 10/01/15

REVISION DATE: 07/30/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Value-Based Purchasing (VBP) Initiative Policy applies to the Regional Behavioral Health Authority (RBHA) Contractors. This Policy applies to dates of service effective on and after October 1, 2015. The purpose of this initiative is to encourage Contractor activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the Contractor and provider through VBP strategies.

II. DEFINITIONS

BLOCK PURCHASE PAYMENT ARRANGEMENT METHODOLOGY

A current payment arrangement methodology where a contracted amount for a block of services is divided by 12 and paid in monthly installments to the provider.

VALUE-BASED PURCHASING STRATEGIES

A model which aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across the dimensions of quality.

VBP strategies for this initiative may include any combination of Primary Care Incentives (PC), Performance-Based Contracts (PB), Bundled/Episode Payments (BE), Shared Savings (SS), Shared Risk (SR) and Capitation + Performance-Based Contracts (CP) purchasing strategies as defined below, in order from least to greatest provider financial risk. See Attachment A to view the continuum of VBP strategies.

FEE-FOR-SERVICE

Purchasing strategy in which providers receive a negotiated or payer-specified payment rate for every unit of service they deliver without regard to quality, outcomes or efficiency.

This strategy shall not be counted towards the minimum qualifying criteria outlined under B.1.

PRIMARY CARE INCENTIVES

Purchasing strategy in which providers/physicians are rewarded with bonus payments for meeting certain performance measures for quality and/or cost. It can also include disincentives, such as eliminating payments for negative consequences of care (i.e. medical errors) or for increased costs and is typically paid in addition to fee-for-service payments. Also known as Pay for Performance or P4P.

PERFORMANCE-BASED CONTRACTS

Purchasing strategy in which a portion of the provider's total potential payment is tied to a provider's performance on cost-efficiency and quality performance measures. While providers may still be paid fee-for-service or through a block purchase payment arrangement methodology for a portion of their payments, they may also be paid a bonus or have payments withheld. The bonus is not paid unless the provider meets cost-efficiency and/or quality targets.

BUNDLED/EPISODE PAYMENTS

Purchasing strategy in which the provider is reimbursed on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care and several services or procedures over time. The provider receives a lump sum for all health services delivered for a single episode of care. An example is payment to obstetricians for the ongoing management of pregnancy, delivery and postpartum care.

SHARED SAVINGS

Purchasing strategy which provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given contract year, for example. Shared savings programs can be based on a fee-for-service or block purchase payment arrangement purchasing system. Shared savings can be applied to some or all of the services that are expected to be used by a patient population and vary based on provider performance.

SHARED RISK	Purchasing strategy in which payer and provider share upside and downside risk against an agreed-upon budget after meeting quality and experience thresholds. Refers to arrangements in which providers accept some financial liability for not meeting specified financial or quality targets. Examples include loss of bonus; baseline revenue loss; or loss for costs exceeding global or capitation payments; withholds that are retained and adjustments to fee schedules. For the purposes of data collection, shared risk programs that include shared savings should only be included in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service or block purchase payment arrangement purchasing system.
CAPITATION + PERFORMANCE-BASED CONTRACTS	Purchasing strategy in which a provider or group of providers are reimbursed a set amount for each enrolled person assigned to them, rather than paying providers for individual services. Providers or groups of providers are expected to assume a certain level of financial risk under a capitated payment system. The provider is responsible for the quality, cost and experience outcomes of specific population of patients and receives payments based on per member per month, rather than fee-for-service. To be considered as a value based purchasing strategy, payment adjustments must be made based on measured performance and patient risk. It is intended to promote efficient and high quality care and coordination among providers for population health management.

III. POLICY

A. GENERAL

The Contractor must meet the VBP strategies qualifying criteria in B.1 and B.3, and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in sanctions up to a maximum of $$200,000 for the RBHA in the North, $400,000 for the RBHA in the South, or $600,000 for the RBHA in Maricopa County for B.1 and up to a maximum of $250,000 for B.3.

B. CONTRACTOR RESPONSIBILITIES

1. A minimum of five percent of the value of total Title XIX payments for integrated adults who have been determined to have a serious mental illness (SMI), VBP and non-VBP, contracted and non-contracted, must be governed by VBP strategies for the contract year. AHCCCS expects the minimum value threshold to grow each year.

   Strategies for this initiative may include any combination of the VBP strategies defined in Section II with the exception of the Block Purchase Payment Arrangement

Methodology and Fee-For-Service Strategy. Strategies utilized must meet the definitions provided under Section II. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.

A minimum of 25 percent of the five percent requirement shall be with an organization that includes Primary Care Providers (PCPs).

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

The same dollars shall not be counted under multiple contracts.

Additionally, one contract shall not be counted under multiple strategies.

In order to count towards meeting the qualifying criteria, strategies shall be evidenced by written contracts executed no later than February 1 of each contract year, and shall only be counted for the time period in the contract year for which contract is in effect.

2. The Contractor will certify to AHCCCS that these requirements will be met by submitting both an executed copy and an electronic copy in an Excel format:
   a. An initial VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager within 60 days of the start of the contract year.
   b. A final VBP strategies Certification as provided in Attachment B to the DHCM Finance Manager due 180 days after the end of the contract year.

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

   Failure to attest to the VBP strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $200,000 for the RBHA in the North, $400,000 for the RBHA in the South, or $600,000 for the RBHA in Maricopa County.

   AHCCCS reserves the right to request an audit of the Certifications included in Attachment B.

3. VBP requirements for non-integrated populations
   a. In addition to those requirements outlined above in Section B.1, the RBHA shall also enter into at least two VBP contracts with integrated providers, who offer physical and behavioral health clinical integration, for aligned members who are not already

integrated under the RBHA contract, but who receive their acute care and behavioral health services from affiliated entities (of the RBHA's Acute Care Contractor partner), e.g. children, non-dual adults with GMH/SA needs, non-integrated adults with SMI. AHCCCS intends to further extend and refine the scope of this requirement in future years.

b. The Contractor shall certify to AHCCCS that this requirement will be met by completing and submitting the comporting section in Attachment B. The Contractor shall submit Attachment B as outlined in Section B.2 above.

Failure to attest to the VBP strategies qualifying criteria in a particular contract year will result in sanctions up to a maximum of $250,000.

AHCCCS reserves the right to request an audit of the Certifications included in Attachment B.

IV. REFERENCES

- RBHA Contract, Scope of Work
- Attachment A, RBHA Value-Based Purchasing (VBP) Strategies
- Attachment B, RBHA Value-Based Purchasing (VBP) Strategies Certification

ATTACHMENT A, RBHA VALUE-BASED PURCHASING (VBP) STRATEGIES

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, RBHA VALUE-BASED PURCHASING (VBP) STRATEGIES CERTIFICATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY