401 - CHANGE OF CONTRACTOR: ACUTE CARE CONTRACTORS

EFFECTIVE DATE: 08/01/94, 10/01/13

REVISION DATE: 02/01/03, 09/25/13, 02/20/14

Staff responsible for policy: DHCM Operations

I. PURPOSE

This Policy applies to Acute Care Contractors. This Policy establishes guidelines, criteria and timeframes for how, when and by whom Contractor change requests will be processed for AHCCCS members outside of Contractor choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This Policy delineates the rights, obligations and responsibilities of the following parties when such changes are made:

- The member;
- The member's current/relinquishing Contractor;
- The receiving Contractor; and
- The AHCCCS Administration.

II. DEFINITIONS

ANNUAL ENROLLMENT CHOICE	The annual opportunity for a member to change his/her Contractor. The member is offered annual enrollment choice in the 10th month following their anniversary date. If an individual member makes a timely (within the period stated on the annual enrollment choice letter) annual enrollment choice, the change in Contractors will occur on the first of the month in which their anniversary date occurs.
DAY	A calendar day, unless otherwise specified.
FREEDOM OF CHOICE	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.
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. CRITERIA FOR CHANGE OF CONTRACTOR OUTSIDE OF INITIAL ENROLLMENT OR AEC PERIOD

Contractor change requests outside of initial enrollment or the member's AEC period will be granted for members if certain conditions are met. These conditions are:

1. ADMINISTRATIVE ACTIONS THAT MAY MERIT A CONTRACTOR CHANGE

a. A member was entitled to freedom of choice, but was not sent an auto-assignment/freedom of choice notice.

b. A member was entitled to participate in an Annual Enrollment Choice but:
   i. Was not sent an Annual Enrollment Choice notice or
   ii. Was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.

c. Family members were inadvertently enrolled with different Contractors A member who is enrolled in a Contractor through the auto-assignment process may inadvertently be enrolled with a different Contractor than other family members. Upon receipt of notification by AHCCCS, the member who was inadvertently enrolled will be disenrolled from the Contractor of assignment and enrolled in the Contractor where the other family members are enrolled when AHCCCS is notified of the problem. Other family members will not be permitted to change to the Contractor to which the new member was auto-assigned. This process shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

d. A member who was enrolled with a Contractor, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled with a different Contractor within 90 days from the date of disenrollment. In this case the member shall be reenrolled with the Contractor that the member was enrolled with prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member with the correct Contractor.

e. Newborns will automatically be assigned to the mother's Contractor. If the mother is Title XIX or Title XXI eligible she will be given 30 days from notification to select another Contractor for the newborn. Newborns of Federal Emergency Services (FES) mothers will be auto assigned and the mother will be given 30 days from notification to select another Contractor.

f. Adoption subsidy children will be auto-assigned and the guardian will be given 30 days from notification to select another Contractor.

g. A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 30 days will be given an opportunity to request a Contractor change following auto-assignment. The member will be given 30 days from the date of the choice letter to request a Contractor change. A member who does not make a selection within 30 days will remain with the auto-assigned Contractor.

h. A member whose eligibility category changed from Sixth Omnibus Budget Reconciliation Act (SOBRA) to the SOBRA Family Planning Extension Program may change to another available Contractor if their current primary care provider (PCP) will not be providing Family Planning Extension Program services.

2. MEDICAL CONTINUITY OF PRENATAL CARE

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

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

The member must be transitioned within the requirements and protocols in the ACOM Policy 402 and in AMPM, Chapter 500.

3. MEDICAL CONTINUITY OF CARE

AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all Contractors serving a specific geographic area. In unique situations, Contractor changes may be approved on a case-by-case basis if necessary to ensure the member access to medical /health care.

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

When the Medical Directors of both the receiving and relinquishing Contractors have discussed the request and have not been able to come to an agreement, the relinquishing Contractor shall submit the request to the AHCCCS Chief Medical Officer (CMO) or

designee. The AHCCCS Acute Care Change of Contractor Form (Attachment A) and the supporting documentation must be sent to the AHCCCS DHCM/Medical Management Manager within 14 business days from the date of the original request.

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

The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

B. CONTRACTOR RESPONSIBILITIES WHEN A CONTRACTOR CHANGE IS NOT WARRANTED

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

1. Quality of care delivery
2. Case management responsiveness
3. Transportation convenience and service availability
4. Institutional care issues
5. Physician or provider preference
6. Physician or provider recommendation
7. Physician or provider office hours
8. Timing of appointments and services
9. Office waiting time
10. Network limitations and restrictions

When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:

1. The current Contractor's Quality Management Department and/or
2. The AHCCCS Medical Director

Additionally, the current Contractor must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

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

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

The current Contractor must notify the member, in writing, that a Contractor change is not warranted. If the Contractor change request was the result of a member concern, as defined in Section III A (2) or A (3) of this policy, the notice must include the Contractor's resolution of this concern. The notice must also advise the member of the AHCCCS and Contractor grievance policy and include timeframes for filing a grievance.

Contractors may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

C. RELINQUISHING CONTRACTOR, RECEIVING CONTRACTOR AND AHCCCS ADMINISTRATION RESPONSIBILITIES WHEN A CONTRACTOR CHANGE IS WARRANTED

1. RELINQUISHING CONTRACTOR RESPONSIBILITIES

If a member contacts the current Contractor, verbally or in writing, and states that the reason for the plan change request is due to situations defined in Section A(1) of this policy, the relinquishing Contractor shall advise the member to telephone the AHCCCS Verification Unit at 602-417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

If the member contacts the relinquishing Contractor, verbally or in writing, to request a plan change for medical continuity of care as defined in III A (2) or A (3) of this policy, the following steps must be taken:

a. The relinquishing Contractor will contact the receiving Contractor to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Contractor Change Request Form (Attachment A) must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both Contractors. When the AHCCCS Contractor Change Request Form is signed it is to be submitted to the AHCCCS Chief Medical Officer.
b. To facilitate continuity of prenatal care for the member, Contractors shall sign off and forward the AHCCCS Contractor Change Request Form to the AHCCCS

Chief Medical Officer within two business days of the member's Contractor change request. The timeframe for other continuity of care issues is 10 business days.

c. The AHCCCS Chief Medical Officer will review the Contractor change documentation and forward to the Communications Center for processing.

2. RECEIVING CONTRACTOR RESPONSIBILITIES

The member must be transitioned within the requirements and protocols in ACOM Policy 402 and in AMPM Chapter 500.

3. MEMBER RESPONSIBILITIES

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

4. AHCCCS ADMINISTRATION RESPONSIBILITIES

The AHCCCS Administration shall process change of Contractor requests that are listed in Section III A (1) and shall send notification of the change via the daily recipient roster to the relinquishing and receiving Contractors. It is the Contractor's responsibility to identify members from the daily recipient roster who are leaving the Contractor.

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

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

If the AHCCCS Administration receives a letter or verbal request from a member requesting a Contractor change for reasons listed in Section III A (2) or A (3) the information will be forwarded to the current Contractor.

IV. REFERENCES

- 9 A.A.C. 22, Article 5 and 9 A.A.C. 31, Articles 3 and 5
- Acute Care Contract, Section D
- ALTCS Contract, Section D
- AMPM Chapter 500
- Attachment A, AHCCCS Contractor Change Request Form
- ACOM 402

ATTACHMENT A: AHCCCS ACUTE CARE CHANGE OF CONTRACTOR FORM

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

402 - MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE AND ELIGIBILITY CHANGES

EFFECTIVE DATE: 08/01/95, 09/01/14

REVISION DATE: 02/01/03, 08/07/14, 12/29/14

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes guidelines, criteria and timeframes for how members are to be transitioned between AHCCCS Contractors and how Contractors are notified for Annual Enrollment Choice (AEC) and eligibility changes. This Policy delineates the rights, obligations and responsibilities of the member's current (relinquishing) Contractor and the requested (receiving) Contractor. The Contractors and AHCCCS work together to ensure the smooth transition of members as they change from one Contractor to another. Maintenance of continuity and the quality of care are the overriding considerations for member transitions.

This Policy does not include requirements for the following transitions:

1. Member transitions due to Contractor Award, Contractor Termination, or material change to the Contractor's network.

2. Member transitions due to member request for Contractor change outside of Contractor choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period (See ACOM Policy 401).

3. Long Term Care member transitions due to enrollment choice in a county with choice and change of Contractor (See ACOM Policy 403).

4. Member transition between ALTCS/EPD and DDD Contractors. Members may be transitioned between ALTCS/EPD Contractors or between an ALTCS/EPD Contractor and DDD. Transfers between ALTCS/EPD Contractors generally occur as a result of the member moving out of one Contractor's service area into another. Transfers between an ALTCS/EPD Contractor and DDD are the result of a change in DDD eligibility, as determined by DDD. AMPM Policy 1620-M discusses Contractor responsibilities related to these transitions.

II. DEFINITIONS

ALTCS TRANSITIONAL PROGRAM	ALTCS Transitional Program is a program for currently eligible ALTCS members who have improved either medically, functionally or both, to the extent that they are no longer at immediate risk of an institutional level of care at a Nursing Facility (NF) or Intermediate Care Facility (ICF) for persons with Intellectual Disabilities level of care. These members continue to require some long term care services, but at a lower level of care. The ALTCS Transitional program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a member to change Contractors every 12 months.
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
CONTRACTOR CHANGE	Members who have been granted a change in Contractor pursuant to ACOM Policy 401 or Policy 403.
ENROLLMENT TRANSITION INFORMATION (ETI)	Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor for those members requiring coordination of services as a result of transitioning to another Contractor. (See AHCCCS Medical Policy Manual, Chapters 500 and 1600).
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)	Organization or entity contracted with ADHS to provide, manage and coordinate all medically necessary behavioral healthcare services either directly or through subcontracts with providers for Title XIX eligible adults. In addition, the organization provides, manages and coordinates all medically necessary physical health services for individuals with Serious Mental Illness.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C.22, Article 1.
MEMBER TRANSITION	The process during which members change from one Contractor to another.
POTENTIAL PLAN LISTING (PPL)	A file which provides the Contractor with the basic demographic information of all members who may be joining or leaving.
RECEIVING CONTRACTOR	The Contractor with which the member will become enrolled as a result of annual enrollment choice, open enrollment, a Contractor change or a change in eligibility.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	An organization under contract with the ADHS to administer covered behavioral health services in a geographically specific area of the state. Refer to A.R.S. §§36-3401, 36-3407 and A.A.C. Title 9, Chapter 22, Article 12.
RELINQUISHING CONTRACTOR	The Contractor in which the member will be leaving as a result of annual enrollment choice, open enrollment, a Contractor change or a change in eligibility.

III. POLICY

A. TRANSITIONS

1. Annual Enrollment Choice (AEC)
   a. Members residing in GSAs with choice of Contractor may change enrollment once a year. AHCCCS sends a choice notice to members with enrollment and other information 60 days prior to the member's AEC date.

i. The member may choose a new Contractor by contacting AHCCCS to complete the enrollment process.
ii. Members who notify AHCCCS of choice of Contractor prior to the anniversary month will transition to the requested Contractor (receiving Contractor) on the first day of the month of the member's anniversary date. Members will receive services from their requested Contractor (receiving Contractor) on the first day of the month in which their anniversary date occurs.
iii. If members do not notify AHCCCS of choice of Contractor before the last day of the month in which the anniversary date occurs, the member will not transition to the requested Contractor (receiving Contractor) until the first day of the month following the anniversary month. Members will continue to receive medical care from their current Contractor (relinquishing Contractor) through the end of the month of the anniversary date.

b. If the member does not participate in the AEC, no change of Contractor will be made during the new anniversary year except for changes approved under ACOM Policy 401.
c. Members must maintain eligibility as a condition of enrollment in the AHCCCS Program.
   i. If a member loses eligibility after making an AEC and regains eligibility within 90 days, the member's AEC will be honored.
   ii. If the member regains eligibility after 90 days, the member will lose their AEC and be auto-assigned to an available Contractor.
   iii. AHCCCS sends a choice notice to the member, after the member is auto-assigned, allowing the member 30 days to choose an available Contractor in the GSA.

2. Eligibility Changes
Member transitions due to eligibility changes include, but are not limited to, the following:
   a. ALTCS/EPD to Acute Member Transition
   Members determined through Pre-Admission Screening (PAS) reassessment to no longer be eligible to receive long term care services through ALTCS/EPD or the ALTCS Transitional Program, and are determined eligible for acute care enrollment, will be transitioned to an Acute Care Contractor.
   b. Acute Care or CRS to ALTCS/EPD or DDD
   Members who become eligible for ALTCS/EPD or DDD will be transitioned as outlined in this Policy, ACOM Policies 401 and 403, and AMPM Chapters 500.
   c. CMDP and DDD to CRS
   Members who become eligible for CRS while enrolled with CMPD or DDD will be automatically enrolled with the CRS Contractor by CRS coverage type as outlined in contract and ACOM Policy 426.
   d. Members No Longer Eligible for CRS
   Members, who have been determined by the AHCCCS Division of Member Services (DMS) to no longer be eligible to receive CRS services, will be

transitioned as indicated in this Policy, ACOM Policy 426 and AMPM Policy 520.

e. Acute Care to Integrated RBHA
Members who are enrolled with an Acute Care Contractor and reside in Maricopa County, and who are subsequently diagnosed with a serious mental illness, will be transitioned to the Integrated RBHA for medical and behavioral health services.

B. AHCCCS NOTIFICATION TO CONTRACTORS

Reference Figure 1 below for a matrix outlining transition notification activity.

1. Annual Enrollment Potential Plan Listing
   a. AHCCCS provides the Contractors with a Potential Plan Listing (PPL).
   b. The PPL is preliminary information only, based on the member's choice during the annual enrollment period, and is subject to change.

2. Enrollment Notification
   a. Final notification data containing the member's choice of Contractor is provided via the 834 file.
   b. Enrollment notification data is provided daily and monthly as follows:
      i. Daily Enrollment Notification (834 File) is completed by AHCCCS between 8:00 p.m. and 11:59 p.m. each night for that day's activity.
      ii. Monthly Enrollment Notification (834 File) occurs three days before the first of the next month for each AHCCCS Contractor.

   See the AHCCCS Technical Interface Guidelines (TIG) for more information pertaining to the 834 Enrollment Notifications.

C. CONTRACTOR TRANSITION POLICY

The Contractor shall develop and implement policies and procedures for the acceptance and transfer of members in accordance with contract and AHCCCS policy.

D. TRANSITION COORDINATOR

The Contractor must identify a representative to serve as Transition Coordinator. The individual appointed to this position must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all transition issues, responsibilities, and activities.

The role of the Transition Coordinator includes:

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

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

3. Facilitating communication between Contractors and with AHCCCS,

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

5. Ensuring that continuity of care is maintained during transitions,

6. Participating in AHCCCS transition meetings.

E. RELINQUISHING CONTRACTOR RESPONSIBILITIES

The relinquishing Contractor must complete and transmit ETI information to the appropriate parties no later than 10 business days of receipt of AHCCCS notification for each member who has special circumstances, as described in the AMPM Chapter 500, and must comply with the notification requirements specified in this Policy for all member transitions.

The relinquishing Contractor shall:

1. Coordinate care for members with special health care needs with the receiving Contractor in order that services are not interrupted.

2. Continue previously approved prior authorizations for 30 days from the date of the member's transition to the requested Contractor unless a different time period is mutually agreed to by the member or member's representative **(Acute, Integrated RBHA).**

3. Continue a member's service plan for 90 days after the date of the member's transition, unless a different time period is mutually agreed to by the member or responsible party , and adhere to timeframes for initial contact and on-site visit as specified in AMPM Chapter 1600 **(CRS, ALTCS/EPD).**

4. Be responsible for timely notification to the receiving Contractor of pertinent information related to any special needs of transitioning members.

5. Utilize the ETI process as outlined in AMPM Chapter 500 in order to notify the member's receiving Contractor when the CRS member turns 21 years of age and chooses to leave the CRS program, or the member is no longer eligible for the CRS program **(CRS).**

6. Notify the receiving Contractor.

   Relinquishing Contractors, who fail to notify receiving Contractors about members that meet the AHCCCS transition notification requirements specified in the AHCCCS Medical Policy Manual Chapter 500, may be responsible for the cost of medically necessary services received by the member. The scope and responsibility for such cases will be reviewed and determined by the AHCCCS Administration.

   In cases where AHCCCS determines that the relinquishing Contractor is responsible for payment of services following the transition date, AHCCCS will require the receiving Contractor to provide AHCCCS with information about all costs incurred by the member during the period determined by AHCCCS. Failure to timely provide the requested information to AHCCCS will void the receiving Contractor's claim to reimbursement in that case.

7. Notify the hospital prior to transitioning a member who is hospitalized on the date of transition and comply with the requirements of the AMPM, Chapter 500.

   For those hospitalized transitioning members in intensive care units, critical care units, and neonatal intensive care units, close consultation between attending physicians, the member's current PCP, and the member's receiving Contractor and PCP is required.

8. Be responsible for ensuring that a transitioning member's medical records are copied and transmitted when requested by the receiving Contractor's transition coordinator, the member's new PCP or designated office staff. In cases where additional information is medically necessary but is exceptionally lengthy, the Relinquishing Contractor is responsible for the cost of copying and postage.

   Under no circumstances is the member required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving Contractor.

9. Ensure coverage and provision of medically necessary services to their assigned members through the date of transition.

   Under no circumstances may a Contractor cancel, postpone, or deny a service based on the fact that a member will be transitioning to another Contractor.

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

11. Remain responsible for adjudicating all pending member grievances and appeals that are filed prior to the member's transition.

12. Be responsible for obtaining the member's choice of Acute Care Contractor and for notifying AHCCCS DMS, as a part of the ALTCS disenrollment process, when the member is transitioning from an ALTCS/EPD to an Acute Care Contractor.

13. Cooperate with the Receiving CRS Contractor in the transition of a member who becomes eligible and enrolls with the CRS Program and provide coordination of care for the member.

14. Be responsible for coordinating care with CMDP or DDD for the transitioning member's CRS and/or behavioral health condition when a member who is enrolled in CMDP or DDD becomes ineligible for CRS.

F. RECEIVING CONTRACTOR RESPONSIBILITIES

Receiving Contractors which fail to timely act upon enrollment transition information or fail to timely coordinate or provide the necessary covered services to transitioning members after being properly notified will be subject to sanctions as outlined in contract and ACOM Policy 408.

The receiving Contractor shall:

1. Coordinate care for members with special health care needs with the relinquishing Contractor in order that services are not interrupted, and provide the new member with Contractor and service information, emergency numbers and instructions about how to obtain services.

2. Extend previously approved prior authorizations for a period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's representative. (Acute, Integrated RBHA).

3. Continue a member's service plan for 90 days after the date of the member's transition unless a different time period is mutually agreed to by the member or responsible party, and adhere to timeframes for initial contact and on-site visit as specified in AMPM Chapter 1600 (CRS, ALTCS/EPD).

4. Maintain CRS members' current providers and service authorizations at the time of enrollment for a minimum of 90 days unless a different time period is mutually agreed to by the member or member's representative (CRS).

5. Members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment (CRS, Integrated RBHA).

6. Provide new members with member information within timeframes outlined in ACOM Policy 404.

7. Ensure that transitioning members are assigned to a PCP and can obtain routine, urgent, and emergent medical care in accordance with AHCCCS standards.

8. Be responsible for the payment of obstetrical and delivery services when a pregnant woman who is considered high-risk, is in her third trimester, or is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery. If the member's current physician and/or facility selected as her delivery site are not within the receiving Contractor's provider network, the receiving Contractor must negotiate for continued care with the member's provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving Contractor's contracted network.

9. Coordinate behavioral health and case management services with the member's assigned RBHA.

10. Maintain ongoing communication with the transition coordinator of the relinquishing Contractor and ensuring all appropriate documents (e.g., medical records if requested, treatment plans, etc.) are received in a timely manner or as specified by both the receiving and relinquishing Contractor.

FIGURE 1: TRANSITION NOTIFICATION MATRIX

TRANSACTION ACTIVITY	RELINQUISHING CONTRACTOR	RECEIVING CONTRACTOR	NOTIFICATION LAYOUT	NOTIFICATION SUBMITTED VIA	NOTIFICATION SUBMITTED TIMEFRAME
ANNUAL ENROLLMENT CHOICE Provides the Contractor with the basic demographic information of all members who may be joining or leaving. This is only **preliminary** information based on the member's choice during the annual enrollment period.	Acute Care	Acute Care	PPL and 834 File	FTP Server	Created by the 10th of the month following the Member's Annual Enrollment Period
	ALTCS/EPD	ALTCS/EPD	PPL and 834 File	FTP Server	
DAILY ENROLLMENT NOTIFICATION New members to a Contractor, disenrolled or deceased, member demographic changes, other changes (rate code change)	All	All	834 File	Dial in to AHCCCS computer system and download the data file for batch processing.	Completes between 8:00 p.m. and 11:59 p.m. each night for the day's activity.
MONTHLY ENROLLMENT NOTIFICATION Files identify the total active population for each Contractor as of the first of the next month	All	All	834 File	FTP Server	

V. REFERENCES

- 9 A.A.C. 22 Article 1
- 9 A.A.C. 22 Article 12
- A.R.S. §36-3401
- A.R.S. §36-3407
- ACOM Policy 401
- ACOM Policy 403
- ACOM Policy 404
- ACOM Policy 408
- ACOM Policy 426
- AMPM Chapter 500
- AMPM Chapter 1600
- 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
- Technical Interface Guidelines (TIG)

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

EFFECTIVE DATE: 10/01/00

REVISION DATE: 08/01/01

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

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

This policy delineates the rights, obligations and responsibilities of:

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

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

II. DEFINITIONS

ALTCS LOCAL OFFICE	The ALTCS local office currently responsible for the member's financial eligibility case record.
ANNIVERSARY DATE	The month for which the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter.
CHOICE COUNTY OR GEOGRAPHIC SERVICE AREA (GSA)	A county or GSA with more than one ALTCS Contractor.
COUNTY OF FISCAL RESPONSIBILITY	The county that is financially responsible for the State's share of ALTCS funding.

CURRENT CONTRACTOR:	The Contractor with whom the member is enrolled at the time the change request is generated.
DAY:	Day means a calendar day unless otherwise specified.
RECEIVING CONTRACTOR:	The Contractor to whom the member is being changed.
REQUESTED CONTRACTOR:	The Contractor to whom the member wants to change.

III. POLICY

Some, but not all, ALTCS applicants and members who reside in a choice county or who are planning to move to a choice county must be offered an opportunity to choose a Contractor.

A. ENROLLMENT CHOICE IN A CHOICE COUNTY

1. Individual Entitled to Enrollment Choice

   An individual is entitled to enrollment choice when:

   a. An applicant resides in a choice county and a choice county is the county of fiscal responsibility.
   b. A member moves from another county to his or her own home in a choice county, unless the member's current Contractor is available in the choice county.
   c. A member moves from another county to a nursing facility or alternative residential setting in a choice county and the current Contractor has chosen to negotiate an enrollment change.
   d. A member is currently enrolled with a Contractor serving a choice county, but a valid condition exists (see Section B) for requesting an enrollment change to another Contractor serving a choice county.
   e. A former member resides in a choice county and reestablishes eligibility that results in reenrollment more than 90 days after disenrollment.
   f. A member attains the annual anniversary date.

2. Individual Who Does Not Have Enrollment Choice

   This policy does not apply to the following individuals:

   a. A member who is developmentally disabled
   b. A member who is a Native American with on-reservation status
   c. A choice county resident whose county of fiscal responsibility is not a choice county (unless the current Contractor chooses to negotiate a change to that choice county)

d. A member who was disenrolled from a Contractor in a choice county, but subsequently reestablishes ALTCS eligibility that results in reenrollment within 90 days from disenrollment.
e. Residents of counties other than a choice county, unless a choice county is the county of fiscal responsibility.
f. A member who moves to a choice county and his or her current Contractor is available in that choice county.

3. INITIAL ENROLLMENT PROCESS

The initial enrollment process is used to obtain enrollment choice from an ALTCS/EPD applicant whose county of fiscal responsibility is a choice county.

STAGE	DESCRIPTION
1	ALTCS staff provides the applicant with: • An explanation of enrollment choice • Marketing materials from the Contractors serving the choice county. • Assistance in choosing a Contractor
2	ALTCS Staff obtains an enrollment choice before the application is approved.
3	Ongoing enrollment is prospective, effective the date the application is approved. Prior period coverage is effective retroactive to the first day of the first eligible month, unless the member is being transferred from an acute Contractor to an ALTCS Contractor.

4. Re-enrollment After Disenrollment

When a member, whose county of fiscal responsibility is a choice county, is disenrolled due to loss of ALTCS eligibility, but is subsequently determined eligible within 90 days from the date of disenrollment, the member will be reenrolled with the former Contractor, if that Contractor is still available. If that Contractor is not available, the member will be given the opportunity to choose a Contractor.

When reenrollment occurs more than 90 days after the disenrollment, or another valid reason for change exists, the member will be given the opportunity to choose a Contractor.

When a member is reenrolled within 90 days, the anniversary date is determined by the previous enrollment date. The member may choose to enroll with a different Contractor on his/her anniversary date, which is established by the initial enrollment with that Contractor.

5. ENROLLMENT CHOICE PROCESS FOR FISCAL COUNTY CHANGES

An enrollment choice must be obtained before a member's enrollment can be changed to a Contractor serving a choice county. The enrollment choice process applies to an ALTCS member who moves to a choice county to:

a. His or her own home
b. A nursing facility or alternative residential setting and the current Contractor requests an enrollment choice in order to negotiate an enrollment change with a Contractor in a choice county.

The enrollment choice process consists of the following steps:

STEP	ACTION
1	The ALTCS local office provides the member with: • an explanation of enrollment choice • marketing materials from each of the Contractors serving a choice county The member is asked to provide a choice prior to actually moving or within 10 days of our request.
2	The ALTCS local office provides the member with assistance in making the decision throughout the process.
3	When the member does not make a choice within 10 days, the ALTCS local office sends an Enrollment Choice Reminder Notice asking the member to provide a choice within the next 10 days.

B. IDENTIFYING & PROCESSING REQUESTS FOR CONTRACTOR CHANGES WITHIN A CHOICE COUNTY

Generally, once enrollment occurs a member cannot change enrollment until their anniversary date. This is called Annual Enrollment. However, an enrollment change from one choice county Contractor to another choice county Contractor can be made for certain reasons.

1. Medical Continuity of Care Requests

In unusual situations, special Contractor changes may be approved on a case-by-case basis to ensure the member's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

The following special process is required:

STEP	ACTION
1	The member's PCP must provide documentation to the Medical Directors of both Contractors that support the need for a Contractor change. Both Contractors must be reasonable in the request for documentation.
2	The Medical Directors of both Contractors must approve the change. • In order to provide continuity of care on a temporary basis for the member's period of illness, the current Contractor may agree to reimburse the member's provider for service rather than approve a Contractor change. • If one of the Contractors denies the request, the change request is forwarded to the AHCCCS Medical Director for a final decision.
3	When both Contractors approve the change the receiving Contractor sends the completed Program Contractor Change Request Form (DE-621) to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations. When the requested Contractor denies the request, the DE-621 is returned to the current Contractor who may forward the DE-621 to the AHCCCS Medical Director.
4	If the AHCCCS Medical Director approves the change, the DE-621 is returned to the current Contractor to negotiate the effective date of the change. The current Contractor sends the DE-621 to the Program Contractor Change Request Coordinator at AHCCCS Central Office Field Operations.
5	The Program Contractor Change Request Coordinator processes the change.
6	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors.

2. Valid Conditions (Excluding Medical Continuity of Care)

When any of the following conditions exist, an ALTCS local office may authorize a change of Contractors within a choice county.

a. Erroneous network information or agency error: The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, PCP or other provider contracting with the chosen Contractor based on information supplied by the network database, marketing materials, or agency error. Erroneous information includes omissions or failure to divulge network limitations and restrictions in the Contractor's marketing material or database submissions.

b. Lack of initial enrollment choice: An ALTCS applicant residing in a choice county is, for any reason, not offered a choice of Contractors during the application process.
c. Lack of annual enrollment choice: The member was entitled to participate in an Annual Enrollment Choice but was not sent an Annual Enrollment Choice notice or the notice was not received, or was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control (i.e., member or representative was hospitalized, anniversary date fell within a 90 day disenroll/reenroll period).
d. Family continuity of care: The member, either through auto-assignment or the choice process, is not enrolled with the same Contractor as the other family members. To promote continuity of care, family members, such as married couples, may choose to be enrolled with the same Contractor.
e. Continuity of institutional or residential setting: The member's Contractor terminates their contract with the institutional or residential setting in which the member resides, and the member or the member's representative requests to change to a Contractor who contracts with their institutional or residential setting. The member must be enrolled and living in the facility at the time of the contract termination.
f. If the provider (nursing facility or alternative residential setting) terminates the contract, the Local Office will request instructions from the Division of Health Care Management/ALTCS Unit before making any changes.
g. Failure to correctly apply the 90-day reenrollment policy: The member lost ALTCS eligibility and was disenrolled, was subsequently reapproved for ALTCS within 90 days of the disenrollment date, but was enrolled with a different Contractor.

3. Processing Enrollment Change Requests

The following procedures apply when a member requests a change of Contractors within a choice county

WHEN…	THEN…
The member makes the request for a change to the Contractor and claims a valid condition exists (see pages 7 and 9).	The Contractor will report the request to the Local ALTCS Office using the ALTCS Member Change Report Form (DE-701).
The ALTCS local office receives a change request from a Contractor or a member	The ALTCS local office will investigate the request to determine if a valid condition exists.
The ALTCS local office determines that a valid change condition exists	The ALTCS local office will change the member's enrollment to the Contractor the member chooses. The enrollment change is effective the day the change is processed by the ALTCS local office.
The ALTCS local offices determines that the nursing facility or alternative residential setting terminated the contract	The ALTCS local office will send written request to the DHCM ALTCS Unit Manager and may change the enrollment only if approved in the response.

WHEN…	THEN…
The ALTCS local office determines that a valid situation does not exist	The ALTCS local office will: • Send the member a Denial of Program Contractor Change Request (DE-548) denying the request and giving the member the right to appeal the decision. • Refer the member to his or her current Contractor for resolution of existing issues.

C. FISCAL COUNTY AND ENROLLMENT CHANGE POLICIES

1. Placements by a Contractor

   When a Contractor places a member in a nursing facility or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the Contractor's county), the county of fiscal responsibility and enrollment do not change.

2. Moves initiated by the member or the member's family

   When a member moves from one county to another county, the county of fiscal responsibility and enrollment are determined according to the following policies:

IF THE MEMBER MOVES TO…	THEN…
His or her own home	<u>County of Fiscal Responsibility</u> • The county of fiscal responsibility changes to the (new county) county in which the home is located. <u>Enrollment</u> • Enrollment remains unchanged if the same Contractor serves both counties • Enrollment changes if the member moves to a county served by a different Contractor. • The Enrollment Choice process must be completed prior to enrollment and fiscal county changes if the home is located in a choice county and the current Contractor is not available in that choice county.

IF THE MEMBER MOVES TO…	THEN…
A nursing facility or an alternative residential setting	• The county of fiscal responsibility and enrollment will remain unchanged unless the current Contractor successfully negotiates a change with a Contractor serving the new county. • The Enrollment Choice process must be completed prior to the negotiation process when the member moves to a choice county.

3. Uncoordinated Moves by the Member

   The Contractor is responsible for explaining the service limitations and exclusions to members who move out of the Contractor's service area.

   The current Contractor is liable only for those services authorized by an ALTCS member's case manager.

D. MEMBER MOVES TO OWN HOME IN ANOTHER COUNTY

When a member resides in his or her own home the following policies apply:

a. The county of fiscal responsibility is the county where the member's or child's parents home is located.
b. Enrollment is with a Contractor serving the geographic service area (or fiscal county) where the home is located.
c. When the member moves to his or her own home in a choice county, and is not already enrolled with a Contractor serving that choice county, the member must be given an opportunity to choose a Contractor. The member will be enrolled with the Contractor selected through the enrollment choice process.
d. The enrollment change and the change in county of fiscal responsibility cannot occur until the enrollment choice process is completed.

1. Member's Responsibilities

   The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Contractor Responsibilities

   The current Contractor is responsible for:
   a. Notifying the ALTCS local office that the member moved by sending a Member Change Report (DE-701),
   b. Explaining service limitations and exclusions to a member who moves out of the Contractor's service area, and
   c. Transitioning the member to the new Contractor, which includes forwarding medical records and other materials to the receiving Contractor.

3. ALTCS Local Office Responsibilities

   The ALTCS local office is responsible for:
   a. Completing the enrollment choice process for members changing to a choice county,
   b. Changing the member's living arrangement (if appropriate) and address when the move occurs,
   c. Making necessary changes in the county of fiscal responsibility and enrollment, and
   d. Making changes to eligibility and share of cost arising from the change in the member's living arrangement.

4. Enrollment Change Procedures

   The ALTCS local office will complete the following steps:

STEP	ACTION
1	Determine if the county of fiscal responsibility and enrollment need to be changed. (The county of fiscal responsibility and enrollment may already be correct.) • If a change is required, proceed to Step 2. • If no change is needed, update the address and living arrangement, and share of cost, if necessary.
2	Complete the Enrollment Choice Process if enrollment needs to be changed to a Contractor serving a choice county. When the member is unable or unwilling to make a choice the current ALTCS local office will either select a Contractor for the member or permit auto assignment to a Contractor by PMMIS in accordance with the criteria in the Eligibility Policy Manual.
3	Process fiscal county and enrollment changes.
4	Determine if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

E. MEMBER MOVES TO A NURSING FACILITY OR ALTERNATIVE RESIDENTIAL SETTING IN ANOTHER COUNTY

When the current Contractor provides services to the county where the member is moving, the enrollment and county of fiscal responsibility do not change.

When the current Contractor chooses to contract with the nursing facility or alternative residential setting, the enrollment and county of fiscal responsibility do not change.

When the current Contractor requests an enrollment change, the approval of both the current and the requested/receiving Contractor is required.

When the member moves to a choice county, the enrollment choice process must be completed before the current Contractor can initiate negotiations with a requested Contractor.

When the receiving/requested Contractor does not agree to the change, the current Contractor may request a decision from the AHCCCS Medical Director.

1. Member's Responsibilities

   The member is responsible for reporting the move or anticipated move to the current Contractor and the ALTCS local office.

2. Current Contractor Responsibilities
   a. When the current Contractor is notified that a member has moved to another county or plans to move to another county, and the member resides or plans to reside in a nursing facility or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:
      i. Retain the member and contract with an out of county provider,
      ii. Negotiate an enrollment change, or
      iii. Pay facility expenses for a limited number of days while plans are being made to move the member to a contracted facility. If the member refuses to move to a contracted facility, follow the non-user procedures in the AHCCCS Eligibility Policy Manual.
   b. When enrollment change is the preferred option, the current Contractor is responsible for:
      i. Calling the ALTCS local office and requesting an enrollment choice when the move is to a choice county
      ii. Completing a Program Contractor Change Request (DE-621) and sending it to the Contractor serving the GSA or the requested choice county Contractor, and
      iii. Transitioning the member when a change is approved.

3. ALTCS Local Office Responsibilities

a. General Responsibilities;
   The ALTCS local office is responsible for:
   i. Assuring that the current Contractor is aware of the move or the member's plan to move, by contacting the current Contractor and advising the member to contact the current Contractor
   ii. Informing the member that the current Contractor:
   iii. Must be involved in the placement change
   iv. Is only liable for services authorized by the case manager
   v. Changing the member's address when the move is verified, and
   vi. Determining whether to retain or transfer the eligibility case file based on the case file transfer policy in the Eligibility Policy Manual.
b. Enrollment Choice for Transfers to a Choice County
   When enrollment choice is requested by the current Contractor, the ALTCS local office is also responsible for:
   i. Informing the member about enrollment choice
   ii. Providing marketing materials to the member
   iii. Providing assistance to the member as necessary, and
   iv. Obtaining an enrollment choice from the member and notifying the current Contractor.

4. Requested Contractor's Responsibilities

   When a Program Contractor Change Request (DE-621) is received the requested Contractor is responsible for:
   a. Approving or denying the change request by completing the DE-621, and
   b. Transitioning the member when the change request is approved or the AHCCCS Medical Director directs the change.

5. AHCCCS Medical Director's Responsibilities

   The AHCCCS Medical Director determines whether an enrollment change is appropriate when the receiving/requested Contractor denies the enrollment change and the current Contractor requests review by the AHCCCS Medical Director.

   If approved, a written decision is issued to the current Contractor. If denied, a written notice of the denial including notice of appeal rights is issued to the current Contractor, the receiving/requested Contractor and the member.

6. AHCCCS Central Office Field Operations Responsibilities

   The AHCCCS Central Office Field Operations is responsible for:
   a. Processing enrollment and county of fiscal responsibility changes, and
   b. Sending the ALTCS local office a copy of the DE-621.

F. Enrollment Change Process

The following steps are involved in the enrollment change process:

STEP	ACTION
1	The member moves or indicates a desire or plan to move to a nursing facility or alternative residential setting in another county.
2	When advised of the move the ALTCS office: • notifies the current Contractor, • advises the member to contact the current Contractor, and • warns the member about limitations on services received from out-of-network providers.
3	When the move has been verified, the ALTCS local office changes only the member's address/living arrangement, not the county of fiscal responsibility.
4	When the move is to a choice county: • The current Contractor asks the ALTCS local office to complete the Enrollment Choice Process. • The ALTCS local office obtains an enrollment choice and informs the current Contractor.
5	The current Contractor completes a Program Contractor Change Request (DE-621) and sends it to the Contractor serving the new county of residence. In a choice county this will be the requested Contractor. If the Contractor serving the new county of residence denies the request, the current Contractor may forward to the AHCCCS Medical Director for a final decision.
6	When the Contractors or the AHCCCS Medical Director approves a change, the Program Contractor Change Request Coordinator at AHCCCS Central Office processes the enrollment and county of fiscal responsibility changes and notifies the ALTCS local office. The current Contractor will forward medical records and other materials to the receiving Contractor.
7	If the change request is denied by the AHCCCS Medical Director, the Division of Health Care Management/ALTCS Unit will provide written notice of the denial including notice of appeal rights to the member and to both the current and receiving/requested Contractors. When the change is denied, the current Contractor continues to provide services to the member.
8	The ALTCS local office determines if the eligibility case record should be transferred according to the criteria in Eligibility Policy Manual.

G. The Contractor's Responsibilities

1. Provide Contractor change policy

   Contractors are responsible for providing information on the Contractor change policy in:
   a. The Member Handbook for new and existing members, and
   b. The Provider Manual for providers

2. Address members' concerns

   The current Contractor is responsible for promptly addressing members' concerns regarding availability and accessibility of services and quality of medical care. These issues include but are not limited to:
   a. Quality of care
   b. Case management responsiveness
   c. Transportation service availability
   d. Institutional care issues
   e. Physician or provider office hours
   f. Office waiting time, and
   g. Network limitations and restrictions.

3. Refer unresolved issues

   When quality of care and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor must refer the issue for review by:
   a. The current Contractor's Quality Management Department and/or
   b. The AHCCCS Medical Director

4. Transitioning Between Contractors

   The current Contractor is responsible for:
   a. Reporting the member's address and living arrangement changes to AHCCCS
   b. Encouraging members to report anticipated moves to another county or geographic service area to them (current Contractor) and to the ALTCS local office prior to moving. Advance notice will facilitate continuity of service delivery.
   c. Advising members to contact the ALTCS local office to request an enrollment change between Contractors serving a choice county if a valid reason other than medical continuity of care is claimed.
   d. Accepting a member's request for an enrollment change to another county. The request may be verbal or in writing and may be addressed to the member's case manager.
   e. Forwarding medical records and other materials to the receiving Contractor.

Both the current Contractor and the receiving Contractor are responsible for assuring a safe transition for the member when an enrollment change occurs. The Contractors will transition within the requirements and protocols in the AHCCCS Medical Policy Manual, Chapter 500.

5. Process Members' Enrollment Change Requests

The Contractor will process enrollment change requests from members as follows:

WHEN THE MEMBER REQUESTS A CONTRACTOR CHANGE	THEN THE CURRENT CONTRACTOR
Within a choice county and the member claims a valid condition exists	Refers the issue to the ALTCS local office for review using the ALTCS Member Change Report (DE-701).
That requires the approval of both the current and the receiving Contractors	Notifies the ALTCS local office if the member lives in a choice county or is moving to a choice county to initiate the Enrollment Choice Process. Negotiates the change with the requested Contractor. Completes a DE-621 and forwards it to the requested Contractor. Notifies the member if the change is approved. May forward the DE-621 to the AHCCCS Medical Director if the requested Contractor denies the change. Notifies the member in writing if the enrollment change is denied at the Contractor level. The denial notice must include • the AHCCCS Program Contractor Grievance Policy, and • timeframes for filing a grievance.

6. Notify hospitals of certain enrollment changes

When an enrollment change occurs while the member is hospitalized, the current Contractor must notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor.

If the current Contractor fails to provide such notice to the hospital, the current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AHCCCS Medical Policy Manual, Chapter 500.

7. Process Grievances

   When an enrollment change requested by the member is denied by the Contractor (not the AHCCCS Medical Director), the current Contractor is responsible for processing any resulting grievances.

H. AHCCCS ADMINISTRATION'S RESPONSIBILITIES

1. Enrollment change requests received from members

   Except for valid changes within a choice county or a change due to the member moving to his or her own home, the AHCCCS Administration or the ALTCS local office will refer a member's request for an enrollment change to the current Contractor.

2. Process enrollment change requests

   The AHCCCSA will process enrollment change requests within 5 days after the request is received, or all conditions for processing an enrollment change have been met, whichever is later.

3. Issue decisions

   The AHCCCSA will notify Contractors of enrollment change approvals via the daily recipient roster. AHCCCSA will mail a new AHCCCS ID card to the member.

   AHCCCSA will send notification to both the current and receiving Contractors and the member when an enrollment change is denied by the AHCCCS Medical Director. When approved by the AHCCCS Medical Director, notification will be sent to the current Contractor.

4. Process Grievances

   When an enrollment change is denied by the AHCCCS Medical Director, AHCCCSA is responsible for processing all resulting member grievance.

   The Division of Health Care Management, ALTCS Unit sends the member a denial notice, which explains the Grievance System under 9 A.A.C. 34.

5. Monitor policy compliance

   The AHCCCS Division of Health Care Management (DHCM) will monitor Contractor compliance with this policy. Any violations of this policy, especially attempts to deny care or steer high cost or difficult members to another Contractor, will be considered contract violations and will be subject to sanctions up to and including contract termination.

IV. REFERENCES

- ALTCS Contract, Section D
- Arizona Administrative Code R9-28, Article 7
- AHCCCS Medical Policy Manual Chapter 500

404 – MEMBER INFORMATION

EFFECTIVE DATE: 06/01/12, 08/17/12, 11/01/12, 03/01/13, 10/01/13, 05/01/14, 12/01/14, 10/01/15

REVISION DATE: 06/09/09, 01/28/10, 08/12/10, 08/11/11, 05/18/12, 06/28/12, 10/24/12, 02/07/13, 07/18/13, 08/30/13, 04/17/14, 07/17/14, 11/20/14, 05/21/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes guidelines for AHCCCS Contractors regarding member information requirements and the approval process for member information materials developed by or used by the Contractor. This Policy pertains to oral and written communication disseminated to a Contractor's own members. It also pertains to the content of a Contractor's website.

II. DEFINITIONS

BUSINESS DAY	A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
FILE AND USE	A process whereby the Contractor submits qualifying member information materials to AHCCCS prior to use, and can proceed with distributing the materials without any expressed approval from AHCCCS.
INCENTIVE ITEM	Items that are used to encourage behavior changes in the Contractor's enrolled members or Health promotion incentives to motivate members to adopt a healthy life style and/or obtain health care services.
INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)	An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.

MEMBER INFORMATION MATERIALS

Materials given to the Contractor's members or potential enrollees. Member information includes but is not limited to:

- Informational material such as health and wellness brochures, member newsletters, videos, form letter templates, mass communications such as voice and text informational material sent to the member's phone and the Contractor's website content
- Retention materials sent to current members to target and maintain membership, and
- Instructional material such as member handbooks and provider directories and other new member materials

MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)

An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

POTENTIAL ENROLLEE

A Medicaid-eligible recipient who is not yet enrolled with a Contractor as described in 42 CFR 438.10 (a); or an enrollee during Annual Enrollment Choice (AEC).

RETENTION MATERIALS

Member information materials sent to members prior to and during their Annual Enrollment Choice for the purposes of retaining members as an enrollee with the Contractor.

TRIBAL/REGIONAL BEHAVIORAL HEALTH AUTHORITY (T/RBHA)

An organization under contract with the State of Arizona that administers covered behavioral health services for Title XIX and XXI members. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority (TRBHA) for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407, and A.A.C. R9-22-1201.

VITAL MATERIALS

Materials provided by a Contractor that include, at a minimum, notices for denials, reductions, suspensions or terminations of services, consent forms, communications requiring a response from the member, detailed description of Early Periodic Screening, Diagnostic and Treatment (EPSDT) services, informed consent and all grievance and request for hearing information as described in the "Enrollee Grievance System Standards" section of the applicable contract.

III. POLICY

A. MEMBER INFORMATION MATERIALS

The Contractor must comply with the requirements in this Policy for all member information materials. In addition, refer to the requirements outlined in ACOM Policy 425 for requirements regarding Social Networking activities.

The Contractor is required to report their member information costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any member information costs included in an allocation from a parent or other related corporation.

The Contractors Chief Executive Officer (CEO) (or designee) shall sign and submit Attachment D, Member Information Attestation Statement, to the designated Operations and Compliance Officer, as specified in the Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

B. LANGUAGE, READABILITY AND ORAL INTERPRETATION REQUIREMENTS

1. Language

   All member materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have Limited English Proficiency (LEP).

   All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP.

   All written notices informing members of their right to interpretation and translation services in a language, shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

   The Contractor is not required to submit to AHCCCS the member material translated into a language other than English. It is the Contractor's obligation to ensure the translation is accurate and culturally appropriate.

2. Readability

   The Contractor shall make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The Contractor should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale. Member information materials shall also be

available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

3. Oral Interpretation

   The Contractor must make oral interpretation services available to its members at no cost. Services for all non-English languages and the hearing impaired must be available.

C. INCENTIVES

The Contractor may offer incentives items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to members to participate in health-related promotions, but the total value of the items at each event or program may not exceed $50.00 per household. Incentives may not be given to members to influence continued enrollment with the Contractor, as specified in A.A.C. R9-22-504.

D. MATERIALS NOT REQUIRING SUBMISSION TO AHCCCS

Customized letters for individual members need not be submitted to AHCCCS as described in this Policy. Information sent by the Contractor to members enrolled in a Contractor's Medicare Dual Special Needs Plan (D-SNP) that clearly and exclusively relate to their Medicare benefits and services do not require submission to AHCCCS. Additionally, information sent to DDD and ADHS/DBHS members that clearly and exclusively relate to benefits related to their non-Medicaid programs do not require submission to AHCCCS.

Health related brochures developed by a nationally recognized organization included in Attachment A, do not require submission to AHCCCS. However, in the event the informational material provided by an approved organization references services that are not medically necessary or are not AHCCCS covered benefits, the Contractor may not distribute the organization's informational materials to members. The Contractor may use the organization's material only as a reference to develop its own member information materials specific to AHCCCS recipients.

Attachment A is not an all-inclusive list. The Contractor may submit names of other organizations to AHCCCS to determine if they should be added to the list. The Contractor should refer to this Policy for updates when considering using information from a nationally recognized organization. The Contractor will be held accountable for the content of materials developed by the organizations listed in Attachment A. The Contractor must review the materials to ensure that:

1. The services are covered under the AHCCCS program;

2. The information is accurate; and

3. The information is culturally sensitive.

It is important to note that in all instances where the Contractor is required by its contract with AHCCCS to educate its members, brochures developed by outside entities must be supplemented or replaced with informational materials developed by the Contractor which are customized for the Medicaid population.

E. GENERAL REQUIREMENTS, REVIEW, AND DISTRIBUTION OF CONTRACTOR MEMBER HANDBOOKS AND PROVIDER DIRECTORY

1. General Requirements
   a. All Contractors must annually produce a Member Handbook and Provider Directory.
   b. The Member Handbook shall contain all information required of the Contractor as identified in Attachment B, Member Handbook Checklist.
   c. The Member Handbook must be submitted as described in the section "Member Handbook Review Process" below.
   d. ADHS/DBHS is responsible for developing and providing a Member Handbook Template for Integrated RBHAs and T/RBHAs that contain all required information identified in Attachment B for those subcontractors.
   e. AHCCCS may require Contractors to publish information modifying or expanding the contents of the Contractors' Member Handbooks, and to distribute this information in the form of inserts and supply these inserts with subsequently distributed Handbooks.

2. Member Handbook Review Process

   Acute Care, ALTCS/EPD, CRS, CMDP, and DDD Member Handbooks and the ADHS/DBHS Member Handbook Templates must be submitted annually, and 30 days prior to any changes to AHCCCS for review and approval as specified in the Contract, Attachment F3, Contractor Chart of Deliverables or as directed by AHCCCS.

   DDD is responsible for the Member Handbooks and Provider Directory issued by its Acute Care subcontractors. ADHS/DBHS is responsible for the Member Handbooks and Provider Directory issued by an Integrated RBHA or TRBHA.

3. Member Handbook and Provider Directory Distribution Requirements

   Member Handbooks and Provider Directory must be provided to each member/ representative or household according to the following timeframes:
   a. Acute Care, ALTCS/EPD, CMDP, CRS, and DDD Contractors, and Integrated RBHAs must provide their members a Member Handbook and Provider Directory within 12 business days of receiving notification of the member's enrollment date.

b. T/RBHAs must provide a Member Handbook and Provider Directory within 12 business days of the member receiving his/her first service.

ALTCS/EPD, DDD, Integrated RBHAs and TRBHAs must provide a **printed** copy of the Member Handbook and Provider Directory to all members. ALTCS (EPD and DDD) Case Managers must also review the Handbook with the member annually and document this review.

All other Contractors have the option of providing the Member Handbook and Provider Directory in hard copy format with the new member packet, or providing the member written notification of how the Member Handbook and Provider Directory information is available to the member on the Contractor's website, via electronic mail or via postal mailing. Should the Contractor elect not to provide the Member Handbook or Provider Directory in hard copy format with the member packet the following provisions apply:

1. The Contractor must submit a request for approval to forgo provision of the hard copy 60 days in advance of the member notification as specified in the Contract, Attachment F3, Contractor Chart of Deliverables.

2. The contents of the member notification must be approved in accordance with this Policy.

3. The written notification must give the member the option to obtain a printed version of the Member Handbook.

4. The information shall be available within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3).

DDD may, at its discretion, require its Acute Care subcontractors to provide written notification that the subcontractor's Member Handbook and Provider Directory are available on the subcontractor's website, or upon request via electronic mail or by postal mailing.

Upon request, Integrated RBHAs and T/RBHAs must provide copies of the Member Handbook to known consumer and family advocacy organizations and other human service organizations in each geographic service area.

F. PROVIDER DIRECTORY CONTENT

1. Provider Directory
   a. Acute Care, ADHS/DBHS, ALTCS/EPD, CMDP, CRS, and DDD
      The Provider Directory shall, at a minimum, contain information about primary care providers, specialists, hospitals and pharmacies. ALTCS/EPD and DDD Contractors shall also include skilled nursing facilities and alternative residential settings.

The Provider Directory shall include:
i. Provider name
ii. Provider address
iii. Provider telephone number
iv. Non-English languages spoken
v. Whether or not the provider is accepting new patients
vi. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract

The Contractor must also include the following provider and MSIC specific information:
i. Specialty Provider and MSIC names
ii. Specialty Provider and MSIC address
iii. Specialty Provider and MSIC telephone number
iv. Non-English languages spoken by providers
v. Whether or not the specialty provider is accepting new patients

The Provider Directory shall also include any restrictions on the member's freedom of choice among network providers and MSICs. This information must be current and can be in the same form as typical correspondence to members.

Contractors who elect to provide notification that the information is available for the Provider Directory information on their website, by electronic mail or by postal mailing must follow the same submission requirements as delineated for the Member Handbook.

b. Additional Requirements for CRS
In addition to the requirements described above, the CRS Provider Directory shall, at a minimum, contain information about CRS providers, specialists, hospitals and pharmacies. The Provider Directory will include:
i. Physicians (including adult and child psychiatrists), laboratory, x-ray and therapy services available onsite at the MSIC and through a network of community-based providers closer to members' homes
ii. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State
iii. Community-based, family support providers in urban, suburban and rural areas of the State

G. REQUIRED CONTRACTOR WEBSITE CONTENT FOR MEMBERS, MINIMUM CONTENT REVIEW

1. Acute Care, ALTCS/EPD, CMDP, CRS, DDD, and ADHS/DBHS

The Acute Care, ALTCS/EPD, CMDP, CRS, DDD, and ADHS/DBHS websites shall contain all the information provided in Attachment B, Member Handbook Checklist, and Attachment C, Contractor Website Certification Checklist and Attestation. The Contractor may meet many of these requirements by providing the updated Member Handbook on its website. The Contractors must sign and submit the Contractor Website Certification Checklist and Attestation verifying their website is current and contains all of the AHCCCS required information. Website content must also meet the requirements in ACOM Policy 416.

All of the information must be located on the Contractor's website in a manner that members can easily find and navigate (e.g. "Consumer, Enrollee, Member or Recipient Page" from the Contractor's home page).

Websites must be specific to the Contractor's Medicaid program and must not include links or references to private insurance. The website may contain links and references to the Contractors' Medicare programs and services exclusively to promote coordination of care for members enrolled in both Medicaid and Medicare.

For the approval process for additional information added to the Contractor's website that is directly related to members or potential members, see subsection III. H.

The Contractor will submit the Contractor Website Certification Checklist and Attestation (see Attachment C) annually, as specified in the Contract, Attachment F3, Contractor Chart of Deliverables. The Division of Health Care Management will review the content of the Contractor's website to ensure the Contractor is in compliance with this Policy and the AHCCCS contract.

ADHS/DBHS and its subcontractors must have a website with links to the following information:

a. Drug List
b. Provider manual
c. Member Handbook
d. Provider Directory

H. SUBMISSION, REQUIREMENTS AND RESTRICTIONS FOR ALL OTHER MATERIALS

The Contractor shall inform all members of any changes considered to be significant by AHCCCS, 30 calendar days prior to the implementation date of the change [42 CFR 438.10(f)(4)]. These changes include but are not limited to:

- Cost sharing,
- Prior Authorization,
- Service delivery,
- Covered Services.

In addition, the Contractor must make a good faith effort to give written notice to enrollees within 15 calendar days after receipt or issuance of a provider termination notice to each member who received their primary care from, or is seen on a regular basis by, the terminated provider. [42 CFR 438.10(f)(5)].

1. Submission
   AHCCCS has adopted a File and Use review process for all other member information materials developed by the Contractor. All other member information materials disseminated by the Contractor to its members must be submitted via electronic mail to the Contractor's AHCCCS Operations and Compliance Officer 30 calendar days before it is to be released.

   The Contractor shall submit the following information to AHCCCS prior to releasing member information materials:
   a. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its members or potential members
      i. Translations of the material into other languages as required by this Policy are not required to be submitted
   b. A description of the process it will use to disseminating the material
   c. The reading level of the material level as measured on the Flesch-Kincaid scale

   The Contractor may disseminate the member information as indicated in their request unless AHCCCS notifies the Contractor otherwise within 30 calendar days from submission. AHCCCS reserves the right to require any changes necessary to the material. AHCCCS may also conduct audits and/or operational reviews to ensure compliance.

   Member information materials can also be used for marketing purposes as defined in ACOM Policy 101. In these cases, the materials must receive prior approval from AHCCCS as outlined in Figure 1 and ACOM Policy 101. In addition, for social networking applications and content requirements, refer to ACOM 425.

2. Requirements and Restrictions
   a. All materials must be labeled with the Contractors name and/or logo; this includes member material that is located on the Contractor's website, e-mail messages and voice recorded phone messages delivered to a member's phone.
   b. The Contractor must ensure that the information contained within the material item is accurate, updated regularly and appropriately based on changes in benefits, Contract, Policy or other relevant updates.
      i. Any updated information must be re-submitted and tracked on the Contractor's log, as described in this section
   c. The Contractor must keep a log of all member material distributed each year; the log must identify the date the materials was originally submitted to AHCCCS as described in section H, 1 above
   d. The Contractor must make the log available to AHCCCS upon request

e. Member information materials developed for services under contract with AHCCCS are not considered proprietary to the Contractor
f. Member information materials cannot directly or indirectly refer to the offering of private insurance, cannot include inaccurate, misleading, confusing or negative information about AHCCCS or the Contractor, or any information that might defraud members
g. Member information materials cannot use the word "free" in reference to covered services
h. Member information materials must directly relate to the administration of the Medicaid program, or relate to health and welfare of the member
i. Member information materials cannot have political implications
j. Retention materials cannot refer to competing plans

FIGURE 1 - GUIDELINES OVERVIEW

IN REFERENCE TO		
MEMBERS	**THE PUBLIC***	**MEMBERS AND THE PUBLIC***
ACOM Policy 404	ACOM Policy 101	ACOM Policies 101 and 404
DEFINITION		
MEMBERS	**THE PUBLIC***	**MEMBERS AND THE PUBLIC***
Any materials given to the Contractor's current members	Materials (brochures, giveaways and other items) that are distributed to the public that can reasonably be interpreted as intended to influence enrollment with the contractor	Any materials intended to be distributed to both the members and the public
PROCESS TO RECEIVE AHCCCS APPROVAL		
MEMBERS	**THE PUBLIC***	**MEMBERS AND THE PUBLIC***
Send to Operations Compliance Operator (OCO)	Send to the Marketing Committee	Send to the OCO, who will coordinate the review with the Marketing Committee
File and Use rules apply for many materials	No file and use, except when information targets dual members and is already approved by CMS	

*The public and/or others who are not recipients enrolled with the Contractor

IV. REFERENCES

- Acute Care Contract, Section D, E
- ADHS/DBHS Contract, Section D, E
- ALTCS/EPD Contract, Section D, E
- CRS Contract, Section D, E
- DCS/CMDP Contract, Section D, E
- DES/DDD Contract, Section D, E
- Contract Section F, Attachment F3, Contractor Chart of Deliverables
- A.A.C. R9-22-504 A.A.C. R9-22-201
- A.A.C. R9-22-1201
- A.R.S. §36-3401
- 42 CFR 438.10(a)
- 42 CFR 438.10(f)(4)
- 42 CFR 438.10(f)(5)
- ACOM Policy 101
- ACOM Policy 416
- ACOM Policy 425
- Attachment A, National Organizations Recognized by AHCCCS
- Attachment B, Member Handbook Checklist
- Attachment C, Contractor Website Certification Checklist and Attestation
- Attachment D, Member Information Attestation Statement

ATTACHMENT A, NATIONAL ORGANIZATIONS RECOGNIZED BY AHCCCS

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, MEMBER HANDBOOK CHECKLIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, CONTRACTOR WEBSITE CERTIFICATION CHECKLIST AND ATTESTATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, MEMBER INFORMATION ATTESTATION STATEMENT

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

405 - CULTURAL COMPETENCY AND FAMILY/PATIENT CENTERED CARE

EFFECTIVE DATE: 03/02/00, 10/01/12, 05/01/14

REVISION DATE: 11/16/10, 01/01/11, 10/02/12, 04/17/14

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This purpose of this Policy is to outline the requirement that Contractors offer accessible and high quality services in a culturally competent manner.

II. DEFINITIONS

COMPETENT	Properly or well qualified and capable.
CULTURAL COMPETENCY	An awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.
CULTURE	The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age.
LIMITED ENGLISH PROFICIENCY (LEP)	Not being able to speak, read, write or understand the English language at a level that permits one to interact effectively with health care providers or the Contractor.
MEMBER	A person eligible for AHCCCS, who is enrolled with a Contractor.
PROVIDER	A person or entity that is registered with AHCCCS and/or subcontracts with an AHCCCS Contractor to provide AHCCCS covered services to members.
SUBCONTRACTOR	A person, agency or organization to which a Contractor has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leased of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.

III. POLICY

A. CULTURAL COMPETENCY PLAN

The Contractor must have a comprehensive cultural competency program, which is described in a written plan. The Cultural Competency Plan (CCP) must describe how care and services will be delivered in a culturally competent manner [42 CFR 438.206(C)(2)]. CCP's shall contain the information provided in Attachment A, Cultural Competency and Family/Patient Centered Care Evaluation and Plan Checklist.

The Contractor must identify a staff member responsible for the CCP. If there is a change in the staff member responsible for the CCP, the Contractor must notify the Division of Health Care Management (DHCM).

The CCP must contain a description of:

1. Education and Training
   a. The training program consists of the methods the Contractor will use to train its staff so that services are provided effectively to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.
   b. The education program consists of methods the Contractor will use for providers and other subcontractors with direct member contact. The education program will be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner. The Contractor must also make additional efforts to train or assist providers and subcontractors in receiving training in how to provide culturally competent services.

2. Culturally Competent Services and Translation/Interpretation Services

   The Contractor describes the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the Contractor evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It must also describe the provision and coordination needed for linguistic and disability-related services. The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation service. A Contractor, at the point of contact, must make members aware that translation services are available. The services that are offered must be provided by someone who is proficient and skilled in translating language(s).

The Contractor must provide translations in the following manner:

a. All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10% (whichever is less) of the Contractor's members who also have Limited English Proficiency (LEP) in that language.
b. All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5% (whichever is less) of the Contractor's members who also have LEP in that language. Vital materials must include, at a minimum, notices for denial, reduction, suspension or termination of services, vital information from the member handbook and consent forms.
c. All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5% (whichever is less) of the Contractor's members speak that language and have LEP.

B. EVALUATION AND ASSESSMENT OF CCP

The Contractor must evaluate the CCP for effectiveness. Evaluations along with any modifications to the CCP are to be made on an annual basis and a copy of the Cultural Competency Plan Assessment submitted to the designated Operations and Compliance Officer 45 days after the start of the contract year. The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member complaints, grievances, provider feedback and/or Contractor employee surveys. If issues are identified, they should be tracked and trended, and actions should be taken to resolve the issue(s).

C. CRS FAMILY CENTERED AND CULTURALLY COMPETENT CARE

The CRS Contractor will provide family-centered care in all aspects of the service delivery system. As per AMPM 330, Covered Conditions and Services for the Children's Rehabilitative Services (CRS) Program, the additional responsibilities of the CRS Contractor, in support of family-centered care, include but are not limited to:

1. Recognizing the family as the primary source of support for the recipients' health care decision-making process. Service systems and personnel should be made available to support the family's role as decision makers.

2. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:
    a. Care of the member;
    b. Development, implementation, and evaluation of programs; and
    c. Policy development.

3. Promoting a complete exchange of unbiased information between recipients, families, and health care professionals in a supportive manner at all times.

4. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.

5. Implementing practices and policies that support the needs of recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.

6. Participating in Family-Centered Cultural Competence Trainings.

7. Facilitating family-to-family support and networking.

8. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.

9. Acknowledging that families are essential to the members' health and wellbeing and are crucial allies for quality within the service delivery system.

10. Appreciate and recognize the unique nature of each recipient and their family.

IV. RESOURCES

http://www.ahrq.gov/research/index.html- Minority Health
http://innovations.ahrq.gov/CulturalCompetence.aspx- Honing Cultural and Linguistic Competence
http://www.ahrq.gov/health-care-information/informacion-en-espanol/index.html- Información en español
http://www.diversityrx.org/topic-areas/cultural-competence-101- Cultural Competence 101
http://minorityhealth.hhs.gov/ - Office of Minority Health, (Choose the Cultural Competency tab)
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 - Office of Minority Health, The National CLAS Standards
http://nccc.georgetown.edu/ - National Center for Cultural Competence
http://www.ahrq.gov/research/data/hcup/index.html- Agency for Healthcare Research and Quality
www.lep.gov – Limited English Proficiency (LEP) – A Federal Interagency Website
http://www.lep.gov/guidance/guidance_DOJ_Guidance.html - LEP Page
www.languageline.com - Translation Service
www.cyracom.net - Translation Service
www.xculture.org - Cross Cultural Health Care Program (CCHCP)
http://minorityhealth.hhs.gov/ - From the home page choose Cultural Competency then choose About the Center for Linguistics and Cultural Competence in Health Care (CLCCHC)
http://www.samhsa.gov - Substance Abuse and Mental Health Services Administration (Children's Issues)
http://www.ama-assn.org/ - Search "Cultural Competency to link to Cultural Competency Issues
www.cdcnpin.org/scripts/population/culture.asp - Centers for Disease Control
http://cecp.air.org/cultural/default.htm - Center for Effective Collaboration and Practice

http://www.childrensnational.org/emsc/ - Emergency Medical Services for Children, Search "Cultural Competency" from the home page
Americans with Disabilities Act: 42 U.S.C., Chapter 126
Balanced Budget Act of 1997 (BBA)
National Standards of Culturally and Linguistically Appropriate Health Care, Volume 65 of the Federal Register (65 Fed. Reg.) 80865-80897 (December 22, 2000)
Title VI of the Civil Rights Act: Title 42 of the United States Code (42 U.S.C.) 2000d (see 45 C.F.R. 80, app. A (1994)
Title VI Prohibition Against National Origin Discrimination as it Affects Persons with Limited English Proficiency, 68 Fed. Reg. 47311, (August 8, 2003)

V. REFERENCES

- 42 CFR 438.206(c)(2)
- 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
- AMPM 330
- Attachment A, Cultural Competency and Family/Patient Centered Care Evaluation and Plan Checklist

ACOM POLICY 405, CULTURAL COMPETENCY EVALUATION AND PLAN CHECKLIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

406 – RESERVED

407 – RESERVED

408 - SANCTIONS

EFFECTIVE DATE: 10/01/03, 10/01/12, 11/01/12, 10/01/15

REVISION DATE: 09/26/12, 10/09/12, 09/17/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy specifies the sanctions which may be imposed by the AHCCCS Division of Health Care Management (DHCM) in accordance with Federal and State laws, regulations and the AHCCCS contract. This Policy does not limit the authority of the AHCCCS Office of the Inspector General to investigate fraud, waste and abuse, conduct audits, and pursue any legal remedies arising from the findings of those investigations and audits.

II. DEFINITIONS

CORRECTIVE ACTION PLAN (CAP) A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

NOTICE TO CURE (NTC) A formal written notice to a Contractor regarding specific non-compliance. The NTC contains specific timelines for meeting performance standards and possible penalties for continued non-compliance. An NTC may contain specific activities or reporting requirements that must be adhered to as the Contractor works toward compliance. Failure to achieve compliance as the result of a Notice to Cure may result in the imposition of a Sanction.

SANCTION A monetary and/or non-monetary penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility. Non-monetary penalties may include, but are not limited to: appointment of temporary management for the Contractor; granting the Contractor's enrollees the right to terminate enrollment with the Contractor; suspension of auto-assignment and/or new enrollment; and/or suspension of payment to the Contractor until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

III. POLICY

A. GENERAL

AHCCCS expects the Contractor to align its performance of the contract with the AHCCCS mission and vision and implement program innovation and best practices on a continual basis while adding value to the AHCCCS program.

In the event the Contractor fails to demonstrate compliance with contractual requirements, AHCCCS may elect to impose an administrative action. AHCCCS reserves the right to issue an administrative action for any occurrence of non-compliance. Each occurrence of non-compliance will be evaluated for determination and issuance of potential administrative action. Administrative actions may include issuance of any or all of the following: Notice of Concern, Notice to Cure, a mandate for a Corrective Action Plan, and Sanctions. The administrative actions described in this Policy are non-exclusive; that is, the issuance of an administrative action or the imposition of any particular sanction by AHCCCS does not preclude AHCCCS from pursuing any other remedy available in law or contract arising from the same conduct.

To promote transparency, administrative actions and related documentation may be published on the AHCCCS website.

B. AHCCCS COMPLIANCE COMMITTEE

1. With the exception of encounter-related sanctions for aged, pended encounters as outlined in the AHCCCS Encounter Manual, and encounter data validation sanctions as outlined in the AHCCCS Encounter Data Validation Technical Document, the AHCCCS Compliance Committee will evaluate recommendations for proposed sanctions and will determine the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee, however, will regularly review encounter-related sanctions to ensure just and consistent application of such sanctions. The Compliance Committee may, but is not required to, review administrative actions that do not include a sanction such as issuing a Notice of Concern, a Notice to Cure, or requiring a Corrective Action Plan.

2. The Compliance Committee is comprised of the following individuals, or their designees:

   - AHCCCS Deputy Director,
   - AHCCCS Chief Medical Officer,
   - An attorney from the AHCCCS-Office of Administrative Legal Services (OALS), and
   - AHCCCS Assistant Directors from the Division of Health Care Management (DHCM).

3. The Compliance Committee may consult with subject matter experts as appropriate and shall consider the following in its decision making:
   a. Applicable statutes and rules and contractual requirements,
   b. Application of consistent standards for determination of sanction type and/or monetary penalty,
   c. The goals and objectives of the agency, and
   d. Aggravating or mitigating factors such as:
      i. Quality of care or safety concerns for members,
      ii. Repeated/continual deficiencies,
      iii. Previous administrative actions,
      iv. Intentional non-compliance,
      v. Self-identification of deficiencies and remediation,
      vi. Risk to the financial viability of the Contractor,
      vii. Non-compliance with key staffing requirements,
      viii. Financial implications for providers,
      ix. Financial harm to the state.

4. Upon the Committee's decision regarding the sanction, DHCM will provide written notification to the Contractor.

C. BASIS FOR IMPOSITION OF SANCTIONS

AHCCCS may impose sanctions for any breach of the contract, or any failure to comply with applicable State or Federal laws or regulations including but not limited to any conduct described in 42 CFR 438.700 et seq.

D. TYPES OF SANCTIONS

AHCCCS may impose the following types of sanctions:

1. Monetary Penalties:

   The amount of the monetary penalty may vary depending on the nature of the Contractor's action or failure to act as follows:
   a. The maximum of $25,000 may be imposed per occurrence for the following actions:
      i. Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members,
      ii. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider
      iii. Failure to comply with physician incentive plan requirements, and
      iv. Distribution directly, or indirectly through any agent or independent Contractor, of marketing or outreach materials that have not been approved by AHCCCS or that contain false or materially misleading information.
   b. The maximum of $100,000 may be imposed per occurrence for the following types of actions:
      i. Discrimination among enrollees on the basis of their health status or need for health care services, and

ii. Misrepresentation or falsification of information furnished to CMS or AHCCCS.

2. Member Enrollment Related Sanctions:

   AHCCCS may sanction a Contractor by:
   a. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll (If another Contractor is available);
   b. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction (If another Contractor is available); and
   c. Suspending payment for members enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

3. Temporary Management:

   AHCCCS retains the right to temporarily manage the Contractor consistent with the terms of the contract and 42 CFR 438.706.

4. Termination of the Contract:

   AHCCCS retains the right to terminate a contract consistent with the terms of the contract.

5. Additional Sanctions:

   AHCCCS may impose additional sanctions as provided under State Laws, regulations, or contract to address areas of non-compliance.

G. CONTRACTOR RIGHT TO APPEAL

The Contractor may dispute the decision to impose a sanction in accordance with A.A.C. R9-34-401 et seq.

H. NOTIFICATION TO CMS

For sanctions imposed or lifted pursuant to Medicaid Managed Care Regulations (42 CFR 438.700 et seq.), AHCCCS will provide CMS with written notice:

1. Whenever it imposes or lifts a sanction for any of the sanctionable items listed in 42 CFR 438.700.
   a. The notice will specify the Contractor, the type of sanction, and the reason for the imposition or lifting of the sanction; and
   b. The notice will be given no later than 30 days after it imposes or lifts a sanction.

IV. REFERENCES

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- A.A.C. R9-34-401 et seq.
- 42 CFR 438.700 et seq.
- AHCCCS Encounter Manual
- AHCCCS Encounter Data Validation Technical Document

409 - RESERVED

410 - RESERVED

411 - PRE-PAID MEDICAL MANAGEMENT INFORMATION SYSTEMS INTERFACE FOR ALTCS CASE MANAGEMENT

EFFECTIVE DATE: 05/01/05, 05/01/12, 10/01/13, 06/01/15

REVISION DATE: 05/01/12, 10/03/13, 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM CASE MANAGEMENT

I. PURPOSE

This Policy applies to ALTCS/EPD, DES/DDD (DDD), and Tribal Contractors, hereafter referred to as ALTCS Contractors. This Policy provides a tutorial on access to and data entry into the Client Assessment and Tracking System (CATS) sub-system of the AHCCCS mainframe computer system, Pre-Paid Medical Management Information Systems (PMMIS) for Arizona Long Term Care System (ALTCS) Case Management.

II. DEFINITIONS

AHCCCS CUSTOMER ELIGIBILITY (ACE)	A computer system that determines eligibility for ALTCS, SSI MAO and other AHCCCS programs.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors.
DIVISION OF HEALTH CARE MANAGEMENT (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.
PRE-PAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.

III. POLICY

PMMIS is made up of several sub-systems, each with a distinct function. The sub-systems, however, are interrelated and share common data and many rules of processing.

ALTCS eligibility information is recorded within the AHCCCS Customer Eligibility (ACE) system and transmits eligibility and enrollment data to PMMIS via an interface.

ALTCS Contractors have primary access to the CATS sub-system in PMMIS for purposes of recording and storing case management related data about ALTCS members.

ALTCS Contractors are required to either directly input data or transmit the information via electronic interface. Comments must be directly entered on the CATS comment screens; they cannot be transmitted electronically. If the ALTCS Contractor does not do direct data input, they are not required to enter comments in CATS. Tribal Contractors are required to do direct data input, including comments.

IV. USER ID AND SECURITY ACCESS REQUESTS

All individuals needing access to PMMIS must complete and submit the following two forms to AHCCCS in order to obtain a UserID#:

- User Access Request Form
- External User Affirmation Statement

These forms are available in the AHCCCS Data Access Forms section of the AHCCCS website. The completed forms for ALTCS case management staff should be faxed to the AHCCCS DHCM Case Management at(602) 252-2180.

AHCCCS will provide each approved user with a permanent seven digit UserID and a temporary password following completion of these forms. The first time the user signs on, s/he will be prompted to change the password before continuing with the sign-on. Passwords must be six-eight digits and contain a combination of alpha and numeric characters, ending with a number. Passwords must then be changed approximately every 30 days thereafter. Users are prompted when the password needs to be changed.

Even if ALTCS Case Managers will not be directly accessing PMMIS for data entry, they will need a six-digit Case Manager Identification Number for use in assigning members to their caseloads. This process requires the case manager to be affiliated, in PMMIS, to an ALTCS Contractor. The instructions for Case Manager Affiliation can be found in Attachment A, ALTCS Contractor Case Manager Affiliation.

SIGNING-ON/OFF

```
                        A D O A   D A T A   C E N T E R
                         INFORMATION SERVICES DIVISION
*************************************************************************
*                              WARNING NOTICE                           *
* THIS SYSTEM IS RESTRICTED SOLELY TO STATE OF ARIZONA AUTHORIZED USERS FOR *
* LEGITIMATE STATE BUSINESS PURPOSES ONLY.  STATE OF ARIZONA STRICTLY    *
* PROHIBITS THE ACTUAL OR ATTEMPTED UNAUTHORIZED ACCESS, USE OR MODIFICATION*
* OF THIS SYSTEM.  UNAUTHORIZED USAGE AND/OR USERS ARE SUBJECT TO        *
* DISCIPLINARY PROCEEDINGS AND/OR CRIMINAL AND CIVIL PENALTIES UNDER STATE, *
* FEDERAL,OR OTHER APPLICABLE DOMESTIC AND FOREIGN LAWS.  THE USE OF THIS   *
* SYSTEM MAY BE MONITORED AND RECORDED FOR ADMINISTRATIVE AND SECURITY   *
* REASONS.  ANYONE ACCESSING THIS SYSTEM EXPRESSLY CONSENTS TO SUCH      *
* MONITORING AND IS ADVISED THAT IF MONITORING REVEALS POSSIBLE EVIDENCE OF *
* CRIMINAL ACTIVITY, STATE OF ARIZONA MAY PROVIDE THE EVIDENCE OF SUCH   *
* ACTIVITY TO LAW ENFORCEMENT OFFICIALS.  ALL USERS MUST COMPLY WITH STATE  *
* OF ARIZONA SECURITY POLICIES REGARDING THE PROTECTION OF STATE OF ARIZONA *
* INFORMATION ASSETS.                                                    *
*************************************************************************
PLEASE ENTER APPLICATION REQUEST: cicsacp

                IP ADDRESS = 170.68.17.115   - IP PORT = 01839
                ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
                      DATE = 05/19/06 - TIME = 10:53:53
                      THE HELP DESK TEL. (602) 364-4444
```

On the ADOA Data Center screen shown above, the user must type "**cicsacp**" in the Application Request field and press <Enter>.

The screen pictured below will then be displayed.

```
                              Signon to CICS                          APPLID
  CICSACPR

   WELCOME TO CICS/TS


   Type your userid and password, then press ENTER:

            Userid . . . . abcde12
            Password . . . *******
            Language . . .

        New Password . . .



   DFHCE3520 PLEASE TYPE YOUR USERID.
   F3=Exit
```

On the screen shown above, the user must type the seven digit UserID and their Password and then press <Enter> to proceed with the sign-on.

```
admn

DFHCE3549 SIGN-ON IS COMPLETE (LANGUAGE ENU)
```

The user must then type “admn” on the screen shown above and press <Enter> to complete the sign-on process. The PMMIS Main Menu (shown on next page) will be displayed.

SIGNING-OFF

Users sign-off PMMIS by pressing the F12 key until the ADOA Data Center screen shown in the previous section.

V. PMMIS MAIN MENU

```
TR: AH000                    AHCCCS - PMMIS                          05/19/06
NTR: _______________________    MAIN MENU                            09:13:07
                                                                     AH00M000

       1. CASE MANAGEMENT                 11. ALTCS MEDICAL ELIGIBILITY(CATS)
       2. ENCOUNTERS                      12. ALTCS FINANCIAL ELIGIBILITY(LEDS)
       3. SYSTEM SERVICE REQUEST          13. ALTCS GENERAL INQUIRY/MAINTENANCE
       4. HEALTH PLAN                     14. ELIGIBILITY QUALITY CONTROL/FRAUD
       5. INFORMATION MANAGEMENT          15. REINSURANCE
       6. PROVIDER                        16. (AVAILABLE)
       7. RECIPIENT                       17. FINANCE
       8. REFERENCES                      18. CLAIMS
       9. UR/QA                           19. SVES - WTPY REQUEST/RESPONSE
      10. SECURITY                        20. KIDS CARE (KEDS)


                        ENTER SELECTION: 11

PF: 1=HLP       3=CLR 4=MSG                                          12=ESC
```

Pictured above is the first screen users will see after completing the sign-on procedure for the AHCCCS system. From this screen users may access a variety of subsystems, including the Client Assessment and Tracking System (CATS) which is the focus of this policy.

Users may either enter "11" in the Selection field as shown above, or type the screen name of the specific screen the user wishes to access, in the NTR field at the top right of the screen and press Enter. Entering "11" will take the user to the CATS main menu which is shown in the next section.

VI. CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS) SCREENS

Each of the screens described in this section share common features for access and movement within them. The following provides information about some of those common features:

The top of all PMMIS screens will look similar to this:

```
TR: SCREEN # HERE              AHCCCS - LONG TERM CARE                DATE
HERE
 NTR:        I                   SCREEN NAME HERE                     TIME
```

- "**TR**" – This field displays the 2-digit Alpha and 3-digit Numeric "name" of the screen or "Transaction" the user is currently accessing. For example: CA160.

- "**NTR**" – The 2-digit Alpha and 3-digit Numeric "name" of the screen that the user wishes to access next may be entered in the 1st position of this field as the "Next Transaction".

The user may access any of the screens described in this section directly by entering the screen name here or s/he may use the Transaction Keys described below to "transaction travel" through them in sequential order.

- **FUNCTION CODES**: these single digit codes, entered in the 2nd position of the "NTR" field, indicate the action the user will take on the screen.

  - **I** - Used to inquire into a record, no changes will be made to the data
  - **C** - Used to change a record. Users may not have "Change" security access to all the screens described in this section.

  See the Cost Effectiveness Study (CA160) section of this policy for information regarding 2 additional Function Codes that apply to that screen only.

- **AHCCCS ID#**: Most of the member data screens described in this policy are accessed by entering the member's 9-digit AHCCCS ID# in the 3rd position of the "NTR" field, to the right of the Function Code described above.

- **TRANSACTION KEYS**: These keys (described on the next page) allow the user to maneuver between the screens and within the system. As the user "transaction travels" with these keys, the data for the member whose AHCCCS ID# was last entered will be displayed until the user changes the AHCCCS ID# in the NTR field as noted above.

TRANSACTION KEYS

F2	From any CATS screen described in this chapter, returns the user to the CATS main menu (CA000) OR from a Comments screen, returns the user to the CATS screen from which they entered the Comments screen.
F3	Takes the user to a Comments screen from those CATS screens that have a Comments feature.
F5	Takes the user to the screen that immediately **precedes** the current one (for example, F5 from CA161 will take the user to CA160).
F6	Takes the user to the screen that immediately **follows** the current one (for example, F6 from CA160 will take the user to CA161).
F7	Takes the user backward, on the same screen, to information from previous dates (e.g., prior CES dates)
F8	Takes the user forward, on the same screen, to information from later dates (e.g., more CES dates)
F9	Scrolls the user back to lines of data (e.g., more placement lines on CA161) or Comments that precede those which are visible on the current screen.
F10	Scrolls the user forward to additional lines of data or comments on the current screen.
F11	Clears data entry errors so the user may proceed without having to resolve the edits first. Changes will not be saved until the edits are resolved.
F12	From any screen except Comments, begins to back the user out of PMMIS by either first returning to the sub-system main menu or going directly to the PMMIS main menu. Pressing F12 from the PMMIS main menu returns the user to the ADOA Data Center sign-on screen.

There are some exceptions to the above Transaction Keys. The user should note the directional information specific to each screen listed at the bottom of each screen.

The following screens that the ALTCS Contractors have access to for inquiry and/or direct data input of member information will be covered in this Policy:

A. CATS Main Menu (CA000)
B. Case Management Name Search (CA105)
C. Cost Effectiveness (CA160)
D. Placement Maintenance (CA161)
E. Community First Choice (CA162)
F. Case Management Service Plan (CA165)
G. ACE Critical Data (CA166)
H. Member Income (CA167)
I. Case Manager Reviews Tracking List (CA225)
J. Inquire Part D Drug Plan (RP214)
K. Inquire FYI Data (RP215)
L. Inquire Eligibility and Enrollment (RP285)

All ALTCS Contractors will use this system to record the Cost Effectiveness Study and Placement History for all enrolled members. Tribal Contractors must also enter service plan authorization data for ALTCS Fee-For-Service members. The remaining screens in this Policy provide inquiry access to other member or case management related data.

A. CATS MAIN MENU (CA000)

```
 TR: CA000                 AHCCCS - LONG TERM CARE                    05/19/06
NTR: _____ _ _______________ MEDICAL ELIGIBILITY MENU                 09:16:59
ASSESS DATE: __________                            WORKER ID: 605636  LT03L820


 A  PAS ADD SCREEN           (CA005)     L  PAS ASSIGNMENT TRACKING  (CA220)
 B  PAS INTAKE SCREEN        (CA010)     M  CASE MGMT NAME SEARCH    (CA105)
 C  OLD PAS MENU             (CA100)     N  COST EFFECTIVENESS STUDY (CA160)
 D  EPD PAS MENU             (CA500)     O  PLACEMENT MAINTENACE     (CA161)
 E  DD PAS MENU              (CA700)     P  SERVICE PLAN             (CA165)
 F  ASSESSMENT SUMMARY       (CA070)     Q  ACE CRITICAL DATA        (CA166)
 G  PAS REOPEN/DELETE        (CA075)
 H  TRANSITIONAL PGM MAINT.  (CA080)     R  SHARE OF COST            (CA175)
 I  PAS SIMULATED SCORE MENU (CA600)     S  CASE MANAGER REVIEW      (CA225)

 J  PAS REFERRAL TRACKING    (CA210)     T  AMADC ERROR MESSAGES     (CA230)
 K  REASSESSMENT TRACKING    (CA215)


                    SELECT LETTER:  _  AND PRESS ENTER


             ENTER=PROCESS       1=HELP       12=SECURITY DRIVER
```

To access the CATS screens used by ALTCS case managers (bolded above), users may either enter the letter code indicated for the screen (M, N, O, P, Q or S) in the space at the middle bottom of this screen (Select Letter) or type the screen name of the specific screen the user wishes to access in the NTR field at the top right of the screen and press Enter.

CA167/Member Income can not be accessed directly from this menu because the user needs to have designated the AHCCCS ID# of the desired member prior to entering CA167. See detailed instructions about CA167 begin in subsection G of this policy for more information.

An example and description of each of the bolded screens follows in this section.

B. CASE MANAGEMENT NAME SEARCH (CA105)

```
TR: CA105                    AHCCCS - LONG TERM CARE                 01/10/03
 NTR: _____ I _______________   CASE MGMT NAME SEARCH                 09:13:24
 WORKER ID: 605636                                                   LT02L105

 NAME: CAMPBELL             __________   DOB: __________   SEX: _

 SEL                NAME                 AHCCCS ID   CASE ID   BIRTHDATE   SEX
 ---  ---------------------------------  ---------  ---------  ----------  ---
  S   CAMPBELL             ED            A12345678  100043562  01/01/1949   M
  _   CAMPBELL             SUE           A98765432  110430905  02/01/1925   F




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN 9=CNF                12=ESC
```

This screen allows the user to search for an ALTCS member by name and/or date of birth.

When searching by name, the system will seek to match the exact spelling of the last name, so the user must either enter the last name in its entirety or an asterisk after as many letters as the user is sure of. For example, if the user entered “CAMPB*”, the system would bring up all names beginning with “CAMPB” but if the user had just entered “CAMP”, the name CAMPBELL would not have appeared.

Both a name or date of birth search may be narrowed by entering an “M” or “F” to indicate the sex of the member sought.

From the list of names provided in the search, the user may enter an “S” to the left of the name and press **F9** to bring up the same demographic screen as shown on page **411- 35 of this policy**.

C. COST EFFECTIVENESS STUDY (CA160)

The purpose of the Cost Effectiveness Study (CES) is to compare the cost of Home and Community Based Services (HCBS) to the cost of institutionalization for each ALTCS member. AHCCCS considers HCBS to be cost effective if the cost is at or below 100% of the cost of institutionalization. The CES must be completed prior to the initiation of HCBS services in order to determine if those services will be cost effective and can be provided.

The CES is a projection of HCBS costs so it should be completed based on the services and amounts that the member **needs**, including any services which are expected to be authorized but may not be authorized currently. In order to determine the ongoing cost effectiveness of services the member needs, the units in each of the three months should reflect the units the member would receive for the entire month, not just the amount from the CES date until the end of the month.

```
TR: CA160                        AHCCCS - LONG TERM CARE                 09/01/04
NTR: _____ 1 ___2_________ CMP - COST-EFFECTIVENESS STUDY              15:28:25
                                                                        LT02L110
CES DATE:____3______  ASSESS DATE: __________
NAME: ____________________________________ _      AHCCCS ID: _________
WORKER ID: 605636    CURR CSMGR: ______    LATEST ACN: ________

 LOC: A INST GRS COST: $ ____4______ SOC: $ ___B______ NET COST: $ ____C______
        HCBS GRS COST: $ ____D______ SOC: $ __E_______ NET COST: $ _____F_____
SERVICE    UNIT           MONTH 1        MONTH 2         MONTH 3     AVG COST
 CODE MOD  COST    UNITS  COST    UNITS  COST    UNITS   COST        PER MONTH
__5__ _6 __7______ _8__ __G_____ __9_ __G_____ _10__ ___G_____    ___H_____
_____ __ __________ ____ __________ ____ __________ ____ ___________   ___________
_____ __ __________ ____ __________ ____ __________ ____ ___________   ___________
_____ __ __________ ____ __________ ____ __________ ____ ___________   ___________
_____ __ __________ ____ __________ ____ __________ ____ ___________   ___________
_____ __ __________ ____ __________ ____ __________ ____ ___________   ___________

                     COMMENTS: I  CUR PLACEMENT: _ DATE: ___J______ REASON: __
HCBS PRCNT : __K___   SSI PRCNT: ____

                                                   Z037 NO APPLICATION FOUND
1=HLP 2=CA000 3=COM 4=EDSUM 5=CA070 6=CA161 7=SBK 8=SFD 9=SUP 10=SDN 11=CLR/ADD
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only, the data can not be changed in these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - Enter the appropriate function code from the options below:

- **A** – Used to add a new CES date. This function code is unique to CA160.
- **C** – Used to change an existing CES. All data except the date can be changed.
- **I** – Used to inquire into a record. No changes can be made to the screen in this function.
- **D** – Used to delete an entire CES record, including the date. This function code is unique to CA160

HINT: If a CES already exists for a member and the case manager wants to create a new one, with a new date, s/he can either:

1. Change the function code to an **"A"**, add a new CES date and type over the existing service/cost data with the desired changes, or

2. Press F11 which will bring up a blank CES screen for the member and automatically change the function code to an **"A"** so that a new CES date can then be added

   Do **NOT** use a function code **"C"** if a new CES needs to be created. An **"A"** function must be used to add a new CES date. The Change function should be used to make changes to an existing CES only. If the user uses a **"C"** and types over the existing data with current information, all the historical CES data will be lost. This is not the appropriate method for making a new CES.

(2) AHCCCS ID – This unlabeled line is where the user enters the AHCCCS ID# of the member whose CES information the user wishes to access. CES information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be available for each member.

(3) CES DATE - The date of the most recent CES will appear, if one already exists for the member. If there is no previously established CES, the message "NO CES RECORDS EXIST" will appear at the bottom right of the screen.

If there are prior CES dates, press F7 to scroll backward to view these. Press F8 to scroll forward again.

Enter the date in this field, along with an "A" Function code to add a new CES. The format is MM/DD/YYYY.

(4) INST GRS COST - The anticipated monthly institutional gross cost should be entered here.

(5) SERVICE CODE - Enter the appropriate five character service codes for the services that the member needs. If more services will be entered than there are lines on the screen, pressing

F10 (after the 1st screen is entered) will provide additional lines. F9 will return the user to the 1st screen after additional line data is entered or viewed.

The word "NONE" may be typed on the 1st service line under the following circumstances:

- Members residing in a Nursing Facility who have no potential for HCBS placement
- Members who are receiving only Hospice services
- Members residing in a Nursing Facility because HCBS would not be cost effective
- Members with Acute Care Only status

(6) MOD - Enter the two character modifier for the service, as needed. A list of all available modifiers can be found on RF114 and the valid modifiers for a specific procedure code can be found via RF122. The following are the most common modifiers:

- U2 – Used to designate Attendant Care provided as Self-Directed Attendant Care.
- U3 – Used to designate Attendant Care provided by the member's spouse.
- U4 – Used to designate Attendant Care provided by a family member who does NOT live with the member.
- U5 – Used to designate Attendant Care provided by a family member who DOES live with the member.
- U6 – Used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver.
- U7 – Used to designate when services are provided through the Agency with Choice delivery model.

(7) UNIT COST - Enter the cost per unit of the service. This is entered as dollars and cents, with a maximum of six digits ($9999.99).

(8) (9) and (10) UNITS - Enter the units of service that are needed per month for each of the three months. The units should reflect the units the member would receive for a whole month, not just the amount from the CES date until the end of the month. The units may vary from month to month if the member's service needs are expected to change over time. The number entered in this field can not exceed four digits (9999). **A zero must be entered in the field if no units of service are expected for one or more months.**

Below is an explanation of the **Lettered, information-only** fields:

(A) LOC – This field will generally be blank but it may show a Level of Care code from the last PAS. Since no LOC is assessed from the PAS process anymore, this information might be very old and most likely will be irrelevant to the member's current status. If a code does appear, the following explains the codes used:

CODE	DESCRIPTION
I	Class 1
P	Class 2
S	Class 3
T	ALTCS Transitional

(B) SOC - The member's anticipated monthly Share of Cost, if s/he were to be placed in a Nursing Facility, will be displayed here, based on the date of the CES. The member's monthly SOC history may be found via the CA166 screen (see information on this screen beginning on page 411-28 of this chapter). The SOC amount will change over time with the member's income and deductions. If the member is not currently known, by ALTCS eligibility staff, to be in a NF, the amount shown in the "CES SOC AMT" field on CA166 is the SOC amount that the member would be expected to pay if s/he were in a NF.

(C) NET COST - The system will display the net institutional cost (gross cost minus SOC) after the CES is entered by the user.

(D) HCBS GRS COST - The system will display the total average cost of the HCB services. This is the sum of the three month average for each service entered on the CES.

(E) HCBS SOC – If the member will have a Share of Cost in an HCBS setting (usually due to an Income-Only Trust), the amount, based on the date of the CES, will be displayed here. The SOC amount will change over time with the member's income and deductions.

(F) NET COST - The system will display the net HCBS cost (gross cost minus SOC) after the CES is entered by the user.

(G) COST - The system will display the total monthly cost (unit cost X units) for each service.

(H) AVG COST - The system will calculate and display the average monthly cost of each service (total cost divided by 3).

(I) COMMENTS - A "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA160 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA160 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA160 screen.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the **Shift key and F10** together will immediately bring up the end of the file so new comments can be added.

(J) CUR PLACEMENT/DATE/REASON - This information is read from the most recent line on CA161/Placement Maintenance.

(K) HCBS PRCNT - The system calculates the HCBS percentage based on the services entered above compared to the cost of an institutional placement. The figure is the HCBS net cost (F) divided by the institutional net cost (C).

NOTE: The "SSI PRCNT" field is no longer used and no data/information will appear in this field.

NOTE: **Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without having to resolve the errors created first.**

D. PLACEMENT MAINTENANCE (CA161)

```
TR: CA161                  AHCCCS - LONG TERM CARE                    10/14/03
NTR: _____ 1 ___2_______     PLACEMENT MAINTENANCE                    11:29:47
                                                   WORKER ID:          LT02L115
NAME: _____ _________ _                           AHCCCS ID: _________
LAST CES DATE: ___A_______ CURR CSMGR: ___3___   LATEST ACN: ________
LAST REVIEW DATE:  ____4______ NEXT REVIEW DATE:  ____B______
LATEST PC: __C___          ENROLL DATE: ___D_______ DISENROLL DATE: ____E____
CTRT TYPE:  F                                     BEHAVIORAL HEALTH CODE:  5
 PLACEMENT  RES   PLACEMENT    PLACEMENT     PLACEMENT    WORKER    DATE LAST
    CDE     CDE    REASON      BEG DATE      END DATE       ID       MODIFIED
    6       7       8         ___9______    ___10_____   __G___    ____H_____
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________
    _       _      __         __________    __________   ______    __________

                                   COMMENTS: I

                                                   Z037 NO APPLICATION FOUND
 1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only and the data cannot be changed from these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) Function Code - Enter the appropriate function code from the options below:

- **C** – Used to change placement information, including adding new placement data.
- **I** – Used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – This unlabeled line is where the user enters the AHCCCS ID# of the member whose placement history the user wishes to access. Placement information is saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) CURR CSMGR - Enter the 6-digit ID# of the Case Manager currently assigned to the case. This field **must** be changed when a new case manager is assigned to a case. It is this field that is read by the system as the current case manager for all reports generated by AHCCCS. This field is also used by the system to generate the information on CA225/CM Review Tracking List.

(4) LAST REVIEW DATE – The date of the last on-site service review with the member should be entered here.

(5) BEHAVIORAL HEALTH CODE – The Behavioral Health code that describes the member's current BH status should be entered here. The code entered must correspond to the member's current Placement and Residence code (see matrix of appropriate combinations shown on the next page). This field must be reviewed and updated, as needed, at the time of each service review to ensure it reflects the member's current BH status, even if the member's Placement has not changed. **This field may not be left blank.**

The following provides a description of the Behavioral Health codes to be used:

CODE	DESCRIPTION
A	**PSYCHOTROPIC MEDICATIONS ONLY** Includes only medications used to modify behavioral health symptoms. Does not include Sedative-Hypnotics when used to treat insomnia or on a PRN basis prior to a procedure, Anti-anxiety medications used for muscle spasms or Anticonvulsants used to treat a seizure disorder. Medication monitoring by the prescribing physician is not considered a separate service so if the member receives no other BH "services", s/he would be included in this category.
B	**BEHAVIORAL HEALTH SERVICES ONLY.** This category would apply to members who receive any Behavioral Health services but who take no psychotropic medications. Does not include members who have only received a Behavioral Health evaluation but do not receive on-going BH services.
C	**BEHAVIORAL HEALTH SERVICES AND PSYCHOTROPIC MEDICATIONS.** See A and B above. Includes members receiving psychotropic medication monitoring by a nurse.
D	**BEHAVIORAL HEALTH PLACEMENT WITHOUT PSYCHOTROPIC MEDICATIONS.** Includes RTC, Behavioral Health Residential facilities and Alternative Residential Settings that are licensed to provide Behavioral Health. Also includes Behavioral Health units within nursing facilities but excludes Wandering/Dementia units in nursing facilities.
E	**BEHAVIORAL HEALTH PLACEMENT WITH PSYCHOTROPIC MEDICATIONS.** See A and D above.
F	**NO BEHAVIORAL HEALTH NEEDS.**

The table below shows appropriate combinations of Placement, Residence and Behavioral health codes. Descriptions of the available Placement and Residence codes can be found following this table.

PLACEMENT	RESIDENCE	BEHAVIORAL HEALTH
H	8, F, K, R	D OR E
H	5, 6, 9, B, E, G	A – F
H	1	A – C, F
Q	2, 4	A – F
Q	W	A – C, F
Q	7, C, J	D OR E
D	1, 2	A – C, F
Z	1	F

(6) PLACEMENT CODE - enter the code for the placement that corresponds to services authorized by the Case Manager. These codes are shown below.

CODE	DESCRIPTION	
Z	**NOT PLACED** – A member must not remain in this placement for more than 30 consecutive days following ALTCS enrollment. No active services can be approved on the service plan during any "not placed" period.	
H	**HCBS** – Members residing in their own home or an approved alternative residential setting. Members residing in their own home must receive at least one of the following LTC services to qualify for an HCBS placement:	
	• Adult Day Health • Attendant Care • Behavior Management • Emergency Alert System • Habilitation • Home Delivered Meals • Home Health Services	• Homemaker • Home Modifications • Partial Care • Personal Care • Psychosocial Rehabilitation • Respite
Q	**INSTITUTIONALIZED** – Members residing in an AHCCCS registered Nursing Facility, ICF-ID, Institution for Mental Disease (IMD) or Behavioral Health inpatient facilities for individuals under age 21 (RTCs).	
D	**ACUTE CARE ONLY** - Members who reside in their own homes but receive no LTC services, members who reside in an uncertified facility, members who reside in alternative residential settings not registered with AHCCCS and/or members who have been disqualified from LTC benefits due to an uncompensated transfer of resources. Acute care services include: physician services, medical equipment and supplies, prescription drugs, medically necessary transportation, rehabilitative therapies (physical, speech, occupational and/or respiratory) and behavioral health services.	

(7) RESIDENCE CODE – Enter the code that best describes the type of placement setting the member resides in. The Residence code must correspond with both the current Placement and Behavioral Health codes (see matrix of appropriate combinations on preceding page). A new Placement line must be started if the Residence code changes, even if the Placement code has not changed. Residence codes are shown below.

CODE	DESCRIPTION
1	Home
2	Nursing Facility
4	ICF/ID
5	Adult Foster Care
6	Group home for DD
7	Residential Treatment Center
8	Traumatically Brain Injured
9	Assisted Living Centers
B	Assisted Living Home
C	Institute for Mental Disease
E	Adult Developmental Home
F	Adult Behavioral Health Therapeutic Home
G	Child Developmental Foster Home
J	Behavioral Health Inpatient Facility
K	Behavioral Health Residential Facilities
R	Substance Abuse Transitional Facility
W	Wandering Dementia Unit in NF

(8) PLACEMENT REASON - Enter the 2-digit code for the reason the placement was authorized by the case manager. Reason codes are shown below – the most commonly used codes are bolded.

CODE	DESCRIPTION
01	HCBS not appropriate or cost effective
02	HCBS not available in member's community
03	**Member/rep desires nursing facility placement**
04	Member voluntarily withdraws/awaiting disenroll
05	**Member in NF with no discharge potential**
06	HCBS recommended, cost expected to decrease
07	HCBS - Ventilator Dependent
08	Member hospitalized prior to initial placement
10	**Hospice – used with HCBS and NF placement codes**
11	Other (**Comments required**)
12	**Acute Care only**
13	**HCBS is available and cost effective**

Placement Reason code "**23**" may be used to delete a placement line if entered in error. This code will remove the entire placement line from the screen.

Reason code "11" should only be used if none of the other reason codes adequately describes the member's circumstances. When Reason code "11" is used, comments to describe those special circumstances are required (there will be a system error if comments are not entered).

(9) PLACEMENT BEG DATE - Enter the start date of the placement. Format is MM/DD/YYYY.

(10) PLACEMENT END DATE - Enter the end date of the placement, if applicable. Format is MM/DD/YYYY. The end date will be left blank for the member's current placement. This field must be completed before a new placement can be entered. There can not be an overlap between the end date and a subsequent placement start date.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - The date of the most recent CES from CA160 is displayed.

(B) NEXT REVIEW DATE – The system will calculate the date the member's next on-site service review is due based on the "Last Review Date" entered and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(C) LATEST PC - The 6-digit ID# of the ALTCS Contractor the member was last, or is currently, enrolled with, is displayed here. A list of AHCCCS Contractor ID Numbers can be found in Attachment B.

(D) ENROLL DATE - The date the member was enrolled with the ALTCS Contractor shown in "Latest PC" field is displayed. The current Placement begin date can not precede this date.

(E) DISENROLL DATE - If the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. The last Placement End date must match this date.

(F) CTRT TYPE – The member's current Contract Type will be displayed here. The following shows the applicable Contract types:

CODE	DESCRIPTION
ALTCS/EPD and DDD Contractors	
J	LTC, Capitated
L	LTC, Capitated, Acute Care Only
M	LTC, Prior Period Coverage
O	LTC, Prior Period Coverage, Acute Care Only
TRIBAL CONTRACTORS	
P	LTC, Partially Capitated
T	LTC, Fee For Service, Acute Care Only

(G) WORKER ID# - The ID# of the worker who last updated the line is displayed.

(H) DATE LAST MODIFIED - The date the line was last updated is displayed.

(I) COMMENTS - A "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA161 so that the user may review or enter comments. The user must be in a "C" (Change) function on CA161 prior to moving to the Comments screen in order to be able to enter comments on that screen. F2 will return the user to the CA161 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

HINT: The beginning of the comments is usually brought up when you first go to this screen. Pressing the Shift key and F10 together will immediately bring up the end of the file so new comments can be added.

Note: Errors can be cleared from this screen by pressing F11. This allows the user to either move out of the screen or start over again without first having to resolve the errors created.

CA161 Provider Search Instructions

On CA161/Placement Maintenance, users can do a "provider" search to determine who the "CURR CSMGR" (Field 3) or "WORKER ID" (Field G) indicated on this screen belong to. The user may place the curser in either Field 3 or Field G (bolded in the screen example below) and press F1.

```
TR: CA161                 AHCCCS - LONG TERM CARE                    07/17/06
NTR: _____ C _______________ PLACEMENT MAINTENANCE                    11:39:54
                                              WORKER ID: 605636    LT02L115
NAME: SMITH                RICHARD            AHCCCS ID: A12345678
LAST CES DATE: 01/26/2006  CURR CSMGR: 605636   LATEST ACN:
LAST REVIEW DATE:  04/27/2006  NEXT REVIEW DATE:  07/26/2006
LATEST PC: 999999         ENROLL DATE: 07/28/2003  DISENROLL DATE: __________
CTRT TYPE:  J                                  BEHAVIORAL HEALTH CODE:  F
PLACEMENT  RES   PLACEMENT    PLACEMENT     PLACEMENT    WORKER    DATE LAST
   CDE     CDE    REASON      BEG DATE      END DATE       ID       MODIFIED
    H       1       13       07/28/2003    __________    605636    07/17/2006
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________
    _       _       __       __________    __________    ______    __________

                                  COMMENTS: N

                          Z171 ACTIVE IN ACE        Z011 END OF FILE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA160 6=CA165 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA161.

```
 TR: CA161 ACT: C      AHCCCS - INFORMATION REFERENCING              07/17/06
                              PROVIDER ID/NAME                       12:54:45
                                                                     AH05L012
 S  SORTED BY PROVIDER ID
 E
 L PR ID  NPI        PROVIDER NAME             -----PROVIDER TYPE-------------
   ______ __________ __________________________
 _ 605636            SANDERS, CAROL            98 CASE MANAGER
 _ 605644            SURBER/SANDRA             98 CASE MANAGER
 _ 605652            GONZALES DOLORES          98 CASE MANAGER
 _ 605660            SALM, JANICE              98 CASE MANAGER
 _ 605678            SULLIVAN MARIE            98 CASE MANAGER
 _ 605686            HUMPHRIES FRED            98 CASE MANAGER
 _ 605694            HEGLUND/MARILYN           98 CASE MANAGER
 _ 605701            HERREID SUSAN             98 CASE MANAGER
 _ 605719            LANGLEY SHEVA             98 CASE MANAGER
 _ 605727            NORRIS/SUSAN              98 CASE MANAGER
 _ 605735            PHILLIPS/WANDALEE         98 CASE MANAGER
 _ 605743            SKERTICH/OLIVE            98 CASE MANAGER
 _ 605751            WINOGRAD ROCHELLE         98 CASE MANAGER
 _ 605769            YANNO/RICHARD             98 CASE MANAGER
PF:       2=RTN                         7=UP  8=DWN       10=TOP 11=BOT
```

E. CASE MANAGEMENT SERVICE PLAN (CA165)

This screen is used by Tribal Contractors to Authorize ALTCS services.

```
TR: CA165                 AHCCCS - LONG TERM CARE                  11/04/03
NTR: _____ 1 ___2_______      CMP - SERVICE PLAN                    14:57:18
KEY DATE: ____3______                                WORKER ID:      LT02L120
NAME: ____________________ __________ _              AHCCCS ID: _________
LAST CES DATE: ___A_______  CURR CSMGR: ___B___   LATEST ACN: ________
LAST PC: ___C___ ENR DT: ____D_____ DISEN DT: ___E______ LST RVW DT: ____F____
CUR: LOC: G_   PLACEMENT: _H   DATE: __________   RSN __  NXT RVW DT: ___I____
PAS DIAG CDS:  ______ __J____ ______   DIAG 1:  ______________________________
DIAG 2: ________________________________ DIAG 3: ________________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
4 __5__ 6_ _ ____7_____ ____8_____ __9__ __10_ __ ___K_____ ___L____ _11___ 12
_ ______ __ _ __________ __________ _____ ________ __________ ________ ______ __
_ ______ __ _ __________ __________ _____ ________ __________ ________ ______ __
_ ______ __ _ __________ __________ _____ ________ __________ ________ ______ __
_ ______ __ _ __________ __________ _____ ________ __________ ________ ______ __

                                   COMMENTS: M

1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA175 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

The **Numbered** fields shown on the prior screen are for data entry. The **Lettered** fields above are information-only and the data can not be changed from these fields.
Instructions for completion of the **Numbered** fields are as follows:

(1) FUNCTION CODE - Enter the appropriate function code from the options below:

- **C** – Used to change information, including adding service authorizations.
- **I** – Used to inquire into a record. No changes can be made to the screen in this function.

The Function Code must be a "C" in order to enter or change any data on this screen.

(2) AHCCCS ID – This unlabeled line is where the user enters the AHCCCS ID# of the member whose service plan history the user wishes to access. Service authorizations are saved by AHCCCS ID# so data from any prior ALTCS enrollments will be displayed for each member.

(3) KEY DATE – This **optional** field may be used to quickly display previous service plan entries beginning with a specific date by entering that date in this field. Format is MM/DD/YYYY. Services with that begin date or later will be displayed. This avoids having to scroll through screens of entries to find a specific service or time period. This field may be left blank if the user does not wish to review previous entries.

HINT: Usually, the end of the file (last authorized services) is brought up when you first go to this screen. F9 will scroll backward to previous authorizations and F10 scrolls forward again.

Pressing the **Shift key and F9** together will immediately bring up the beginning of the file (first screen of authorized services) and the **Shift key and F10** together will immediately bring up the end of the file.

(4) ACT - Enter the appropriate action code from the options below:

- **I** – Used to initiate a new service authorization.
- **C** – Used to make changes to an existing service authorization.
- **T** – Used to terminate an existing service authorization that has unclaimed units. This Action code requires a Reason code at the end of the service line (see table of Termination Reason codes beginning on the next page).

(5) SERV - Enter the appropriate procedure 5-digit HCPCS or 4-digit Revenue code for the service being authorized.

(6) MOD - enter the second character modifier for applicable services. Durable Medical Equipment and medical supplies must have a modifier to be authorized. Fee-For-Service

(FFS) Transportation intended as "Rural" will need a modifier entered in order for AHCCCS to pay the rural rate. The following are the most common modifiers:

- **U2** – Used to designate Attendant Care provided as Self-Directed Attendant Care.
- **U3** – Used to designate Attendant Care provided by the member's spouse.
- **U4** – Used to designate Attendant Care provided by a family member who does NOT live with the member.
- **U5** – Used to designate Attendant Care provided by a family member who DOES live with the member.
- **U6** – Used to designate Self Directed Attendant Care when skilled services are being provided by the caregiver.
- **U7** – Used to designate when services are provided through the Agency with Choice delivery model.
- **NU** – Used for a DME or medical supply purchase.
- **RR** – Used for a DME rental.
- **RA** – Replacement of a DME item.
- **RB** – Replacement of a part of DME furnished as part of a repair.
- **TN** – Used for rural transportation.

All valid modifiers for a specific procedure code may be found in the PMMIS Reference subsystem, on RF122.

(7) EFF DT - Enter the start date for the service authorization. Format is DD/MM/YYYY.

(8) END DT - Enter the end date for the service authorization. The end date of an authorization must not exceed 90 days for an HCBS service or 180 days for an institutional service.

Service authorization begin and end dates must not overlap Placement begin and end dates on CA161/Placement Maintenance.

(9) UNITS - Enter the number of units being authorized for the dates of service indicated. Information about maximum units allowed for a specific procedure code can be found in the PMMIS Reference subsystem, on RF113.

(10) UNIT COST - Enter the unit cost of the service being authorized. The system will not allow this cost to exceed the AHCCCS FFS rate (if one has been set) for ALTCS FFS members. The maximum allowable charge for a specific procedure code can be found in the PMMIS Reference subsystem, on RF112.

(11) PROV - Enter the 6-digit ID# of the Provider authorized to render the service. The provider must be eligible to provide the specific type of service authorized. Refer to PR035, in the PMMIS Provider subsystem, for the Categories of Service a specific provider is registered to provide.

NOTE: The following "dummy" Provider codes should be used to show that ALTCS covered services are provided but they are not paid for with AHCCCS funds:

029108 - Signifies any service paid completely by another payer source, for example Tribal or private pay. In these cases, the appropriate service code would be used (for example, G0154 for Home Health Nursing), however, 029108 would be used as the provider number and the unit cost would be $0.00 to indicate the service will not be paid by AHCCCS.

042490 - Signifies services provided in an uncertified facility.

(12) RSN – When a service line is being terminated, a Reason Code must be entered in this field. The termination of a service authorization should be rare. Changes in service code, begin or end dates, units and unit cost should be made using the (C)hange action code instead and no Reason Code is needed for these types of changes. Terminations Reason Codes are listed below.

CODE	DESCRIPTION
01	Member does not meet medical/functional PAS criteria of AHCCCS
02	Member becomes financially ineligible
03	Member becomes financially and medically ineligible
04	Member's needs have been met and service is no longer required
05	Member's request for suspension or termination of service
06	Member moved out of provider's service area
07	Member died
08	Member moved out of state
09	Contact with member has been lost
10	Provider has been changed
11	No service is available
12	Another source is available
13	Member's caregiver/family is able to take over care
14	Member discharged to home
15	Member left against medical advice
16	Member discharged to other
17	Member needs a higher level of care
18	Member needs a lower level of care
19	Hospitalization
20	Covered by Medicare
21	Member refused services
22	Assessment only – completed
23	Delete - This code may be used to delete a service line if entered in error. The entire service line will be removed from the screen as long as AHCCCS has not paid any claims from that authorization.

Below is an explanation of the **Lettered, information-only** fields:

(A) LAST CES DATE - The most recent CES date from CA160 will be displayed here.

(B) CURR CSMGR - the 6-digit ID# of the case manager currently assigned to the case on CA161 will be displayed here.

(C) LAST PC - The 6-digit ID# of the Contractor the member was last or is currently enrolled with is displayed. A list of AHCCCS Contractor ID Numbers can be found in Attachment B, AHCCCS Contractor Identification Numbers.

(D) ENR DAT - The date the member was enrolled with the Contractor shown in "LAST PC" field is displayed.

(E) DISEN DAT - If the member is not currently enrolled with an ALTCS Contractor, the date the member was last disenrolled is displayed. **If a date appears in this field, the member is not currently enrolled and no service can be authorized beyond the date shown.**

(F) LST RVW DT - The last date the case manager has entered in "LAST REVIEW DATE" field on CA161/Placement Maintenance will be displayed here. The field will be blank if no reviews or placement data has been entered.

(G) LOC – This field is currently not used. It used to show either the member's Level of Care from the most recent PAS or the Level of Care, for members in a nursing facility, based on the Nursing Facility service/revenue code authorized by the case manager on this screen.

(H) PLACEMENT/DATE/RSN - The Placement/Reason codes and begin date from the current placement on CA161 will be displayed here.

(I) NXT RVW DT - The date the next service review is due, as calculated based on the date entered in the "LAST REVIEW DATE" field on CA161/Placement Maintenance, is displayed here. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(J) PAS DIAG CDS - Up to three diagnostic (ICD-9) codes from the last PAS will be displayed. The three lines next to and below this, labeled "DIAG 1/2/3", will display the definition of those codes.

(K) TOTL COST - The total cost of the service authorized on the line (units X unit cost).

(L) TOT USED - The total number of units AHCCCS has paid to the provider to date will be displayed. The number in this field will not exceed the number of units authorized but may be less.

(M) COMMENTS - A "Y" or "N" is displayed here to indicate if comments are present or not. F3 will bring up the comments screen for CA165. The user must be in a "C" (Change) function on CA165 prior to moving to the Comments screen in order to be able to enter comments on that screen. The oldest comments saved for the member are displayed when the screen is first accessed. F9 will scroll backward to prior comments and F10 will scroll forward. Pressing the **Shift key and F9** together will take you immediately to the beginning of the comments and the **Shift key and F10** together will take you immediately to the end of the comments. F2 will return the user to the CA165 screen.

System comments should be used to explain special circumstances or miscellaneous codes that the data on the corresponding screen does not explain adequately.

CA165 Provider Search Instructions

On CA165/Service Plan, users can do a provider search to determine who the Provider ID# on any service authorization line and/or who the Case Manager ID# on this screen belong to. The user may place the curser on either the Provider ID# (one at a time) or the Current Case Manager ID# (examples shown bolded in the screen example below) and press F1.

```
TR: CA165                  AHCCCS - LONG TERM CARE                    05/30/06
NTR: _____ I _______________   CMP - SERVICE PLAN                      07:41:43
KEY DATE: __________                              WORKER ID: 605636    LT02L120
NAME: BROWN                SAMUEL                 AHCCCS ID: A23456789
LAST CES DATE: 04/13/2006  CURR CSMGR: 124412   LATEST ACN:
LAST PC: 999999 ENR DT: 11/01/2005 DISEN DT:            LST RVW DT: 05/16/2006
CUR: LOC: _    PLACEMENT: H   DATE: 11/01/2005   RSN 13  NXT RVW DT: 08/14/2006
PAS DIAG CDS:  3449                     DIAG 1:  PARALYSIS, UNSPECIFIED
DIAG 2: _______________________         DIAG 3:  ______________________________
A SER  MOD RES EFF DT    END DT    UNITS UNIT COST TOT COST TOT USED  PROV RSN
_ 97113 __ _ 04/20/2006 06/22/2006    28    31.74    888.72     0.00 020876 __
_ 97535 __ _ 04/20/2006 06/22/2006    28    29.87    836.36     0.00 020876 __
_ S5125 __ _ 05/08/2006 06/30/2006   960     3.88   3724.80   312.00 076433 __

                                 COMMENTS: Y

                           Z171 ACTIVE IN ACE        Z022 MORE DATA AVAILABLE
1=HELP 2=CA000 3=COM 4=EDSUM 5=CA161 6=CA166 9=SUP 10=SDN 11=CLR 21=TOP 22=BOT
```

A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA165.

```
TR: CA165 ACT: I       AHCCCS - INFORMATION REFERENCING                05/30/06
PROVIDER ID/NAME                      07:43:08
                                                                      AH05L012
S  SORTED BY PROVIDER ID
E
L PR ID  NPI        PROVIDER NAME             -----PROVIDER TYPE-------------

  ______ __________ _____________ ___________
_ 076433             LA CASA HEALTH CARE, INC  24 PERSONAL CARE ATTENDANT
_ 076442             HARTNER/SHEILA A.         93 SCHOOL BASED ATTENDANT CARE
_ 076449             VOIGHTLANDER/GEORGE       08 MD-PHYSICIAN
_ 076455             BENNETT/DENISE            93 SCHOOL BASED ATTENDANT CARE
_ 076457             MICKLE/RICHARD ALAN       31 DO-PHYSICIAN OSTEOPATH
_

PF:       2=RTN                          7=UP  8=DWN       10=TOP 11=BOT
```

F. AHCCCS CUSTOMER ELIGIBILITY (ACE) CRITICAL DATA (CA166)

Information available about a member through the ACE Critical Data screen is accessed in the same way as the previously described CATS screens, via member AHCCCS ID# entered in the field labeled **(A)** below. This screen is inquiry only; no information can be changed on this screen.

1. Main screen:

```
TR: CA166              AHCCCS - LONG TERM CARE                 09/07/04
NTR: _____ I ___A__________  ACE CRITICAL DATA                 07:54:48
WORKER ID: 605636                                   LT02L130
NAME: CAMPBELL              ED       STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A12345678  ACE ID: 900000000 TRIBE CD: 07  RES CD: 07  NET TEST: F
CASE MANAGER: 123456 MANAGER, CASEY                OFFICE: 12A  PAS LOC: I
FIN REDE DUE DATE: 07/13/2005    MED REASS DUE DATE: NONE       DD STATUS: 4

LIVING ARRANGEMENT(LAR): HS   LAR PROVIDER: ______   LAR BEG DATE: 07/23/2004
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: 12/01/1999   END DATE: 05/31/2001
 MAJOR DIAG 1: 03B(7169 )  MAJOR DIAG 2: 06G(3109 )  MAJOR DIAG 3: 12C(     )

  AUTH REP: CAMPBELL           MARY       _         RELATION: SP
       STREET ADDRESS: 1234 E NORTHVIEW AVE      _______________________
    CITY: PHOENIX           ST: AZ  ZIP: 85034 ____  RES PHO: 602 555 5555
                                   BUS PHO: ___ ___ ____
 LEGAL REP: _____________________ __________ _        RELATION: __
       STREET ADDRESS: _________________________   _______________________
    CITY: ___________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                   BUS PHO: ___ ___ ____
                  Z171 ACTIVE IN ACE       Z008 RECORD FOUND
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA225 (7=DEM 8=SOC 9=VER 10=MHS)
11=CLEAR
```

The following tables provide information regarding codes that appear on the CA166 screen:

ALTCS ELIGIBILITY SITE CODES	
12	Phoenix
15	Freedom to Work
21	Tucson
22	Sierra Vista
31	Flagstaff
32	Prescott
34	Chinle
35	Cottonwood
41	Yuma
42	Lake Havasu City
43	Kingman
51	Casa Grande
52	Globe

DD STATUS CODES	
1	Potential DD member
2	DD member In ICF/MR or Home/Group Home
3	DD member in Nursing Facility
4	EPD member

STATUS CODES	
A	Active enrollment
I	Inactive enrollment

TRIBE/RESERVATION CODES					
01	Ak Chin	**08**	Havasupai	**15**	Salt River Pima-Maricopa
02	Camp Verde Yavapai	**09**	Hopi	**16**	San Carlos Apache
03	Cocopah	**10**	Hualapai	**17**	Yavapai-Apache
04	Colorado River	**11**	Kaibab Paiute	**18**	Fort Mohave
05	White Mountain Apache	**12**	Navajo	**19**	Quechan
06	Fort McDowell	**13**	Tohono O'Odham	**20**	Pascua Yaqui
07	Gila River	**14**	Tonto Apache	**21**	San Juan Southern Paiute

More Codes from CA166 Main Screen

LIVING ARRANGEMENT CODES	
AH	CLIENT IS IN ACUTE HOSPITAL BED
HA	CLIENT IS IN AN ASSISTED LIVING HOME
HB	BEHAVIORAL HEALTH RESIDENTIAL FACILITY
HC	DD CHILD IN DD CHILD DEVELOPMENT FOSTER HOME
HF	LIVES IN AN ADULT FOSTER CARE HOME
HG	LIVES IN A GROUP HOME
HI	LIVES AT HOME AND INTENDS TO RECEIVE SERVICES
HL	CLIENT IS IN AN ASSISTED LIVING CENTER
HN	LIVES AT HOME AND DOESN'T RECEIVE IN-HOME SERVICES
HO	QMB-ONLY LIVING ARRANGEMENT (SERVICES N/A)
HR	SUBSTANCE ABUSE TRANSITIONAL FACILITY
HS	LIVES AT HOME AND RECEIVES IN-HOME SERVICES
HT	LIVES IN AN ADULT BEHAVIORAL HEALTH THERAPEUTIC HOME
HZ	ALZHEIMER ASSISTED LIVING FACILITIES
LH	A/R IN LTC HOSPITAL BED OR ACUTE PSYCHIATRIC HOSPITAL
LT	CLIENT IS IN LTC FACILITY OR RTC
OS	CLIENT IN OUT-OF-STATE FACILITY (HOSPITAL OR LTC)
RH	CLIENT REFUSING LTC SERVICES
SC	ALTERNATE ACUTE LIVING ARRANGEMENT

RELATIONSHIP CODES (FOR AUTHORIZED AND/OR LEGAL REPRESENTATIVE)			
AU	AUNT	**NB**	NEIGHBOR
BR	BROTHER	**NO**	NONE
CH	CHILD	**NR**	NOT RELATED
CO	COUSIN	**OT**	OTHER
DA	DAUGHTER	**PA**	PARENT
FA	FATHER	**PO**	PARENT OF ADULT
FF	FOSTER FATHER	**PS**	STEP PARENT
FM	FOSTER MOTHER	**NO**	NONE
GD	GRANDDAUGHTER	**SI**	SISTER
GF	GRANDFATHER	**SO**	SON
GM	GRANDMOTHER	**SP**	SPOUSE
GS	GRANDSON	**UN**	UNCLE
MO	MOTHER		

2. Pressing **F7** will bring up the Demographic screen shown below. **F2** will return the user to CA166.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    10/27/11
                             DEMOGRAPHIC INQUIRE                    15:19:32
                                                                     RP01L035
A12345678 CAMPBELL ED                    SEX F DOB 12/04/1966 DOD

      HOME ADDRESS           RES CTY: MARICOPA             HEAD OF HOUSE?: N
SOUTH MOUNTAIN CARE          FIS CTY: MARICOPA            ON RESERVATION?: N
6420 S. 22ND ST                  SSN: 555-55-5555
PHOENIX                      CASE ID: 555555555              OTHER RECORDS?
AZ 85040                        RACE: CAUCASIAN/WHITE         SPECIAL PGMS:
                            TRIBE ID:                             MEDICARE: Y
     MAILING ADDRESS         MAR STA: SINGLE                 THIRD PTY CHG: Y
SOUTH MOUNTAIN CARE          LANG: ENGLISH                    ALTERNATE ID: Y
6420 S. 22ND ST               LANG SRC: ON-LINE, DMS
PHOENIX                      CITIZEN: US US CITIZEN          MEDICAL COND:
AZ 85040                CITIZEN SRC: AZ                    CORRESPONDENCE: Y
                            CARE LVL:
                            FACILITY:                              CO-PAY: N
HOME PH: (602) 555-0000  ATTN:
 EMG PH: (   )    -        EMAIL SRC: WB
E-MAIL: MYNAME@NETZERO.NET
PF: 1=HLP 2=RTN                   6=NXT                              12=ESC
          14=MDC 15=TPL 16=ALT        18=COR
```

NOTE: The F14, F15 and F16 options above will only appear on the screen if there is data to report (i.e. F14 will not appear on this screen if the member does not have Medicare).

3. If "F14=MDC" is shown as an option on the demographic screen (#2), pressing **Shift and F2** will bring up the Medicare Coverage screen shown below. **F2** will return the user to the demographic screen.

```
 TR: CA166 ACT: I              AHCCCS - RECIPIENT    USER-ID: 57N    05/19/06
                            INQUIRE MEDICARE COVERAGE                13:21:30
                                                                     RP01L050
A12345678 CAMPBELL ED                    SEX M DOB 01/01/1949 DOD __________

      MEDICARE   PAYER  BEGIN     END           CHG    DATE      LAST MOD
PART  CLAIM NO.   ID    DATE      DATE      SRC RSN  REC ADDED  DATE      USR
 A  123456789A   FREE 05/01/1995           AS      01/13/1995 09/07/2005 BAT
 B  123456789A   030  05/01/1995           SI      01/13/1995 01/12/2001 BAT
 C  123456789A        07/01/2005           AS      06/14/2005 06/14/2005 BAT
 D  123456789A        01/01/2006           MS      12/15/2005 12/15/2005 BAT


PF: 1=HLP 2=RTN                         7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

If this screen indicates the member has "Part C" as shown in the example above, this means the member is eligible for the Qualified Medicare Beneficiaries (QMB) program.

If the screen indicates that the member has "Part D' as shown in the example on the preceding page, refer to the RP214 screen (instructions on page 411-42 of this chapter) to determine which Part D drug plan the member is enrolled with.

4. If "F15=TPL" is shown as an option on the demographic screen (#2), pressing **Shift and F3** will bring up the Third Party Coverage Summary screen shown below. **F2** will return the user to the demographic screen.

```
TR: CA166 ACT: I            AHCCCS - RECIPIENT   USER-ID: 57N  01/13/03
                  INQUIRE THIRD PARTY COVERAGE SUMMARY      10:48:56
                                   RP01L055
A12345678 CAMPBELL ED              SEX M DOB 01/01/1949 DOD __________

     CARRIER                                  COV CHG
 SRC NUM   NAME              POLICY NUMBER  BEGIN DATE  END DATE TYP RSN
 S OA      BCBS              1234-5678      07/10/2002


PF: 1=HLP 2=RTN                 7=UP  8=DWN                12=ESC
```

For more information on any TPL listed in the screen above, put an **"S"** in the selection field to the left of the policy and press Enter. The Third Party Coverage Detail screen shown in #5 below will be displayed.

5. Pressing **F2** from this Third Party Coverage Detail screen will return the user to the TPL screen shown in #4.

```
TR: RP155 ACT: I              AHCCCS - RECIPIENT  USER-ID: 57N   01/13/03
                    INQUIRE THIRD PARTY COVERAGE DETAIL       10:49:17
                                          RP02L055
A12345678 CAMPBELL ED                 SEX M DOB 01/01/1949 DOD __________
          SOURCE: OA
    CARRIER NUMBER:         CARRIER NAME: BCBS
   STREET ADDRESS-1: 123.W EAST ST
   STREET ADDRESS-2:
           CITY: PHX              STATE: AZ    ZIP: 85223
     CARRIER PHONE: (     )     -
      GROUP NUMBER:
     POLICY NUMBER: 1234-5678          COVERAGE TYPE:
  POLICY BEGIN DATE: 07/10/2002          DATE VERIFIED:
    POLICY END DATE:
     CHANGE REASON:
POLICY HOLDER'S NAME: CAMPBELL ED
 POLICY HOLDER'S SSN: 555-55-5555
         EMPLOYER:
RELATIONSHIP OF POLICY HOLDER TO RECIPIENT: SELF
DATE RECORD ADDED: 07/10/2002  LAST MOD. DATE: 07/10/2002 LAST MOD. USER: 067

PF: 1=HLP 2=RTN                                          12=ESC
```

6. If "F16=ALT" is shown as an option on the demographic screen (#2), pressing **Shift and F4** will bring up the Alternate ID screen shown below. **F2** will return the user to the demographic screen.

```
TR: CA166 ACT: I           AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
NTR: _______________________  INQUIRE ALTERNATE ID                 10:49:51
                                          RP01L085
A12345678 CAMPBELL ED                 SEX M DOB 01/01/1949 DOD __________

   ALTERNATE ID  ID   ID DESCRIPTION   BEGIN        LAST MOD       DAT REC
          TYPE                DATE   SRC  DATE      USR   ADDED

 90014760       AC APPLICATION CONT 06/19/2002 OA 06/19/2002 0A1 06/19/2002
 100555555      AS ACE SYSTEM ID NU 07/23/2002 OA 07/23/2002 0A1 07/23/2002
 123456780A      MC MEDICARE CLAIM I 01/01/2002 OA 07/10/2002 067 07/10/2002
 555-55-5555    SN UNVERIFIED SSN/P 06/19/2002 OA 06/19/2002 0A1 06/19/2002
```

7. From CA166 (#1), pressing **F8** will bring up the Share of Cost screen shown below. **F2** will return the user to CA166. The "CES SOC AMT" field indicates the SOC amount an HCBS member would have to pay if s/he were admitted to an institutional placement.

```
TR: CA166 ACT: I        AHCCCS - RECIPIENT        USER-ID: 57N   04/23/04
NTR: _________________  INQUIRE SHARE OF COST                    09:42:15
                                   RP03L075
A12345678 CAMPBELL ED              SEX   DOB 19490101   DOD

                                T  ORIGINAL    DATE    USER
  SOC     SOC       SOC      SOC      CES   Y  POSTING    LAST    LAST
  DATE    AMOUNT    ADJ AMT  USED AMT  SOC AMT P   DATE      MOD     MOD

 04/2004    .00        .00   963.69 I 03/29/2004 03/29/2004 BAT
 03/2004    .00        .00   963.69 I 02/27/2004 02/27/2004 BAT
 02/2004    .00        .00   963.69 I 01/26/2004 01/26/2004 LC*
 01/2004    .00        .00   946.49 I 12/26/2003 12/26/2003 LC*
 12/2003    .00        .00   946.53 I 11/28/2003 11/28/2003 BAT
 11/2003    .00        .00   946.53 I 10/29/2003 10/29/2003 BAT
 10/2003    .00        .00   946.53 I 09/28/2003 09/28/2003 BAT
 09/2003    .00        .00   946.53 I 08/29/2003 08/29/2003 BAT
 08/2003    .00        .00   946.53 I 07/29/2003 07/29/2003 BAT
 07/2003    .00        .00   946.53 I 06/28/2003 06/28/2003 BAT
 06/2003    .00        .00   946.53 I 05/29/2003 05/29/2003 BAT
 05/2003    .00        .00   946.53 I 04/28/2003 04/28/2003 BAT

PF: 1=HLP 2=RTN 3=CLR 4=MSG          7=UP  8=DWN                12=ESC
```

8. From CA166 (#1), pressing **F9** will bring up the Verification screen shown below. The user must enter a date in "DOS FROM DATE" field in order for eligibility/enrollment data to appear. This date can be the specific date for which eligibility or enrollment information is sought or the current date.

```
TR: CA166 ACT: I          AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
NTR:                    VERIFICATION                  11:38:29
                                              RP07L050
A12345678 CAMPBELL ED                 SEX M DOB 01/01/1949 DOD

AS OF DATE 01/13/2003 DOS FROM DATE _________ DOS THRU DATE _________ FYI
THE RECIPIENT'S ELIGIBILITY IS:                        ADDED ON
                BEGIN ON:        ENDED ON
                BEGIN ON:        ENDED ON

THE RECIPIENT'S  ENROLLMENT IS:      BEGIN     END     RATE
   HEALTH PLAN        CTRT TYP    DATE      DATE    CODE CSA  ADDED ON

PART A BEGINS:          AND ENDS:          MEDICARE CLAIM #:
PART B BEGINS:          AND ENDS:
THE RECIPIENT HAS THIRD PARTY COVERAGE WITH:
THE POLICY NO IS              BEGINNING ON          ENDING ON

PF: 1=HLP 2=RTN 3=CLR 4=MSG          7=UP  8=DWN                12=ESC
```

9. Entering a "DOS FROM DATE" brings up information as shown below. **F2** will return the user to CA166.

```
TR: CA166 ACT: I          AHCCCS - RECIPIENT     USER-ID: 57N     01/13/03
NTR:                    VERIFICATION                  10:39:17
                                                RP07L050
A12345678 CAMPBELL ED                 SEX M DOB 01/01/1949 DOD

AS OF DATE 01/13/2003 DOS FROM DATE 11/01/2002 DOS THRU DATE _________ FYI N
THE RECIPIENT'S ELIGIBILITY IS:                          ADDED ON
L SD MAO              BEGIN ON: 11/01/2000 ENDED ON          06/19/2002
                  BEGIN ON:          ENDED ON

THE RECIPIENT'S  ENROLLMENT IS:       BEGIN      END      RATE
    HEALTH PLAN         CTRT TYP    DATE       DATE     CODE CSA  ADDED ON
ANY LTC PLAN          LTC/CAP     08/01/2002          2200 13 07/24/2002
ANY LTC PLAN          LTC/CAP     06/19/2002 07/31/2002 2210 13 06/19/2002
ANY LTC PLAN          LTC/PPC     10/01/2000 06/18/2002 221Z 13 06/19/2002

PART A BEGINS: 01/01/2002 AND ENDS:          MEDICARE CLAIM #: 555555555A
PART B BEGINS:          AND ENDS:
THE RECIPIENT HAS THIRD PARTY COVERAGE WITH: BCBS
THE POLICY NO IS 1234-5678      BEGINNING ON 07/10/2002 ENDING ON

PF: 1=HLP 2=RTN 3=CLR 4=MSG           7=UP  8=DWN                12=ESC
          15=TPL
```

10. From CA166 (#1), pressing **F10** will bring up the BHS/FYI Data screen shown below. Pressing **F2** from this screen will generate an error. **F12 must be used to return the user to CA166 from the BHS/FYI Data screen.**

```
 TR: CA166 ACT: I            AHCCCS - RECIPIENT    USER-ID: 57N    06/04/04
NTR: _____                  INQUIRE BHS/FYI DATA                 07:36:10
                                        RP04L016
A12345678 CAMPBELL          ED      SEX  M  DOB 19490101   DOD _________

        BHMIS ID: XXXXXXXXXX
   TYPE                    CHG                    LAST MOD
    ID   BEGIN DATE END DATE   STA  RSN SITE CAT   DATE ADDED   DATE    USER

   079999 09/01/1994 06/20/2002  A   CH   23   S    09/24/2003 09/24/2003 CNV
   079999 06/01/1994 07/31/1994  A   RO   23   S    09/24/2003 09/24/2003 CNV
   079999 04/19/1994 04/30/1994  A   RO   23   S    09/24/2003 09/24/2003 CNV



PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=DSP 7=UP  8=DWN      10=TOP 11=BOT 12=ESC
```

"BHMIS ID" is an identification number assigned by ADHS/BHS for their tracking purposes only.
"TYPE ID" should be 079999 which indicates enrollment with ADHS/BHS.
"CHG RSN" (Change Reason) codes may be found on RF525 in PMMIS.

SITE CODES	
02	CENPATICO 2
03	YUMA BEHAVIORAL HEALTH SERVICE
05	COMCARE
07	MAGELLAN
08	VALUE OPTIONS
11	GILA RIVER INDIAN TRIBE
14	NAVAJO NATION
15	NORTHERN AZ REG BEHAVIORAL SER
17	SALT RIVER PIMA-MARICOPA IND
18	SOUTHEAST AZ BEHAVIORAL SERV
22	CENPATICO 4
23	PINAL/GILA BEHAVIORAL SERVICES
24	AZ CENTER FOR CLINICAL MGMT
25	PASCUA YAQUI TRIBE
26	COMM PARTNER SO AZ SVC AREA 5
27	COMM PARTNER SO AZ SVC AREA 3

MENTAL HEALTH CATEGORIES	
C	CHILDREN SERVICES
D	SUBSTANCE/ALCOHOL ABUSE MENTAL HEALTH SERVICES
G	GENERAL MENTAL HEALTH SERVICES
S	SMI
Z	SED CHILDREN

CA166 Provider Search Instructions

On CA166/ACE Critical Data, users can do a provider search to determine who the Provider ID# in the "LAR Provider" (Living Arrangement) field belongs to, if applicable. The Provider ID# that appears in this field will reflect only the Nursing Facility or Assisted Living Facility provider that AHCCCS eligibility has recorded as the member's current living arrangement in ACE.

```
TR: CA166                  AHCCCS - LONG TERM CARE                    05/30/06
NTR: _____ I _______________  ACE CRITICAL DATA                        07:53:31
WORKER ID: 605636                                                     LT02L130
NAME: JONES                ALICE           STATUS: A  EFF TERM DAT: __________
AHCCCS-ID: A87654321  ACE ID: 100000000 TRIBE CD: 15  RES CD: __  NET TEST: P
CASE MANAGER: 123456 MANAGER, CASEY                   OFFICE: 13A  PAS LOC: I
FIN REDE DUE DATE: 10/31/2006    MED REASS DUE DATE: NONE        DD STATUS: 4

LIVING ARRANGEMENT(LAR): LT   LAR PROVIDER: 355752   LAR BEG DATE: 07/22/2000
MOST RECENT TRANSITIONAL PERIOD BEGIN DATE: __________   END DATE: __________
 MAJOR DIAG 1: 3109        MAJOR DIAG 2: 582         MAJOR DIAG 3: __________

  AUTH REP: JONES                PHYLLIS    _          RELATION: OT
         STREET ADDRESS: 12345 E THOMAS
     CITY: ANYWHERE            ST: AZ  ZIP: 85256 ____  RES PHO: ___ ___ ____
                                                       BUS PHO: 555 555 5555
 LEGAL REP: ____________________ __________ _          RELATION: __
         STREET ADDRESS: ________________________    ________________________
     CITY: ___________________  ST: __  ZIP: _____ ____  RES PHO: ___ ___ ____
                                                       BUS PHO: ___ ___ ____

                                                   Z026 RETURN FROM HELP
1=HLP 2=CA000 3=ADD 4=ERR 5=CA165 6=CA167 (7=DEM 8=SOC 9=VER 10=MHS) 11=CLEAR
```

The user should place the curser on the Provider ID# in the LAR Provider field (bolded in the screen example above) and press F1. A screen such as the one shown below will be displayed. The provider information from the ID chosen on the screen will be at the top of the list shown. Pressing F2 will return the user to CA166.

```
TR: CA166 ACT: I      AHCCCS - INFORMATION REFERENCING                05/30/06
                               PROVIDER ID/NAME                        07:54:14
                                                                       AH05L012
S  SORTED BY PROVIDER ID
E
L PR ID  NPI        PROVIDER NAME             -----PROVIDER TYPE-------------
  ______ __________ ________________________
_ 355752             PLAZA HEALTHCARE          22 NURSING HOME
_ 355760            DUNKIN/MARTHA(BETH)       50 ADULT FOSTER CARE
_ 355778            JOHNSON/LEONILA(MILA)     50 ADULT FOSTER CARE
_ 355786            WHITE MNTN REG MED CENTER 22 NURSING HOME
_ 355794            LEAR/LISA A.              07 DENTIST
_ 355801            CARDOZA/MARTY             50 ADULT FOSTER CARE
_ 355819            THE WILLOWS               50 ADULT FOSTER CARE

PF:       2=RTN                        7=UP  8=DWN       10=TOP 11=BOT
```

G. MEMBER INCOME (CA167)

Monthly income data for a member is displayed on this screen. Data is available by the Budget Months recorded in the AHCCCS Customer Eligibility (ACE) system, not necessarily for every calendar month. This data is made available to case managers for purposes of determining Room & Board charges if/when the member is admitted to an Assisted Living Facility.

Users may not designate or switch between members on the CA167 screen. Users can access CA167 from any of the other member data screens (CA160, CA161, CA165 or CA166) as long as the member's AHCCCS ID# has already been entered on that previous screen. For example, if the user is viewing John Smith's CA160/CES, s/he may type "CA167" in the NTR field and bring up CA167 for John Smith but could not travel to CA167 from John Smith's CA160 and plan to view Mary Jones' Income data. To switch between members for income data, the user may press F5 to return to CA166, enter another member's AHCCCS ID and then return to CA167 for <u>that</u> member's income data by either pressing F6 or by typing "CA167" in the NTR field.

Upon entering CA167 for a specific member, the current month will appear in the Budget Month field (e.g. March 2006 = Budget Month 200603) but the user must press the Enter key in order for any income data available for that month to be displayed. As eligibility does not record income data for every month, if the member's income has not changed since it was last recorded, income data may not appear for the current month. The F7 key will scroll the user backward, month by month, to view data for prior months. If there is no data recorded for a particular month, the message "NOT FOUND IN ACE" will appear at the top of the screen. Users may continue to scroll until income data is displayed or a specific Budget Month can be entered to bring the user directly to that month.

```
2519 NOT FOUND IN ACE
TR: CA167                    AHCCCS - LONG TERM CARE                 04/12/06
NTR:       I                      MEMBER INCOME                      09:38:21
BUDGET MONTH: 200604                                                  LT02L135

NAME: BUNNY               BUGS             ACN:           AHCCCS ID: A12345678

 TYPE OF INCOME            SOURCE OF INCOME             REPORTED AMOUNT




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

In the example below, the last Budget Month for which income was recorded in ACE is March 2006. All Earned and Unearned income for the member will be displayed, including the Type, Source and Amount. Up to 14 income types/sources may be displayed for a member as applicable.

```
TR: CA167                    AHCCCS - LONG TERM CARE                 03/09/06
NTR:       I                      MEMBER INCOME                      08:41:32
BUDGET MONTH: 200603                                                  LT02L135

NAME: BUNNY               BUGS             ACN:           AHCCCS ID: A12345678

 TYPE OF INCOME            SOURCE OF INCOME             REPORTED AMOUNT
 SOCIAL SECURITY           SOCIAL SECURITY ADMINISTR        227.00
 NO EARNED INCOME                                             0.00




1=HLP 2=CA000       5=CA166 6=CA225                              12=AH000
```

H. CASE MANAGER REVIEWS TRACKING LIST (CA225)

```
TR: CA225                  AHCCCS - LONG TERM CARE                      10/01/03
 NTR: _____ I _____________ CASE MANAGER REVIEWS TRACKING LIST          08:01:59
                   FROM MONTH: ____1____ THRU MONTH: ____2_____         LT02L170
 CASE MANAGER: ___3__   ________________________________   WORKER ID: 605636
                                                        CURRENT
  DUE DATE                 CLIENT NAME       AHCCCS ID PLC LOC   FACILITY
 ____A_____ ___________B________ __________ _____C__  D_ E ___F__ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________
 __________ ______________________ __________ __________  __ _ ______ ____________

  ENT=PROCESS   1=HELP   2=CA000   6=CA165   9=SUP  10=SDN  11=CLEAR  12=CA000
```

This screen is designed to provide the user with a list of member service assessment/review due dates within a specified time period for a specific case manager. This information is obtained from the "CURR CSMGR" (current case manager) and "Next Review Date" fields on CA161. This screen is one of only 2 CATS screens that is not accessed with a member's AHCCCS ID# (CA105 is the other).

The **Numbered** fields shown on the screen above are for data entry. The **Lettered** fields above are information-only, the data cannot be changed in these fields.

Instructions for completion of the **Numbered** fields are as follows:

(1) FROM MONTH - This field will contain the current month/year when the user enters this screen. If the user wants to view an earlier time period, that month/year should be entered (for example if, in April 2006, the user wants to see if there are any overdue cases back to January 2006, 01/2006 would be entered in this field). The format is MM/YYYY.

(2) THRU MONTH - This field will contain the current month/year when the user enters this screen. If the user wants to view a later time period, that month/year should be entered. The format is MM/YYYY.

(3) CASE MANAGER - Enter the 6-digit ID# of the case manager for whom case review information is sought. Only review information about enrolled members who are currently assigned to this case manager on CA161 will appear when this ID# is entered.

Below is an explanation of the **Lettered, information-only** fields:

(A) DUE DATE - The date from the "NEXT REVIEW DATE" field on CA161 will be displayed here. The system calculates the date the member's next on-site service review is due based on the "Last Review Date" entered on CA161 and the member's current placement. Members in "H" and "D" placement will be due in 90 days and members "Q" placement will be due in 180 days. Members still in "Z" placement when a "Last Review Date" is entered will show a Next Review Date in 30 days.

(B) CLIENT NAME - The member's name (last, first) will be displayed here.

(C) AHCCCS ID - The member's AHCCCS ID# will be displayed here.

(D) CURRENT PLC - The member's current placement code will be displayed here. This information is read from CA161.

(E) CURRENT LOC - The information in this field is inconsistent and should not be relied on. This field used to display the Level of Care from either the most recent PAS or as updated by the case manager on CA165.

(F) FACILITY - The provider ID# and name of the nursing facility the member resides in, if applicable, will be displayed here. This information is read from CA165/Service Plan. If there is no open service authorization for the facility on CA165, this field will be blank.

I. INQUIRE PART D DRUG PLAN (RP214)

```
 TR: RP214 ACT: I              AHCCCS - RECIPIENT    USER-ID: MA3    10/25/10
NTR: _______________________  INQUIRE PART D DRUG PLAN               16:35:40
   (A)           (B)                      (C)          (D)    (E)     RP01L014
A12345678  BEET VICTORY H                SEX F DOB 01/01/1900  DOD
     (F)
ALTERNATE DOB:
  (F)                                                    (L)
  S  (G)   (H)          (I)            (J)     (K)     DATE         (M)
  T EN   DRUG                        BEGIN    END     REC       LAST MOD
  A TP  PLAN ID     PLAN NAME        DATE     DATE    ADDED    DATE   USER

  A EC  S5678001  HEALTH NE/HEALTH N 01/01/09         12/27/08 12/27/08 BAT
  A EC  S5884086  HUMANA IN/HUMANA S 01/01/07 12/31/08 11/27/07 12/27/08 BAT
  A AA  S5960028  UNICARE L/MEDICARE 01/01/06 12/31/06 03/24/06 09/25/08 CV*





PF: 1=HLP 2=RTN 3=CLR 4=MSG            7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

The RP214/Inquire Part D Drug Plan screen may be used to determine which Medicare Part D drug plan the member is enrolled with and whether this was an enrollment choice or an auto-assignment by CMS. This information may be used by Contractors to determine if the member has Medicare Part D coverage so that this can be coordinated with the member's other AHCCCS benefits. AHCCCS does not cover prescriptions or the copayments when a member has Medicare Part D drug coverage.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the enrollment segment was totally inactivated.

(G) This is the enrollment type. "EC" is enrollment choice by the member. "AA" is auto-assignment to the plan by CMS (Centers for Medicare and Medicaid Services).

(H) This is the drug plan ID# for the Medicare Part D plan the member is assigned to. RF568 provides a reference table of plan IDs. This reference table will show you the full name of the Part D plan and the effective dates of the plan availability.

(I) This is the abbreviated name of the Medicare Part D drug plan.

(J) This is the begin date of the member's coverage with the specific Medicare Part D drug plan. In the example on the screen, you can see the begin and end dates of three different Medicare Part D drug plans.

(K) This is the end date of the member's coverage with the specific Medicare Part D drug plan.

(L) This is the date the record was added to the system.

(M) This is the date the particular record was last modified and how it was modified. If there is a "*CV", this record is a result of conversion. If there is a "BAT", this is record is a result of the batch process.

J. INQUIRE FYI DATA (RP215)

```
 TR: RP215 ACT: I                AHCCCS - RECIPIENT    USER-ID: MA3    10/26/10
NTR: _______________________      INQUIRE FYI DATA                    16:52:29
(PRIMARY)                                                             RP02L015
   (A)        (B)                            (C)        (D)            (E)
A12345678 BALDMAN GERM                     SEX M DOB 06/01/1982 DOD

           CRS CLIENT ID:    (F)                  TSC CLIENT ID:  (G)
         AZEIP CLIENT ID:    (H)
      (I)       (J)         (K)     (L)  (M)               (N)           (O)
    TYPE                                CHG                            LAST MOD
     ID   BEGIN DATE  END DATE   STA RSN SITE CAT  DATE ADDED     DATE    USR

   H7352  03/01/2008              A                06/09/2010  06/09/2010 BAT
   999222 01/01/2008              A                01/04/2008  10/03/2010 BAT
   999222 07/01/1999 12/31/2007   A                12/22/2004  12/03/2007 BAT
```

The RP215/Inquire FYI Data screen is used to show special enrollments. This information is used by Contractors to determine if the member is enrolled with a Medicare HMO, Children's Rehabilitative Services (CRS), AzEIP (Arizona Early Intervention Program) or TSC (Targeted Support Coordination).

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) This is the member's AHCCCS ID number. If you scroll to this screen on a case you are already looking at, the information displayed will be for the same member. If you want to look at a different case, enter the appropriate AHCCCS ID and press ENTER. This is the only field on this screen that allows entry.

(B) This is the member's last name, first name and middle initial.

(C) This is the member's gender.

(D) This is the member's date of birth.

(E) This is the member's date of death, as applicable.

(F) This is the member's Children's Rehabilitative Services client ID number, if applicable.

(G) This field was created to display the member's Targeted Support Coordination client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(H) This is the member's Arizona Early Intervention Program (AzEIP) client ID number, as applicable. Since the Department of Economic Security (DES) uses the member's AHCCCS ID number instead, this field will be blank.

(I) The type ID will show the member's special enrollment as follows.

Medicare HMO enrollment shows a Type ID starting with an "H". The reference table to look up the Medicare HMO plan names is RF517.

999111 = CRS

999555 = AzEIP

999222 = TSC

(J) This is the begin date of the member's special enrollment.

(K) This is the end date of the member's special enrollment. If there is no end date, the member's enrollment in that special category continues. Members can have more than one special enrollment active at one time. In the example on the screen, the member has a Medicare HMO enrollment and TSC enrollment active.

(L) This is the status of the line. This is almost always (A)ctive. It will only be (I)nactive if the special enrollment segment was totally inactivated.

(M) If there is a change to the Medicare HMO enrollment, there will be a change reason in this field. Refer to RF525 for a list of change reasons.

The "Site" and "CAT" fields on this screen are no longer used.

(N) This is the date the record was added to the system.

(O) This is the date the particular record was last modified and how it was modified. This information is updated by daily/monthly electronic matches between DES and PMMIS so this field will usually show "BAT". This means that the record was updated in that the batch process.

K. INQUIRE ELIGIBILITY AND ENROLLMENT (RP285)

```
TR: RP285 ACT: I              AHCCCS - RECIPIENT  USER-ID: MA3 11/12/10
 NTR: _____                  INQUIRE ELIGIBILITY AND ENROLLMENT      15:12:58
                                          RP02L085
 A12345678 JOHNS WILBUR                SEX M DOB 07/18/1929 DOD
            (A)
            ELG        COMB BEG        COMB END
            KEY         DATE            DATE
            140       02/01/2009
            587       07/01/2008      01/31/2009
            587       10/01/2005      08/31/2007



    (B)  (C)                          (E)     (F)
   HEALTH PLAN/    ENROLLMENT    ENROLLMENT     RATE     ENRL
   CSA/CTRT TYP (D) BEGIN DATE     END DATE     CODE     TYP     STA
   110015 19 J     10/28/2010                  2210      MA      A
   110306 13 J     07/01/2010    10/27/2010     2210      EC      A
   110088 13 J     03/16/2009    06/30/2010     2210      EC      A
   110088 13 M     03/01/2009    03/15/2009     221Z      RA      A
   010497 05 A     12/11/2008    02/28/2009     3618      RE      A
PF: 1=HLP 2=RTN 3=CLR 4=MSG           7=UP  8=DWN      10=UP  11=DWN 12=ESC
```

The Inquire Eligibility and Enrollment (RP-285) screen is used to review the combined eligibility and enrollment history for a specific member. The top half of the screen contains eligibility data and the bottom half of the screen contains enrollment information. This screen is useful to quickly reference which AHCCCS Program a member is eligible for, the dates of that enrollment and their health plan.

The only entry field on this screen is the member's AHCCCS ID number. Enter the number for the member you wish to inquire about and press ENTER. The member's information will appear on the screen.

Below is an explanation of the **Lettered** fields. This is an **information-only** screen for Contractors – no data can be added or changed on this screen by users.

(A) ELIGIBILITY KEY: Use RF534 to determine what each eligibility key code means. Enter the code you are looking for on RF534 and press ENTER. A full description of the code will be displayed.

(B) HEALTH PLAN: See Attachment B for a list of current AHCCCS Contractors.

(C) COUNTY: Use the following table for Arizona County codes:

CODE	COUNTY
01	APACHE
03	COCHISE
05	COCONINO
07	GILA
09	GRAHAM
11	GREENLEE
13	MARICOPA
15	MOHAVE
17	NAVAJO
19	PIMA
21	PINAL
23	SANTA CRUZ
25	YAVAPAI
27	YUMA
29	LA PAZ

(D) Contract Type: RF410 displays a list of contract types. The most common contract types for Long Term Care are:

CODE	COUNTY
J	Long Term Care Capitated
L	Long Term Capitated Acute Care Only
P	Long Term Care Partially Capitated (for FFS members)
T	Long Term Care FFS Acute Care Only

(E) Rate Code: RF401 displays a list of rate codes.

(F) Enrollment Type: RF513 displays a list of enrollment types.

VII. REFERENCES

- AMPM, Chapter 1200
- AMPM, Chapter 1600
- Attachment A, ALTCS Contractor Case Manager Affiliation
- Attachment B, AHCCCS Contractor ID Numbers

POLICY 411, ATTACHMENT A, ALTCS CONTRACTOR CASE MANAGER AFFILIATION

PURPOSE: The purpose of the following information is to provide the procedures to follow regarding the affiliation of case managers with ALTCS Contractors. These procedures are necessary to assign case managers their 6-digit Case Manager ID#.

- **PROCEDURE ONE, NEW CASE MANAGER, NEVER AFFILIATED** includes the steps to follow to affiliate a case manager who has never before been affiliated with an ALTCS Contractor.

- **PROCEDURE TWO, TRANSFERRED CASE MANAGER, PRIOR AFFILIATION STILL ACTIVE** includes the steps to follow to affiliate a case manager who was affiliated previously with another ALTCS Contractor and that affiliation is still active. The prior affiliation must be terminated before a new one can be initiated.

- **PROCEDURE THREE, REINSTATED CASE MANAGER** includes the steps to follow to affiliate a case manager who was affiliated previously with an ALTCS Contractor and that affiliation has been terminated.

- **PROCEDURE FOUR, TERMINATING A CASE MANAGER** includes the steps to follow to terminate a case manager's affiliation when s/he no longer works for the ALTCS Contractor.

- **PROCEDURE FIVE, CHANGING A CASE MANAGER'S NAME** includes the steps to follow to change a case manager's name.

PROCEDURE ONE

NEW CASE MANAGER, NEVER AFFILIATED

1. Go to the PR800A AHCCCS - PROVIDER CASE MANAGER SEARCH screen.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
 NTR: _______________________  CASE MANAGER SEARCH                      07:54:18
                                                                        PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: ___________________________            SSN: ___________
     PROVIDER TYPE:

 SEL             NAME                        ID    STATUS     SSN       PR TYPE





 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. Search for the case manager by last name.

```
7337 ENTER SEARCH CRITERIA - OR - PRESS PF6 TO ADD NEW CASE MANAGER
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/17/11
NTR: _______________________  CASE MANAGER SEARCH                      07:54:18
                                                                       PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: doe_______________________            SSN: ___________
    PROVIDER TYPE:

SEL             NAME                        ID    STATUS     SSN       PR TYPE





PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

```
7338 NO MATCH FOUND FOR SEARCH CRITERIA
 TR: PR800 ACT: A            AHCCCS - PROVIDER                      05/17/11
NTR: _______________________ CASE MANAGER SEARCH                    07:58:48
                                                                    PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: ___________________________           SSN: 234-23-2345
    PROVIDER TYPE:

SEL             NAME                        ID    STATUS     SSN       PR TYPE





PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. If the above name search does not result in a listing for the case manager and with the SSN number displayed, press the <F6> key to go to the PR800A AHCCCS – PROVIDER CASE MANAGER DEMOGRAPHICS SCREEN.

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                      05/17/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS                08:00:10
                                                                       PR01L193
      CASE MANAGER  ID:        NAME: ___________________________ SSN: 234-23-2345



 ENROLLMENT BEGIN DATE: __________


CORRESPONDENCE ADDRESS:
         STREET LINE 1: ___________________________
         STREET LINE 2: ___________________________
        CITY/STATE/ZIP: ___________________________ __ _____
           COUNTY CODE: __                  COUNTRY CODE: __
        BUSINESS PHONE:( ___ ) ___ - ____ EMERGENCY PHONE:( ___ ) ___ - ____
          ATTENTION TO: ___________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                      12=ESC
```

5. The case manager's Social Security Number will be transferred from the previous screen. Complete the screen as follows. For "Name", enter the case manager's last name (comma) (space) case manager's first name. For Enrollment Begin Date, enter the employment begin date with the new ALTCS Contractor. For Street Line 1, enter the new ALTCS Contractor name. For Street Line 2, enter the ALTCS Contractor office address where the case manager is located. For City/State/Zip, enter the ALTCS Contractor office information. For County Code, enter the ALTCS Contractor office county location (must agree with zip code). For Country Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

```
TR: PR800 ACT: A              AHCCCS - PROVIDER                      05/17/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS               14:37:44
                                                                      PR01L193
      CASE MANAGER  ID:        NAME: doe, john_________________ SSN: 234-23-2345


 ENROLLMENT BEGIN DATE: 03/01/2008


CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY ALTCS CONTRACTOR
         STREET LINE 2: 1111 w. elm st___________
        CITY/STATE/ZIP: phoenix__________          az  85034
           COUNTY CODE: 13                COUNTRY CODE: 01
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO: __________________________




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI                                      12=ESC
```

6. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED". The ID assigned to the case manager will be displayed on the screen.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR800 ACT: A              AHCCCS - PROVIDER                    05/17/1
NTR: _______________________  CASE MANAGER DEMOGRAPHICS             14:41:0
                                                                    PR01L19
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 16  PENDING-AFFILIATION MISSING


 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY ALTCS CONTRACTOR
         STREET LINE 2: 1111 W. ELM ST
        CITY/STATE/ZIP: PHOENIX                    AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO:




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

7. Press the <F6> key to go to the PR800A AHCCCS - HEALTH PLAN CASE MANAGER AFFILIATIONS screen. For ALTCS Contractor, enter the ALTCS Contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
TR: PR800 ACT: A                 AHCCCS - HEALTH PLAN                 05/17/11
NTR: _______________________     CASE MANAGER AFFILIATIONS             14:56:21
                                                                       HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY                START DATE   END DATE

110007                              13                     03 01 08    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __
______                              __                     __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT       8=DWN                   12=ESC
```

8. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED".

```
9200 RECORD(S) SUCCESSFULLY ADDED
  TR: PR800 ACT: A                 AHCCCS - HEALTH PLAN                 05/17/11
 NTR: _______________________     CASE MANAGER AFFILIATIONS             14:57:47
                                                                        HP07L690

    ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
      CASE MANAGER'S NAME: DOE, JOHN
    CURRENT ENRLMT STATUS: 01 ACTIVE

 ALTCS
 AFFILIATION
 CONTRACTOR                         COUNTY                START DATE   END DATE

 110007 LTC DD DES                  13 MARICOPA            03 01 08
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __
 ______                             __                     __ __ __    __ __ __

 PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT       8=DWN                   12=ESC
```

9. Press the <F6> key to go to the PR800A AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

```
TR: PR800 ACT: A                AHCCCS - PROVIDER                    05/17/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          14:59:38
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 P  16 PENDING-AFFILIATIO        A 03/01/2008 05/16/2011 05/17/2011
 A  01 ACTIVE                    A 05/17/2011            05/17/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT 7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

10. For “Change Enrollment Status”, enter “01”. For “Begin Date”, enter employment begin date. For “End Date”, enter 99/99/9999.

```
 TR: PR800 ACT: A                AHCCCS - PROVIDER                    05/17/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          14:59:38
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   01  BEGIN DATE: 03/01/2008  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 P  16 PENDING-AFFILIATIO        A 03/01/2008 05/16/2011 05/17/2011
 A  01 ACTIVE                    A 05/17/2011            05/17/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT 7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: “RECORD(S) SUCCESSFULLY CHANGED”. The screen will display “Enr Sta

Type/Enr Sta Cod/Description" of "A 01 ACTIVE" and for "Begin Date" the employment begin date.

12. To confirm case manager affiliation with the new ALTCS Contractor, go to the HP014I

```
9202 RECORD(S) SUCCESSFULLY CHANGED
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                 05/17/11
NTR: _______________________ INQUIRE CASE MANAGER AFFILIATIONS        15:08:33
                                                                      HP07L190

   ENTER CASE MANAGER ID: 606962 OR SSN: ___ __ ____
     CASE MANAGER'S NAME:
   CURRENT ENRLMT STATUS:

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                     AFFILIATION
CONTRACTOR                          COUNTY              START DATE   END DATE




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
 PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT 7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

AHCCCS - HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

13. Enter the case manager ID and press the <ENTER> key. The screen will display the "ALTCS Contractor", "County" and "Affiliation Start Date".

```
TR: HP014 ACT: I                 AHCCCS - HEALTH PLAN                 05/17/11
NTR: _______________________ INQUIRE CASE MANAGER AFFILIATIONS         15:12:16
                                                                       HP07L190

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                      AFFILIATION
CONTRACTOR                        COUNTY              START DATE   END DATE

110007 LTC DD DES                 13 MARICOPA         03/01/2008




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

PROCEDURE TWO

TRANSFERRED CASE MANAGER, PRIOR AFFILIATION STILL ACTIVE

1. Go to the PR800A AHCCCS – PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the name search provides a listing for the case manager, place an "S" in the "SEL" field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
 TR: PR800 ACT: A             AHCCCS - PROVIDER                        05/23/11
NTR: _______________________  CASE MANAGER SEARCH                      15:29:15
                                                                       PR01L091

   CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

CASE MANAGER NAME: DOE                                  SSN: ___________
    PROVIDER TYPE:

SEL            NAME                          ID    STATUS     SSN       PR TYPE

 S   DOE, JOHN                             606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                   123456   A 01   000-00-0000    98
 _   DOHERTY TOM                          456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                       987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                        654321   T 30   333-44-5555    98

PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS – PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C              AHCCCS - PROVIDER                      05/17/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS               15:29:06
                                                                      PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 03/01/2008  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY ALTCS CONTRACTOR
         STREET LINE 2: 1111 W. ELM ST
        CITY/STATE/ZIP: PHOENIX                    AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO: ___________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

4. If the PR810C screen displays a former ALTCS Contractor with a current enrollment status of ***01 Active***, go to the HP014C AHCCCS – HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen.

```
TR: HP014 ACT: C                AHCCCS - HEALTH PLAN                 05/17/11
NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS         15:31:36
                                                                      HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: ___ __ ____
     CASE MANAGER'S NAME:
   CURRENT ENRLMT STATUS:

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

5. Enter the case manager ID and press the <ENTER> key.

```
TR: HP014 ACT: C                 AHCCCS - HEALTH PLAN                 05/17/1
NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS          15:32:4
                                                                       HP07L49

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                     AFFILIATION
CONTRACTOR                         COUNTY               START DATE   END DATE

110007 LTC DD DES                  13 MARICOPA           03 01 08    __ __ __




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

6. Enter the Affiliation End Date one day prior to the employment begin date with the new ALTCS Contractor.

```
 TR: HP014 ACT: C                 AHCCCS - HEALTH PLAN                 05/23/11
NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS          14:37:40
                                                                       HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS
AFFILIATION
CONTRACTOR                         COUNTY               START DATE   END DATE

110007 LTC DD DES                  13 MARICOPA           03 01 08    04 30 11




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

7. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: HP014 ACT: C                 AHCCCS - HEALTH PLAN                 05/23/11
NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS          14:39:31
                                                                       HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE

110007 LTC DD DES                   13 MARICOPA           03 01 08    04 30 11




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

8. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

```
 TR: PR815 ACT: C                 AHCCCS - PROVIDER                    05/23/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS           14:40:44
                                                                      PR01L295
      CASE MANAGER ID: 606962                              SSN:
        PROVIDER TYPE:
CURRENT ENRLMT STATUS:

 CHANGE ENROLLMENT STATUS:       BEGIN DATE:             END DATE:

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

9. For Current Enrollment Status, enter "30". For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          14:42:02
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING

 CHANGE ENROLLMENT STATUS:   30  BEGIN DATE: 05/01/2011  END DATE: 99/99/9999

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 03/01/2008 05/22/2011 05/17/2011
 P  16 PENDING-AFFILIATIO        A 05/23/2011            05/23/2011



PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

10. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED". The screen will display "Enr Sta Type/Enr Sta Cod/Description" of "T 30 TERMINATION-OTHER" and for "BEGIN DATE" the date previously entered.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/11
 NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          14:44:00
                                                                      PR01L295
       CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR               REPLACEMENT
 STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                    A 03/01/2008 04/30/2011 05/17/2011
  T  30 TERMINATION-OTHER         A 05/01/2011            05/23/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Go to the PR810C AHCCCS – PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C              AHCCCS - PROVIDER                      05/23/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS               15:10:50
                                                                      PR01L293
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: ANY ALTCS CONTRACTOR
         STREET LINE 2: 1111 W. ELM ST
        CITY/STATE/ZIP: PHOENIX                    AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 5555 EMERGENCY PHONE:( 602 ) 555 - 5556
          ATTENTION TO: __________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG                                            12=ESC
```

12. For Enrollment Begin Date, enter the employment begin date with the new ALTCS Contractor. For Street Line 1, enter the new ALTCS Contractor name. For Street Line 2, enter the ALTCS Contractor office address where the case manager is located. For City/State/Zip, enter the ALTCS Contractor office information. For County Code, enter the ALTCS Contractor office county location (must agree with zip code). For Country Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and

```
TR: PR810 ACT: C              AHCCCS - PROVIDER                       05/23/1
NTR: _______________________  CASE MANAGER DEMOGRAPHICS                15:10:5
                                                                      PR01L29
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN                 SSN: 234-23-234
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 03/01/2008
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: NEW ALTCS CONTRACTOR
         STREET LINE 2: 5555 E. oak ST
        CITY/STATE/ZIP: PHOENIX                    AZ  85034
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
          ATTENTION TO: __________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG                                            12=ESC
```

13. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR810 ACT: C              AHCCCS - PROVIDER                    05/23/11
 NTR: _______________________  CASE MANAGER DEMOGRAPHICS             15:14:29
                                                                     PR01L293
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN                SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 05/01/2011  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 03/01/2008
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
          STREET LINE 1: NEW ALTCS CONTRACTOR
          STREET LINE 2: 5555 E. OAK ST
         CITY/STATE/ZIP: PHOENIX                    AZ  85034
            COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
         BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
           ATTENTION TO: ___________________________


 PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

14. Go to the HP014A AHCCCS – HEALTH PLAN ADD CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key.

```
  TR: HP014 ACT: A                AHCCCS - HEALTH PLAN                 05/23/11
 NTR: _______________________ ADD CASE MANAGER AFFILIATIONS           15:16:20
                                                                       HP07L690

    ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
      CASE MANAGER'S NAME: DOE, JOHN
    CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

 ALTCS
 AFFILIATION
 CONTRACTOR                          COUNTY              START DATE   END DATE

 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __
 ______                              __                   __ __ __    __ __ __

 PF: 1=HLP 2=RTN 3=CLR 4=MSG                    8=DWN                 12=ESC
```

15. For ALTCS Contractors, enter the new ALTCS Contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

```
 TR: HP014 ACT: A                 AHCCCS - HEALTH PLAN                 05/23/11
NTR: _______________________  ADD CASE MANAGER AFFILIATIONS            15:17:28
                                                                       HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE

110065 PINAL/GILA LTC               21                    05 01 11       __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                    8=DWN                    12=ESC
```

16. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED".

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                 AHCCCS - HEALTH PLAN                 05/23/11
NTR: _______________________  ADD CASE MANAGER AFFILIATIONS            15:20:11
                                                                       HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE

110065 PINAL/GILA LTC               21 PINAL              05 01 11
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __
______                              __                    __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                    8=DWN                    12=ESC
```

17. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the <ENTER> key.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/1
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          15:21:2
                                                                     PR01L29
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                     A 03/01/2008 04/30/2011 05/17/2011
 T  30 TERMINATION-OTHER          A 05/01/2011            05/23/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

18. For "CHANGE ENROLLMENT STATUS", enter "01". For "BEGIN DATE", enter employment begin date. For "END DATE", enter 99/99/9999.

```
 TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          15:21:21
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

 CHANGE ENROLLMENT STATUS:   01  BEGIN DATE: 05/01/2011  END DATE: 99/99/9999

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                     A 03/01/2008 04/30/2011 05/17/2011
 T  30 TERMINATION-OTHER          A 05/01/2011            05/23/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

19. Press the <ENTER> key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED". The screen will display "Enr Sta Type/Enr Sta Cod/Description" of "A 01 ACTIVE" and for "BEGIN DATE" the employment begin date.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR815 ACT: C                AHCCCS - PROVIDER                    05/23/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          15:24:18
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR               REPLACEMENT
STA STA                PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION      NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 03/01/2008 04/30/2011 05/17/2011
 A  01 ACTIVE                    A 05/01/2011            05/23/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

20. To confirm case manager affiliation with the new ALTCS Contractor, go to the HP014I AHCCCS – HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the <ENTER> key. The screen will display the "ALTCS CONTRACTOR", "COUNTY" and "AFFILIATION START DATE".

```
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                 05/23/1
NTR: _______________________ INQUIRE CASE MANAGER AFFILIATIONS        15:25:3
                                                                     HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                     AFFILIATION
CONTRACTOR                          COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC               21 PINAL            05/01/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

PROCEDURE THREE

REINSTATED CASE MANAGER

1. Go to the PR800A AHCCCS – PROVIDER CASE MANAGER SEARCH screen. Search for the case manager first by last name. If the search by last name does not find a listing for the case manager, then search for the case manager by Social Security Number (SSN).

2. If the name search provides a listing for the case manager, place an "S" in the "SEL" field at the beginning of this line.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A             AHCCCS - PROVIDER                        08/22/11
 NTR: _______________________  CASE MANAGER SEARCH                      14:44:35
                                                                        PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                  SSN: ___________
     PROVIDER TYPE:

 SEL             NAME                          ID    STATUS     SSN       PR TYPE

 S   DOE, JOHN                            606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                  123456   A 01   000-00-0000    98
 _   DOHERTY TOM                         456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                      987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                       654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Press the <ENTER> key. This action will bring up the PR810C AHCCCS – PROVIDER CASE MANAGER DEMOGRAPHICS screen.

```
 TR: PR810 ACT: C              AHCCCS - PROVIDER                      08/22/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS               14:43:12
                                                                      PR01L093
      CASE MANAGER  ID: 606962 NAME: DOE, JOHN             SSN: 234-23-2345
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
     STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 10/25/2006
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: EVERCARE SELECT
         STREET LINE 2: 3141 N. 3RD AVE STE100
        CITY/STATE/ZIP: PHOENIX                    AZ  85013
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 331 - 5100 EMERGENCY PHONE:( 602 ) 745 - 7992
          ATTENTION TO:


PF: 1=HLP 2=RTN 3=CLR 4=MSG                                          12=ESC
```

4. If the PR810C screen displays a former ALTCS Contractor with a current enrollment status of ***30 TERMINATION-OTHER***, do the following. For Enrollment Begin Date, enter the employment begin date with the new ALTCS Contractor. For Street Line 1, enter the new ALTCS Contractor name. For Street Line 2, enter the ALTCS Contractor office address where the case manager is now located. For City/State/Zip, enter the ALTCS Contractor office information. For County Code, enter the ALTCS Contractor office county location (must agree with zip code). For Country Code, enter "01". For Business Phone, enter the case manager's phone number. Optional entries can be entered for both "Emergency Phone" and "Attention To".

5. Press the < ENTER > key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR810 ACT: C              AHCCCS - PROVIDER                    08/22/11
 NTR: _______________________  CASE MANAGER DEMOGRAPHICS             15:01:29
                                                                     PR01L293
       CASE MANAGER  ID: 606962 NAME: DOE, JOHN               SSN: 234-23-2345
          PROVIDER TYPE: 98  CASE MANAGER
  CURRENT ENRLMT STATUS: 30  TERMINATION-OTHER
      STATUS BEGIN DATE: 10/26/2007  STATUS END DATE: 99/99/9999

  ENROLLMENT BEGIN DATE: 10/01/2011
    ENROLLMENT END DATE: 99/99/9999

 CORRESPONDENCE ADDRESS:
          STREET LINE 1: NEW ALTCS CONTRACTOR
          STREET LINE 2: 5555 E. OAK ST.
         CITY/STATE/ZIP: PHOENIX                    AZ  85034
            COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
         BUSINESS PHONE:( 602 ) 555 - 1111 EMERGENCY PHONE:( 602 ) 555 - 1112
           ATTENTION TO: ___________________________


PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

6. Press the <F6> key to go to the HP014A AHCCCS – HEALTH PLAN CASE MANAGER AFFILIATIONS screen.

```
 TR: HP014 ACT: A                 AHCCCS - HEALTH PLAN                 08/22/1
NTR: _______________________  ADD CASE MANAGER AFFILIATIONS            15:05:5
                                                                       HP07L69

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

ALTCS                                                     AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE

_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                   8=DWN                     12=ESC
```

7. For ALTCS Contractor, enter the ALTCS Contractor ID. For County, enter the appropriate county code. For Affiliation Start Date, enter the employment begin date.

8. Press the < ENTER > key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY ADDED".

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: HP014 ACT: A                 AHCCCS - HEALTH PLAN                 08/22/11
NTR: _______________________  ADD CASE MANAGER AFFILIATIONS            15:10:58
                                                                       HP07L690

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 30 TERMINATION-OTHER

ALTCS
AFFILIATION
CONTRACTOR                          COUNTY               START DATE   END DATE

110044 NEW ALTCS CONTRACTOR       13 MARICOPA            10 01 11    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __
_______                             __                    __ __ __    __ __ __

PF: 1=HLP 2=RTN 3=CLR 4=MSG                   8=DWN                     12=ESC
```

9. Press the <F6> key to go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen.

10. For "CHANGE ENROLLMENT STATUS", enter "01". For "BEGIN DATE", enter employment begin date. For "END DATE", enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                     08/22/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS           15:15:42
                                                                      PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

 CHANGE ENROLLMENT STATUS:   01  BEGIN DATE: 10/01/2011  END DATE: 99/99/9999

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

 T  30 TERMINATION-OTHER         A 10/26/2007            10/25/2007
 A  01 ACTIVE                    A 10/01/2011 10/25/2007 08/22/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

11. Press the < ENTER > key. In the upper left portion of the screen, the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED". The screen will display "Enr Sta Type/Enr Sta Cod/Description" of "A 01 ACTIVE" and for "BEGIN DATE" the employment begin date.

```
9200 RECORD(S) SUCCESSFULLY ADDED
 TR: PR815 ACT: C                AHCCCS - PROVIDER                    08/22/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          15:19:19
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 01      ACTIVE

 CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

 T  30 TERMINATION-OTHER          A 10/26/2007 09/30/2011 10/25/2007
 A  01 ACTIVE                     A 10/01/2011            08/22/2011





PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

12. To confirm case manager affiliation with the new ALTCS Contractor, go to the HP014I AHCCCS – HEALTH PLAN INQUIRE CASE MANAGER AFFILIATIONS screen.

13. Enter the case manager ID and press the < ENTER > key. The screen will display the "ALTCS CONTRACTOR", "COUNTY" and "AFFILIATION START DATE".

```
TR: HP014 ACT: I                AHCCCS - HEALTH PLAN                 08/22/1
NTR: _______________________ INQUIRE CASE MANAGER AFFILIATIONS        15:25:1
                                                                      HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                    AFFILIATION
CONTRACTOR                          COUNTY             START DATE   END DATE

110044 NEW ALTCS CONTRACTOR      13 MARICOPA         10/01/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

PROCEDURE FOUR

TERMINATING A CASE MANAGER

1. If the case manager's current CM ID is not known, go to the PR800A AHCCCS – PROVIDER CASE MANAGER SEARCH screen to search for the individual by last name. As shown below, the ID is displayed on this screen once the case manager is found.

```
7342 PLACE 'S' BESIDE DESIRED NAME AND PRESS ENTER
  TR: PR800 ACT: A            AHCCCS - PROVIDER                        08/22/11
 NTR: _______________________ CASE MANAGER SEARCH                      14:44:35
                                                                       PR01L091

    CASE MANAGERS ARE HIGHLIGHTED WHEN THEIR SSNS MATCH NON-CASE MANAGER SSNS

 CASE MANAGER NAME: DOE                                  SSN: ___________
     PROVIDER TYPE:

 SEL            NAME                          ID    STATUS     SSN       PR TYPE

 S   DOE, JOHN                              606962   A 01   234-23-2345    98
 _   DOHANYOS, MEREDITH                     123456   A 01   000-00-0000    98
 _   DOHERTY TOM                            456789   T 30   111-22-3333    98
 _   DOLLEY, SYLVIE                         987654   T 30   222-33-4444    98
 _   DOLORES JOSSE                          654321   T 30   333-44-5555    98


 PF: 1=HLP 2=RTN 3=CLR 4=MSG      6=NXT  7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

2. If the case manager's CM ID is known, go to the HP014C AHCCCS – HEALTH PLAN CHANGE CASE MANAGER AFFILIATIONS screen. Enter the case manager ID and press the < ENTER > key.

```
TR: HP014 ACT: I                 AHCCCS - HEALTH PLAN                 05/23/1
NTR: _______________________ INQUIRE CASE MANAGER AFFILIATIONS         15:25:3
                                                                       HP07L19

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                     AFFILIATION
CONTRACTOR                         COUNTY              START DATE   END DATE

110065 PINAL/GILA LTC              21 PINAL            05 01 09




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

3. Enter the Affiliation End Date as the day the individual's employment with the ALTCS Contractor ended.

```
 TR: HP014 ACT: C                 AHCCCS - HEALTH PLAN                 05/23/11
NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS          12:22:03
                                                                       HP07L490

   ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
     CASE MANAGER'S NAME: DOE, JOHN
   CURRENT ENRLMT STATUS: 01 ACTIVE

DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

ALTCS                                                     AFFILIATION
CONTRACTOR                         COUNTY              START DATE   END DATE

110065 PINAL                       21 PINAL             05 01 09    08 31 11



PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

4. Press the < ENTER > key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: HP014 ACT: C                 AHCCCS - HEALTH PLAN                 09/06/1
 NTR: _______________________ CHANGE CASE MANAGER AFFILIATIONS          12:30:1
                                                                       HP07L49

    ENTER CASE MANAGER ID: 606962 OR SSN: 234 23 2345
      CASE MANAGER'S NAME: DOE, JOHN
    CURRENT ENRLMT STATUS: 16 PENDING-AFFILIATION MISSING

 DISPLAY:  S CURRENT AFFILIATIONS    _ OLD AFFILIATIONS    _ ALL AFFILIATIONS

 ALTCS                                                     AFFILIATION
 CONTRACTOR                         COUNTY               START DATE   END DATE

 110065 PINAL                       21 PINAL              05 01 09    08 31 11




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP  8=DWN       10=TOP 11=BOT 12=ESC
```

5. Go to the PR815C AHCCCS – PROVIDER CASE MANAGER ENROLLMENT STATUS screen. Enter the case manager ID and press the < ENTER > key.

6. For Current Enrollment Status, enter "30". For Begin Date, enter the date following the enrollment end date indicated on the HP014C screen. For End Date, enter 99/99/9999.

```
TR: PR815 ACT: C                AHCCCS - PROVIDER                    09/06/11
NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          12:33:48
                                                                     PR01L295
      CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
        PROVIDER TYPE: 98      CASE MANAGER
CURRENT ENRLMT STATUS: 16      PENDING-AFFILIATION MISSING

 CHANGE ENROLLMENT STATUS:   30  BEGIN DATE: 09/01/2011  END DATE: 99/99/9999

ENR ENR                REPLACEMENT
STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

 A  01 ACTIVE                    A 12/13/1999 08/31/2011 12/22/1999
 P  16 PENDING-AFFILIATIO        A 09/01/2011            09/06/2011




PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

7. Press the < ENTER > key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED. The screen will display "Enr Sta

Type/Enr Sta Cod/Description" of "T 30 TERMINATION-OTHER" and for "BEGIN DATE" the date previously entered.

```
9202 RECORD(S) SUCCESSFULLY CHANGED
  TR: PR815 ACT: C                AHCCCS - PROVIDER                    09/06/
 NTR: _______________________  CASE MANAGER ENROLLMENT STATUS          12:44:
                                                                      PR01L2
       CASE MANAGER ID: 606962  DOE, JOHN                 SSN: 234-23-2345
         PROVIDER TYPE: 98      CASE MANAGER
 CURRENT ENRLMT STATUS: 30      TERMINATION-OTHER

  CHANGE ENROLLMENT STATUS:   __  BEGIN DATE: __________  END DATE: __________

 ENR ENR                REPLACEMENT
 STA STA                 PROVIDER REC  BEGIN      END        SYSTEM     SYSTEM
 TYP COD DESCRIPTION       NUMBER STA  DATE       DATE      BEG DATE   END DATE

  A  01 ACTIVE                     A 12/13/1999 08/31/2011 12/22/1999
  T  30 TERMINATION-OTHER          A 09/01/2011            09/06/2011




 PF: 1=HLP 2=RTN 3=CLR 4=MSG             7=UP 8=DWN       10=TOP 11=BOT 12=ESC
```

PROCEDURE FIVE

CHANGING A CASE MANAGER'S NAME

1. Go to the PR810C AHCCCS – PROVIDER CASE MANAGER DEMOGRAPHICS screen using the Case Manager's ID. Type over the existing name with the changed name.

```
TR: PR810 ACT: C              AHCCCS - PROVIDER                      10/14/1
NTR: _____________________  CASE MANAGER DEMOGRAPHICS                 11:11:5
                                                                      PR01L29
      CASE MANAGER  ID: 123456 NAME: BROWN, MARY           SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                   AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY BROWN



PF: 1=HLP 2=RTN 3=CLR 4=MSG                                            12=ESC
```

2. Press the <ENTER> key. In the upper left of the screen the following message will be displayed: "RECORD(S) SUCCESSFULLY CHANGED".

```
9202 RECORD(S) SUCCESSFULLY CHANGED
 TR: PR810 ACT: C               AHCCCS - PROVIDER                      10/14/11
NTR: _______________________  CASE MANAGER DEMOGRAPHICS                11:02:15
                                                                       PR01L293
      CASE MANAGER  ID: 123456 NAME: SMITH, MARY            SSN: 123-45-6789
         PROVIDER TYPE: 98  CASE MANAGER
 CURRENT ENRLMT STATUS: 01  ACTIVE
     STATUS BEGIN DATE: 08/27/2010  STATUS END DATE: 99/99/9999

 ENROLLMENT BEGIN DATE: 08/27/2010
   ENROLLMENT END DATE: 99/99/9999

CORRESPONDENCE ADDRESS:
         STREET LINE 1: MERCY CARE PLAN
         STREET LINE 2: 4350 E COTTON CTR BLVD #4
        CITY/STATE/ZIP: PHOENIX                    AZ  85040
           COUNTY CODE: 13 MARICOPA        COUNTRY CODE: 01 UNITED STATES OF
        BUSINESS PHONE:( 602 ) 555 - 0000 EMERGENCY PHONE:( 602 ) 263 - 3000
          ATTENTION TO: MARY SMITH


PF: 1=HLP 2=RTN 3=CLR 4=MSG 5=PRI 6=NXT                                12=ESC
```

POLICY 411, ATTACHMENT B, AHCCCS CONTRACTOR ID NUMBERS

ID	NAME	ID	NAME
ACUTE CARE CONTRACTORS		**DES/DDD**	
010088	Bridgeway Health Solutions	110007	DES/DDD
010422	Health Net Access, Inc.	**ALTCS/EPD CONTRACTORS**	
010158	UnitedHealthcare Community Plan	110049	UnitedHealthcare Community Plan - LTC
010166	DES/CMDP	110088	Bridgeway Health Solutions - LTC
010254	Care1st Health Plan	110306	Mercy Care Plan - LTC
010299	PHP/Community Connection	**TRIBAL CONTRACTORS**	
010306	Mercy Care Plan	190000	Native American Community Health
010314	University Family Care	190009	White Mountain Apache Tribe
010383	Maricopa Health Plan	190017	Navajo Nation
010497	Health Choice Arizona	190025	Gila River Indian Community
999998	American Indian Health Plan	190033	Tohono O'Odham Nation
000850	Federal Emergency Services	190075	Pasqua Yaqui Tribe
002220	AHCCCS Non-Pay	190083	San Carlos Apache Tribe
003335	FFS Regular	190091	Hopi Tribe
008040	SLMB - Part B Buy-In Only	**CRS CONTRACTOR – UNITED HEALTHCARE COMMUNITY PLAN**	
008050	QI1 - Part B Buy-In Only		
008690	FFS Temporary	010115	CRS Fully Integrated
008715	AHCCCS QMB Only	010145	CRS Partially Integrated - Acute
888886	FFS LTC (Residual)	099125	CRS Partially Integrated – Behavioral Health
		099135	CRS Only

412 - CLAIMS REPROCESSING

EFFECTIVE DATE: 10/01/08, 10/01/13, 12/01/14

REVISION DATE: 09/01/09, 11/01/11, 07/01/12, 10/24/12, 08/15/13, 11/20/14

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes guidelines for Contractors for claims recoupment and refund activities.

II. DEFINITIONS

DAY Calendar day unless otherwise specified.

PROVIDER Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a Provider delivering such services. For the purposes of this Policy, a Provider delivering services pursuant to A.R.S. §36-2901.

RECOUPMENT An action initiated by the Contractor to recover all or part of a previously paid claim(s). Recoupments include Contractor initiated/requested repayments, as well as overpayments identified by the Provider where the Contractor seeks to actively withhold or withdraw funds to correct the overpayment from the Provider. For purposes of this Policy, a recoupment is a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days. An adjustment that is greater than $50,000 and is completed within 30 days is not considered a recoupment but must be tracked and made available to AHCCCS upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

REFUNDS An action initiated by a Provider to return an overpayment to a Contractor. In these instances the Provider writes a check or transfers money to the Contractor directly.

III. POLICY

The Contractor is responsible for reimbursing providers and coordinating care for services provided to a member pursuant to state and federal regulations, including, but not limited to A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq., and the Deficit Reduction Act of 2005 (Public Law 109-171).

The Contractor is required to follow AHCCCS recoupment policies as outlined in Contract and Policy. For requirements for adjudication and payment of claims and encounters refer to ACOM Policy 203. The Contractor's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims.

A. SINGLE RECOUPMENTS IN EXCESS OF $50,000

Prior to initiating any single recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Contractor must submit a written request for approval to the designated AHCCCS Operations and Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
   a. How the need for recoupment was identified,
   b. The systemic causes resulting in the need for a recoupment,
   c. The process that will be utilized to recover the funds,
   d. Methods to notify the affected Provider(s) prior to recoupment,
   e. The anticipated timeline for the project,
   f. The corrective actions that will be implemented to avoid future occurrences,
   g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted, and
   h. Other recoupment action specific to this Provider within the contract year.

2. An electronic file containing the following:
   a. AHCCCS Member ID,
   b. Date of Service,
   c. AHCCCS Original Claim Number,
   d. Date of Payment,
   e. Amount Paid,
   f. Amount to be Recouped.

3. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication must include a minimum:
   a. How the need for the recoupment was identified,
   b. The process that will be utilized to recover the funds,
   c. The anticipated timeline for the recoupment,

d. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped,
e. Listing of impacted claim CRNs.

The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

B. RECOUPMENT OF PAYMENTS INITIATED MORE THAN 12 MONTHS FROM THE DATE OF ORIGINAL PAYMENT

The Contractor is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of a clean claim unless approval is obtained from AHCCCS. Retroactive Third Party Recoveries are not included in this discussion. For Coordination of Benefits involving third party liability recoveries see ACOM Policy 434.

To request approval from AHCCCS, the Contractor must submit a request in writing to the designated AHCCCS Operations and Compliance Officer with all of the following information:

1. A detailed letter of explanation must be submitted that describes:
   a. How the need for recoupment was identified,
   b. The systemic causes resulting in the need for a recoupment,
   c. The process that will be utilized to recover the funds,
   d. Methods to notify the affected Provider(s) prior to recoupment,
   e. The anticipated timeline for the project,
   f. The corrective actions that will be implemented to avoid future occurrences,
   g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.

2. An Electronic file containing the following:
   a. AHCCCS Member ID,
   b. Date of Service,
   c. AHCCCS Original Claim Number,
   d. Date of Payment,
   e. Amount Paid,
   f. Amount to be recouped.

3. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication must include at a minimum:
   a. How the need for the recoupment was identified,
   b. The process that will be utilized to recover the funds,
   c. The anticipated timeline for the recoupment,
   d. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped,
   e. Listing of impacted claim CRNs.

The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

C. CUMULATIVE RECOUPMENTS IN EXCESS OF $50,000 PER PROVIDER PER CONTRACT YEAR

Contractors must continuously track recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the Contractor must report the cumulative recoupment monthly to the designated AHCCCS Operations and Compliance Officer as outlined in the AHCCCS Claims Dashboard Reporting Guide.

D. AHCCCS RESPONSIBILITY AND AUTHORITY

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of the Agency.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating such factors as validity, accuracy, and efficiency of Contractor processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail contingent upon receipt of all required information from the Contractor.

E. DATA PROCESSES FOR RECOUPMENT

Upon receipt of approval for recoupment from AHCCCS, the Contractor shall have no more than 120 days to complete the project and submit the following to the designated AHCCCS Operations and Compliance Officer:

1. Notification of the submission for the voided or replacement encounters (which must reach adjudicated status) and the appropriate associated information for all impacted encounters for recouped claims;

2. Upon completion of the recoupment project, a separate electronic file containing all of the following information for all recouped claims (this is independent of the 837 file(s) submitted through Encounters):
   a. AHCCCS Member Identification number,
   b. Date of Service,
   c. Original AHCCCS CRN,
   d. New AHCCCS CRN,
   e. Health Plan Allowed amount,
   f. Health Plan Paid amount,
   g. Provider Identification Number.

The Contractor must submit the above information for each adjudicated encounter.

Dependent on the size and/or volume of the recoupment request, AHCCCS may require the Contractor to submit an external file in order to directly update impacted encounters in the timeframe prescribed above.

Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in compliance action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of amending the encounter data, AHCCCS may adjust related reinsurance payments, reconciliation payments, or any other amounts paid to the Contractor that are impacted by the recoupment.

F. DATA PROCESSES FOR REFUNDS

Upon receipt of refund from a Provider, the Contractor shall have 120 days from the date of the refund to void or replace related encounters. All voided or replaced encounters must reach an adjudicated status within the 120 day timeframe.

1. The Contractor must also be able to identify the following for all refunds received and provide this information to AHCCCS upon request:
   a. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred,
   b. The corrective actions that will be implemented to avoid future occurrences, if applicable,
   c. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund,
   d. List of impacted claim CRNs.

G. ATTESTATION

All documentation and data submitted by the Contractor for purposes of recoupment and refund activities must be certified by the Contractor as specified in the Medicaid Managed Care Regulations 42 CFR 438.600 et seq. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Contractor failed to comply with any provision of this policy, the Contractor may be subject to corrective action, up to and including sanctions under the Sanctions paragraph of the contracts.

IV. REFERENCES

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- DCS/CMDP Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- A.A.C. R9-22 Article 7 (R9-22-701 et seq.)
- A.A.C. R9-28 Article 7 (R9-28-701 et seq.)A.R.S. §36-2901
- 42 CFR 438.600 et seq.
- Deficit Reduction Act of 2005 (Public Law 109-171)
- ACOM Policy, 203
- ACOM Policy, 434
- AHCCCS Claims Dashboard Reporting Guide

413 - GAP IN CRITICAL SERVICES

EFFECTIVE DATE: 04/01/07, 10/01/15

REVISION DATE: 07/01/10, 01/08/14, 06/18/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to ALTCS/EPD and DES/DDD (DDD) Contractors. This Policy establishes guidelines, criteria and timeframes for responding to and reporting of gaps in the provision of critical services provided to ALTCS members receiving Home and Community Based (HCBS) services.

II. DEFINITIONS

CONTINGENCY PLAN OR BACK-UP PLAN	Includes information about actions that the member/ representative should take to report any gaps in critical services.
CRITICAL SERVICES	Include Attendant Care, Personal Care, Homemaking and Respite care.
GAP IN CRITICAL SERVICES	The difference between the number of hours of home care worker critical services scheduled in each individual's HCBS care plan and the hours of the scheduled type of critical services that are actually delivered to the qualified individual.
MEMBER SERVICE PREFERENCE LEVEL	Indication of the timeframe in which the member chooses to have a critical service gap filled if the scheduled caregiver of that critical service is not available.

III. POLICY

The Contractor shall implement policies and procedures to identify, correct, and track gaps in critical services as outlined in contract, AMPM Chapter 1600, and this Policy. These policies and procedures shall, at a minimum, cover the following areas:

a. Information (verbally and in writing) to members on their right to receive services as authorized, including the right to have any gaps in critical services filled within two hours and the right to have a back-up caregiver to substitute when an unforeseeable gap in critical services occurs.

b. Information to members on how to contact the Contractor, its Subcontractor or AHCCCS when a critical service is not provided as scheduled.
c. At the time of the initial and quarterly reassessment case managers are required to assess a member's needs, including a member's service preference level if a gap in critical services were to occur and develop a contingency plan in the event of a gap in a member's critical services.
d. The Contractor's process for providing services in the event of a gap in critical services. This shall include a description of the process used to ensure that the Contractor or its Subcontractor timely provide a back-up caregiver in the event of an unforeseeable gap in critical service.
e. Tracking and trending gaps in critical services and grievances as a result of gaps in critical services.

A. GAP IN CRITICAL SERVICES REPORT

1. The Gap In Critical Services Report must be submitted semi-annually to the designated Operations and Compliance Officer as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

2. The semi-annual report must contain at a minimum:

DATA

a. Total number of authorized critical service hours
b. Total number of authorized critical service hours that were gap hours
c. Percentage of gap hours to authorized critical service hours
d. Number of hours provided to resolve gaps
e. Percentage of hours provided to resolve gaps to total gap hours reported
f. Number hours to resolve gaps provided by unpaid caregivers
g. Percentage of hours provided by unpaid caregivers to resolve gaps to total gap hours reported
h. Number of members with gaps
i. Percentage of members whose preference level were not met
j. Total number of providers
k. Monthly average number of providers reporting gaps
l. Number of service gaps reported
m. Data a. through l. above from the previous reporting period

NARRATIVE SUMMARY

a. Percent of gap critical hours to authorized critical hours
b. Grievances
c. Trends identified – By GSA, County, and provider-specific issues
d. Corrective Action Plans initiated
e. Network Development
f. Telephone Survey Results

B. GAP IN CRITICAL SERVICES LOG

1. The Contractor must monitor authorized critical hours and gaps in critical services on a monthly basis utilizing Attachment A-1 and A-2 Gap In Critical Services Log (GAP Log) and Authorized Critical Hours Log Form.

2. The Gap In Critical Services Log shall be submitted quarterly to the designated Operations and Compliance Officer as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables with the data for each month during the quarter using Attachment A-1 and A-2.

C. TELEPHONE SURVEY REPORT

1. The Contractor must conduct telephone surveys quarterly, verifying that each contracted provider agency of critical services has availability after normal business hours, including weekends.

2. The results of the telephone surveys must be submitted semi-annually as part of the Gap in Critical Services Report to the designated Operations and Compliance Officer as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

3. AHCCCS may at any time direct a Contractor to conduct Telephone Surveys more frequently.

4. A provider agency is considered available to address a member's potential gap in critical services if:
   a. The provider immediately answers the phone call, or
   b. The provider returns the phone call within 15 minutes.

5. See Attachment B for the Telephone Survey Instructions and Template.

IV. REFERENCES

- ALTCS/EPD Contract, Section D
- DES/DDD Contract, Section D
- Contract, Section F, Attachment F3, Contractor Chart of Deliverables
- AMPM Chapter 1600, Case Management
- Attachment A, Gap In Critical Services Log and Authorized Critical Hours Log Form Instructions
- Attachment A-1 and A-2, Gap In Critical Services Log and Authorized Critical Hours Log Form
- Attachment B, Telephone Survey Instructions and Template

ATTACHMENT A, GAP IN CRITICAL SERVICES LOG AND AUTHORIZED CRITICAL HOURS LOG FORM INSTRUCTIONS

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT A-1 AND A-2, GAP IN CRITICAL SERVICES LOG AND AUTHORIZED CRITICAL HOURS LOG FORM

SEE THE ACOM WEBPAGE FOR ATTACHMENT A 1 AND A-2 OF THIS POLICY

ATTACHMENT B, TELEPHONE SURVEY INSTRUCTIONS AND TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

414 – NOTICES OF ACTION FOR SERVICE AUTHORIZATIONS

EFFECTIVE DATE: 08/01/07, 11/01/12, 03/01/13, 06/01/13, 10/01/13, 01/01/14, 09/01/14

REVISION DATE: 08/01/08, 10/01/09, 01/01/11, 10/11/12, 02/07/13, 05/24/13, 08/29/13, 10/29/13, 03/06/14, 08/07/14, 11/20/14

STAFF RESPONSIBLE FOR POLICY: DHCM MEDICAL MANAGEMENT

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP, and DES/DDD (DDD) Contractors (hereafter referred to as Contractor). This Policy provides clarification to the Contractor's contract regarding required content of a Notice of Action (NOA) relating to coverage and authorization of services. Contractors must follow all other requirements regarding Notice of Action set forth in the AHCCCS contract.

II. DEFINITIONS

ACTION	The denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.
APPEAL	A request for review of an action.
APPEAL COMPUTATION OF TIME	Computation of time for appeals is in calendar days and begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the "count" always begins on the day after the event.
EXPEDITED SERVICE AUTHORIZATION REQUEST	A request for services in which either the requesting provider indicates or the Contractor determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In these circumstances, the authorization decision must be expedited and must be made within **three** working days from the date of receipt of the service request.

LEGAL HOLIDAYS

Legal holidays as defined by the State of Arizona are:

1. New Year's Day – January 1;
2. Martin Luther King Jr./Civil Rights Day – 3rd Monday in January;
3. Lincoln/Washington Presidents' Day – 3rd Monday in February;
4. Memorial Day – Last Monday in May;
5. Independence Day – July 4;
6. Labor Day – 1st Monday in September;
7. Columbus Day – 2nd Monday in October;
8. Veterans Day – November 11;
9. Thanksgiving Day – 4th Thursday in November;
10. Christmas Day – December 25.

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

NOTICE OF ACTION

The written notice to the effected member regarding an action by the Contractor.

NOTICE OF EXTENSION

The written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to fourteen days if criteria for a service authorization extension are met.

RECEIPT OF A SERVICE AUTHORIZATION REQUEST

The date the Contractor receives the service request is considered the date of receipt. The Contractor may use electronic date stamps or manual stamping for logging the receipt. If the Contractor sub-contracts prior authorization to a delegated entity, the date the delegated entity receives the request is the date of the request.

SERVICE REQUEST COMPUTATION OF TIME	Computation of time for standard authorization requests (both with and without extensions of time) is in **calendar** days, and begins the day after the act, event (the receipt of request), or decision and includes all calendar days and the final day of the period. The first day of the "count" always begins on the day after the event. However, if the due date for a decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, the decision must be made on the day preceding the weekend or holiday. The due date for a decision is the working day immediately *prior* to the last day of the "count" if the last day falls on a weekend or legal holiday. If the last day of the "count" falls on a weekday, then that weekday is the due date. Computation of time for expedited requests is computed in **working days** and begins the day after the act, event or decision and includes all working days as defined by this Policy.
STANDARD SERVICE AUTHORIZATION REQUEST	A request from the member, their representative, or a provider for a service for the member. The authorization decision must be made within 14 calendar days from the date of receipt of the service request.
WORKING DAYS	"Working Day" as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless: 1. A legal holiday falls on one of these days; or 2. A legal holiday falls on Saturday or Sunday and a Contractor is closed for business the prior Friday or following Monday.

III. POLICY

When a Contractor makes a decision to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services, the Contractor shall provide a written Notice of Action (NOA) to the member Refer to Attachment A, Notice of Action. When a Contractor requires more information to make a decision and it is in the member's best interest, the Contractor shall provide a written Notice of Extension (NOE) to the member Refer to Attachment D, Notice of Extension.

The NOA must contain, in easily understood language, the information necessary for the member to understand what decision and action the Contractor has made, and how to appeal that decision. Members must be able to understand from the NOA the reason for the action to help them decide if they want to appeal the decision, and how to best argue their case if they decide to appeal. Additionally, if the reason for the denial is a lack of necessary

information, the member must be informed so that they can provide the necessary information.

The NOE must contain, in easily understood language, the information that the Contractor requires to make the service determination and how to grieve the NOE decision. The member must be able to understand what information is required to make the service determination so they can provide necessary information in the event they have access to the information.

The Contractor must use the templates incorporated in this policy. The templates can not be altered except for the areas designated in the notice.

The Contractors' Member Handbooks must inform the members that they can complain to the Contractor about an inadequate NOA. Additionally, the Contractor must inform the member that if the Contractor does not resolve the complaints about the NOA to the member's satisfaction the member may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management.

IV. RIGHT TO BE REPRESENTED

Contractors must acknowledge the member's right to be assisted by a representative, including an attorney, during an appeal. A list of legal aid services is provided in Attachment B, Legal Services Program. The Contractor's appeals process must register the existence of the third party and the Contractor must ensure that the required communications related to the appeals process occur between the Contractor and the representative. The member's representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy regulations, Contractors must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member; however, if the Contractor questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

V. NOTICE OF ACTION CONTENT REQUIREMENTS

A. THE NOA MUST CONTAIN AND CLEARLY EXPLAIN IN EASILY UNDERSTOOD LANGUAGE THE FOLLOWING INFORMATION:

1. The requested service,

2. The reason/purpose of that request,

3. The action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request,

4. The reason for the action, including factual findings about the member's condition that were the basis for the Contractor's action,

5. The legal basis for the action,

6. Where members can find copies of the legal basis (the local public library and the web page with links to legal authorities; when a legal authority or an internal reference to the Contractor's policy manual is available on-line, the Contractor shall provide the accurate URL site to enable the member to find the reference on-line),

7. The right to appeal a decision and the process for filing the appeal,

8. A listing of legal aid resources

B. A GENERAL STATEMENT

It is unacceptable to cite lack of medical necessity as a reason for denial, without an explanation of why the service is not medically necessary. Failure to provide a reason for an action will result in regulatory action by AHCCCS, including but not limited to sanction per event (notice) and/or capping of enrollment. Refer to Section II of the Guide for examples where medical necessity is appropriately used in denying/limiting services.

C. EPSDT

The Contractor must cite Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule A.A.C. R9-22-213 and federal law 42 U.S.C. 1396d(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than 21 years of age when these provisions are applicable. The Contractor must explain why the requested EPSDT services do not meet the conditions as described in this Policy and the AMPM Chapter 400, Policy 430. The Contractor must specify why the requested services do not meet the EPSDT criteria and are not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 U.S.C. 1396(d)(a) to correct or ameliorate (make better) defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

D. A NOTICE

When a notice does not explain why the service has been denied/reduced and merely refers the member to a third person for more information is unacceptable. The NOA must state the reasons supporting the denial/reduction. The Contractor may also include a statement referring a member to a third person for more help when the third person can explain treatment alternative in more detail.

VI. MEMBER COMPLAINTS REGARDING THE ADEQUACY AND/OR UNDERSTANDABILITY OF NOA

If a member complains about the adequacy of a NOA, the Contractor shall review the initial notice against the content requirements of this Policy. If the Contractor determines that the original notice is inadequate or deficient, the Contractor must issue an amended NOA consistent with the requirements of this Policy. Should an amended notice be required, the timeframe for the member to appeal and continuation of services starts from the date of the amended notice.

If the member complains to the Contractor regarding the adequacy of the amended NOA, the Contractor must promptly inform AHCCCS, DHCM, MM of the complaint. Additionally, the Contractor must inform the member of their right to contact AHCCCS, DHCM, MM, if the issue is not resolved to the member's satisfaction.

VII. TIMEFRAMES FOR DECISIONS AND THE NOTICE OF ACTION

Each Contractor must meet the following timeframes for issuing a decision.

A. STANDARD AUTHORIZATION DECISION TIMEFRAME

For standard authorization decisions, the Contractor must provide a decision as expeditiously as the member's condition warrants but no later than fourteen days from receipt of the request. The Contractor may issue a NOE of up to fourteen additional calendar days, if the criteria for a service authorization extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday.

B. EXPEDITED AUTHORIZATION DECISION TIMEFRAME

For expedited authorization decisions, the Contractor must provide a decision as expeditiously as the member's health condition warrants but no later than three **working** days from the receipt of the request, with a possible extension of up to fourteen additional calendar days, if the criteria for an extension are met. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday.

C. EXPEDITED AUTHORIZATION REQUEST DOWNGRADED TO A STANDARD REQUEST

When a Contractor receives an expedited request for a service authorization and the requested service is not of an expedited medical nature, the Contractor may downgrade the expedited authorization request to a standard request. The Contractor must have a process included in the Contractor's policy for prior authorization that describes how the requesting provider will be notified of the downgrade and given an opportunity to

disagree. The requesting provider must be allowed to send additional documentation supporting the need for an expedited authorization.

D. SERVICE AUTHORIZATION DECISIONS NOT REACHED WITHIN THE TIMEFRAMES

A decision that is not reached within the required timeframes for a standard or expedited request, constitutes a denial. The Contractor must issue a NOA denying the request on the date that the timeframe expires. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday [42 CFR 438. 404(c)(5)].

E. SERVICE AUTHORIZATION DECISIONS NOT REACHED WITHIN THE EXTENDED TIMEFRAMES

A decision that is not reached within the timeframe noted in the NOE, constitutes a denial. The Contractor must issue a NOA denying the request on the date that the timeframe expires. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday [42 CFR 438.210 (d)(1 and 2)].

F. THE CONTRACTOR MUST MAIL THE NOTICE WITHIN THE FOLLOWING TIMEFRAMES:

1. For termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least 10 days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 210 providing exceptions to advance notice. [42 CFR 438.404 (c)(1)].

2. For standard service authorization decisions that deny or limit services, the Contractor must provide notice no later than 14 days from the receipt of the request; unless there is a NOE (refer to Notice of Extension in this Policy) [42 CFR 438.404 (c)(3)].

3. For decisions when an NOE has been sent, the Contractor must mail the notice by the end date of the NOE, not to exceed fourteen additional calendar days from the end of the standard or expedited decision timeframe, and may never exceed 28 calendar days.

VIII. NOTICE OF EXTENSION

A. The Contractor may extend the timeframe to make a service authorization determination for both the standard and expedited request when the member or provider requests an extension, or when the Contractor can justify that the need for additional information is in the member's best interest. [42 CFR 438.404] The Contractor may extend the 14 calendar day timeframe to make a decision for a standard authorization request by up to an additional 14 calendar days, not to exceed 28 calendar days from the service request date. The Contractor may extend the three working day timeframe to make a decision

for an expedited authorization request by up to an additional 14 calendar days, not to exceed 17 days from the service request date. The NOE must not be sent until the Contractor has made sufficient attempts to obtain the necessary information from the requesting provider. The NOE must be sent on the 14th day from receipt of the standard authorization request and on the 3rd day from receipt of an expedited authorization request. Refer to Service Request Computation of Time under "Definitions" for further information when the end date falls on a weekend or legal holiday.

B. If the Contractor extends the timeframe in order to make a decision, the Contractor must:

1. Give the member written notice of the reason for the decision to extend the timeframe,

2. Include what information is needed in order to make a determination,

3. Inform the member of the right to file a grievance (complaint) if he or she disagrees with the decision to extend the timeframe,

4. Make the decision as expeditiously as the member's condition and no later than the date the extension expires.

NOTE: For examples of easily understood NOA language, please refer to Attachment C, Guide to Language in Notices of Action and access the following link on the AHCCCS website: AHCCCS Guide to Language in Notices of Action (NOA)

IX. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- CMDP Contract, Section D
- DES/DDD Contract, Section D
- A.A.C. R9-22-213
- A.A.C. R9-34-202
- 42 CFR 438.210
- 42 CFR 438.404
- 42 U.S.C. 1396
- AMPM Chapter 400
- Attachment A, Notice of Action
- Attachment B, Legal Services Programs
- Attachment C, AHCCCS Guide to Language in Notices of Action
- Attachment D, Notice of Extension
- www.azlawhelp.org/

ATTACHMENT A: NOTICE OF ACTION

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B: LEGAL SERVICES PROGRAM

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C: AHCCCS GUIDE TO LANGUAGE IN NOTICES OF ACTION

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D: NOTICE OF EXTENSION

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

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

EFFECTIVE DATE: 06/01/10, 10/01/11, 12/01/11, 11/01/12, 10/01/13, 03/01/14, 09/01/14, 10/01/15

REVISION DATE: 09/28/09, 01/28/10, 05/10/10, 08/26/10, 01/24/11, 12/01/11, 10/24/12, 10/25/12, 04/04/13, 07/18/13, 07/29/13, 02/20/14, 08/27/14, 09/21/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. Provider networks must be a foundation that supports an individual's needs as well as the membership in general. This Policy establishes guidelines for the submission of the Network Development and Management Plan to AHCCCS.

II. DEFINITIONS

AGENCY WITH CHOICE (AWC)	An option offered to ALTCS members who reside in their own home. Under the Agency with Choice option, the provider agency and the member/individual representative enter into a partnership agreement. The provider agency serves as the legal employer of the Direct Care Worker (DCW) and the member/individual representative serves as the day-to-day managing employer of the DCW.
CLOSED PANEL	Indicates when a provider is no longer accepting new patients.
DIMINISHED SCOPE OF SERVICE	Indicates when a provider has decreased its capacity or eliminated a service previously provided.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.

INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)	An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.
PROVIDER	Any person or entity (including Tribal/Regional Behavioral Health Authorities) who contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	An organization under contract with the ADHS to administer covered behavioral health services in a geographically specific area of the state. Refer to A.R.S. §36-3401, §36-3407 and 9 A.A.C. Chapter 22, Article 1201.
TRIBAL/REGIONAL BEHAVIORAL HEALTH AUTHORITY (T/RBHA)	An organization under contract with the State of Arizona that administers covered behavioral health services for Title XIX and XXI members. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407, and A.A.C. R9-22-1201.

III. POLICY

The Contractor shall develop and maintain a provider Network Development and Management Plan, which assures the Administration that the provision of covered services will occur as stated in the contract [42 CFR 438.207(b)]. The Network Development and Management Plan must be evaluated, updated and submitted along with Attachments A, Network Attestation Statement, B, Network Development and Management Plan Checklist and applicable requirements delineated in ACOM Policy 417 to the designated Operations and Compliance Officer, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. Attachment C, ALTCS/EPD Contractor Supplement must also be provided by ALTCS/EPD Contractors.

The Contractor shall notify AHCCCS in writing when there has been a significant change in operations that would affect network capacity and services as outlined in contract and ACOM

Policy 439. The changes include, but are not limited to, changes in services, geographic service areas, and payments or eligibility of a new population.

IV. PROCEDURE

The Network Development and Management Plan shall outline the Contractor's process to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to provide access to all services covered under the contract. For a specific listing of the items to be included in the Network Development and Management Plan, see Attachment B, Network Management and Development Plan Checklist.

V. PROVIDER/NETWORK CHANGES DUE TO RATES REPORT

The Contractor shall submit as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables, a Provider/Network Changes Due to Rates Report, which consists of Attachment D and E of this Policy.

A. PROVIDER TERMINATIONS DUE TO RATES

Attachment D, Provider Terminations Due to Rates, documents providers who have terminated their contract due to rates. Submission of Attachment D is required for each GSA even when the Contractor does not have any terminations to report.

B. PROVIDERS THAT DIMINISH THEIR SCOPE OF SERVICE AND/OR CLOSE THEIR PANEL DUE TO RATES

Attachment E, Providers That Diminished Their Scope of Services and/or Closed Their Panel Due to Rates, documents providers that have diminished their scope of service and/or closed their panel due to rates. Submission of Attachment E is required for each GSA even when the Contractor does not have any providers to report.

VI. DIRECT CARE WORKER TRAINING AND TESTING AND AGENCY WITH CHOICE ROSTER

ALTCS/EPD and DES/DDD Contractors shall submit Attachment F, Direct Care Worker Training and Testing and Agency With Choice to the designated Operations and Compliance Officer, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. The roster outlines the plan and the effective date of the plan that provider agencies have in place to train and test direct care workers to meet established competencies. Additionally, the roster outlines those provider agencies that offer the Agency With Choice member-directed option. The roster must be updated and maintained on a regular basis and be available upon request to AHCCCS. Information pertaining to the provider agencies offering the Agency With Choice member-directed option should be made available to case managers to use in assisting members to identify a provider agency for the provision of services. ALTCS/EPD Contractors and DES/DDD may provide the Agency With Choice data in an alternate format for case managers and/or members.

VII. DDD THERAPEUTIC SERVICES AND HCBS SERVICES WAIT LIST ROSTER

DDD will submit to the designated Operations and Compliance Officer as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables, a DDD Therapeutic Services and HCBS Services Wait List. The report shall include information in the excel format identified in Attachment Ga, DDD Therapeutic Services Wait List Roster and Attachment Gb, HCBS Services Wait List Roster.

VIII. 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, Chart of Deliverables
- Attachment A, Network Attestation Statement
- Attachment B, Network Development and Management Plan Checklist
- Attachment C, ALTCS/EPD Contractor Supplement
- Attachment D, Provider Terminations Due to Rates
- Attachment E, Providers that Diminished their Scope of Service and/or Closed their Panel Due to Rates
- Attachment F, Direct Care Worker Training and Testing and Agency with Choice Roster
- Attachment Ga, DDD Therapeutic Services
- Attachment Gb, HCBS Services Wait List Roster
- 9 A.A.C. 22, Article 1
- 9 A.A.C., Chapter 22, Article 1201
- A.R.S. §36-2901
- A.R.S. §36-3401
- A.R.S. §36-3407
- 42 CFR 438.207(b)
- ACOM Policy 417
- ACOM Policy 439

ATTACHMENT A, NETWORK ATTESTATION STATEMENT

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, NETWORK DEVELOPMENT AND MANAGEMENT PLAN CHECKLIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

ATTACHMENT C, ALTCS/EPD CONTRACTOR SUPPLEMENT

SEE THE ACOM WEBPAGE FOR ATTACHMENT C OF THIS POLICY

ATTACHMENT D, PROVIDER TERMINATIONS DUE TO RATES

SEE THE ACOM WEBPAGE FOR ATTACHMENT D OF THIS POLICY

ATTACHMENT E, PROVIDERS THAT DIMINISHED THEIR SCOPE OF SERVICE AND/OR CLOSED THEIR PANEL DUE TO RATES

SEE THE ACOM WEBPAGE FOR ATTACHMENT E OF THIS POLICY

ATTACHMENT F, DIRECT CARE WORKER TRAINING AND TESTING AND AGENCY WITH CHOICE ROSTER

SEE THE ACOM WEBPAGE FOR ATTACHMENT F OF THIS POLICY

ATTACHMENT GA, DDD THERAPEUTIC SERVICES WAIT LIST ROSTER

SEE THE ACOM WEBPAGE FOR ATTACHMENT GA OF THIS POLICY

ATTACHMENT GB, HCBS SERVICES WAIT LIST ROSTER

SEE THE ACOM WEBPAGE FOR ATTACHMENT GB OF THIS POLICY

416 - PROVIDER NETWORK INFORMATION

EFFECTIVE DATE: 10/01/08, 11/01/12, 10/01/13, 05/01/14, 10/01/14, 04/01/15

REVISION DATE: 08/12/10, 10/24/12, 07/18/13, 04/17/14, 07/17/14, 11/01/14, 04/02/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors.

This Policy establishes guidelines for Contractors regarding provider information requirements and the content of a Contractor's website.

II. DEFINITIONS

MATERIAL CHANGE An alteration or development within a provider network that may reasonably be foreseen to affect the quality or delivery of services provided under the contract.

PROVIDER Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901.

SUBCONTRACTOR

1. A provider of health care who agrees to furnish covered services to members.
2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/ administrative functions or responsibilities.
3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

III. POLICY

The contract contains multiple requirements for communications between Contractors and their provider network. The list below instructs the Contractor on content and timing of these communications. The list does not supersede any additional requirements that may be outlined in contract.

A. PROVIDER MANUAL

The Contractor shall develop, distribute and maintain a provider manual. The Contractor shall ensure that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual and is encouraged to distribute a provider manual to any individual or group that submits claim and encounter data. The Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements with regard to covered services, billing, etc.

At a minimum, the Contractor's provider manual must contain information on the following *(items below apply to all Contractors, with the exception of the items in bolded parenthetical notation. The items in bolded parenthetical notation are Contractor specific and only apply to those Contractors listed)*:

1. Introduction to the Contractor which explains the Contractor's organization and administrative structure

2. Provider responsibility and the Contractor's expectation of the provider

3. Overview of the Contractor's Provider Service department and function

4. Listing and description of covered and non-covered services, requirements and limitations including behavioral health services

5. Emergency room utilization (appropriate and non-appropriate use of the emergency room)

6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/ behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.

7. Description of Dental services coverage and limitations

8. Description of Maternity/Family Planning services

9. The Contractor's policy regarding Primary Care Physician (PCP) assignments

10. Referrals to specialists and other providers, including access to behavioral health services

11. Grievance system process and procedures for providers and enrollees

12. Billing and encounter submission information

13. Information about policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission

14. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e. Medicare and Medicaid)

15. Cost sharing responsibility

16. Explanation of remittance advice

17. Prior authorization and notification requirements, including a listing of services which require authorization

18. Claims medical review

19. Concurrent review

20. Fraud, waste, and abuse

21. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.

22. Minimum Required Prescription Drug List (MRPDL) information, including:
    a. How to access the MRPDL (electronically and hard copy - by request)
    b. How and when updates are communicated

23. AHCCCS appointment standards

24. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable

25. Eligibility verification

26. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English including Sign Language

27. Peer review and appeal process

28. Medication management services as described in the contract.

29. Information about a member's right to be treated with dignity and respect as specified in 42 CFR 438.100

30. Notification that the contractor has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102

31. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions

32. Information related to payment responsibilities as outlined in ACOM Policy 432.

33. (**Acute and ALTCS/EPD**) Description of the Change of Contractor policies. See ACOM Policy 401 and 403.

B. WEBSITE

The Contractor must develop and maintain a website that is focused, informational, functional, and capable of the following:

The Contractor's website must have links to the items listed below:

1. MRPDL (both searchable and comprehensive listing), which shall be updated twice per year or as needed and within 30 calendar days of AHCCCS notification

2. Provider Manual

3. Provider Directory that is current and updated within 15 calendar days of a network change, is user friendly and allows members to search by the following provider information:
   a. Name of provider or facility
   b. Provider or service type
   c. Specialty
   d. Languages spoken by the practitioner
   e. Office location (i.e., allow the member to find providers by location such as county, city or zip code)

4. Contractor's Performance Measure Results

5. Performance Measure Results via link to AHCCCS website

6. Medical Determination Criteria and Practice Guidelines

7. Contractor provider survey results, as available.

The Contractor's website must also provide the following electronic functionality:

1. Enrollment Verification

2. Claims Inquiry (adjustment requests; information on denial reasons)

3. Accept HIPAA compliant electronic claims transactions

4. Display Reimbursement Information.

See ACOM Policy 404, Attachment C, Contractor Website Certification Checklist and Attestation for other requirements that apply to the Contractor's website.

The Contractor shall submit annually 45 calendar days after the start of the contract year the Contractor's Annual Website Certification Checklist and Attestation (See ACOM 404, Attachment C, Contractor Website Certification Checklist and Attestation).

The Division of Health Care Management will review the content of the Contractor's website to ensure the Contractor is in compliance with this Policy and the AHCCCS contract.

C. REQUIRED NOTIFICATIONS

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

The Contractor is expected to provide written or electronic communication to contracted providers in the following instances:

1. **Exclusion from Network** - Under Federal Regulation 42 CFR 438.12 the Contractor is required to provide written notice of the reason for declining any written request for inclusion in the network.

2. **Contractor Policy/Procedure Changes** – Any change in overall operations (i.e., policy, process, protocol), such as prior authorization or retrospective review, performance and network standards) which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in Contract. Notice must be provided to the designated operations Compliance Officer to which the Contractor is assigned 60 calendar days in advance of the proposed change. The Contractor is required to notify affected providers 30 calendar days in advance of any material change to operations.

3. **AHCCCS Guidelines, Policy, and Manual Changes -** The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals.

4. **Subcontract Updates** – In the event of a modification to the AHCCCS Minimum Subcontract Provisions the Contractor shall issue a notification of the change to its

subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.

5. **Termination of Contract** – The Contractor must provide written notice to hospitals and/or provider groups at least 90 calendar days prior to any contract termination without cause. Contracts between Contractors and individual practitioners are exempted.

6. **Disease/Chronic Care Management** – The Contractor must disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.

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
- A.R.S. §36-2901
- 42 CFR 438.12
- 42 CFR 438.100
- 42 CFR 438.102
- Americans with Disabilities Act
- False Claims Act
- Deficit Reduction Act
- Civil Rights Act of 1964
- ACOM Policy 401
- ACOM Policy 403
- ACOM Policy 404, Attachment C, Contractor Website Certification Checklist and Attestation
- ACOM Policy 432
- AHCCCS Medical Policy Manual (AMPM) Policy 1020

417 - APPOINTMENT AVAILABILITY,MONITORING AND REPORTING

EFFECTIVE DATE: 10/01/12, 10/01/13, 04/01/15

REVISION DATE: 01/08/08, 06/26/12, 10/24/12, 07/03/13, 03/05/15, 04/02/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes a common process for Contractors to monitor and report appointment accessibility and availability in order to ensure compliance with AHCCCS standards as set forth in Section D, Appointment Standards of the contracts.

II. DEFINITIONS

1800 REPORT	An AHCCCS generated document, provided quarterly, that identifies PCPs with a panel of more than 1800 AHCCCS members.
DAY	A calendar day unless otherwise specified.
ESTABLISHED PATIENT	A member who has received professional services from the physician or any other physician with that specific subspecialty that belongs to the same group practice, within the past three years from the date of appointment.
NEW PATIENT	A member who has not received any professional services from the physician or another physician with that specific specialty and subspecialty that belongs to the same group practice, within the past three years from the date of appointment.

III. POLICY

A. MONITORING APPOINTMENT STANDARDS

1. The Contractor must ensure the following contractual appointment and assessibility standards are met [42 CFR 438.206].

2. The Contractor must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization.

3. The Contractor shall have written policies and procedures about educating its provider network regarding appointment time requirements. The Contractor must develop a corrective action plan when appointment standards are not met. In addition, the Contractor must develop a corrective action plan in conjunction with the provider when appropriate [42 CFR 438.206(c)(1)(iv), (v) and (vi)].

MATERNITY CARE	
1st trimester	14 days
2nd trimester	7 days
3rd trimester	3 days
High risk pregnancy	3 days*

**within three days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists.*

APPOINTMENT STANDARDS					
APPLICABLE TO:	**ROUTINE**			**URGENT**	**EMERGENT**
PCP S	21 Days			2 days	Within 24 hours
SPECIALISTS	45 days			3 days	Within 24 hours
DENTAL PROVIDERS	45 days			3 days	Within 24 hours
BH PROVIDERS	*Contractor responsible for the provision of behavioral health services*: initial assessment within seven days of referral	*Contractor responsible for the provision of behavioral health services*: Ongoing services within 23 days of initial assessment	(ALTCS/ EPD and DDD) within 30 days of referral	(CRS): CMDP enrolled members no later than 72 hours after notification by DCS that a child has been or will be removed from their home	Within 24 hours of referral

B. PROVIDER APPOINTMENT AVAILABILITY REVIEW

The Contractor is required on a quarterly basis to conduct review of the availability of Routine, Urgent and Emergent appointments for Primary Care, Specialist, Dental, CRS providers and Behavioral Health providers. The Contractor must also review these standards for Maternity Care providers relating to the first, second, and third trimesters as well as high risk pregnancies.

Contractors must conduct Provider Appointment Availability Reviews in sufficient quantity to ensure results are meaningful and representative of the Contractor's network. Appropriate methods include:

- Appointment schedule review where the Contractor independently validates appointment availability,
- Secret shopper phone calls, where the Contractor anonymously validates appointment availability,
- Other methods approved by AHCCCS.

The Contractor may supplement these efforts by targeting specific providers identified through performance monitoring systems such as the 1800 report, quality of care concerns, complaints and the credentialing process..

To obtain approval for any additional methods, the Contractor should contact their designated Operations and Compliance Officer outlining details (including scope, selection criteria, and any tools used to collect the information) at least 30 days prior to implementing the proposed method, as specified in Contract Attachment F, Contractor Chart of Deliverables.

C. TRACKING AND REPORTING

The Contractor must track provider compliance with appointment availability on a quarterly basis for both New and Established Patients by Provider Type. The Contractor must utilize the reporting template included in this Policy. See Attachment A, Appointment Availability Provider Report.

The Contractor shall track Appointment Availability Reports quarterly and submit as specified in section D below as a component of the Network Development and Management Plan. See ACOM Policy 415 for additional guidelines for the submission of the Network Development and Management Plan. The Contractor must also include an attestation affirming the validity of the methodologies utilized, including the significance of the results. A cover letter must be included which summarizes the data, explains significant trending in either direction (positive or negative), and describes any interventions, applied to areas of concern including, corrective action plans.

AHCCCS may review Contractor monitoring and corrective action plans implemented as a result of provider non-compliance with appointment standards.

D. ATTACHMENT A APPOINTMENT AVAILABILITY PROVIDER REPORT

Instructions for Completing Attachment A, Appointment Availability Provider Report:

PCP, SPECIALIST, DENTAL, BEHAVIORAL HEALTH PROVIDERS

SURVEYS	Enter the total number of provider surveys conducted for both New and Established patients for each provider type.
PASS	Enter total number of providers that were in compliance with the AHCCCS appointment standards (Routine, Urgent and Emergent).
FAIL	Enter total number of providers that were not in compliance with the AHCCCS appointment standards.
COMPLIANCE PERCENTAGE	The percentage of providers that are compliant with the AHCCCS appointment standards.

MATERNITY CARE PROVIDERS

SURVEYS	Enter the total number of provider surveys conducted with Maternity care providers related to compliance with the AHCCCS standards for initial prenatal care appointments by trimester and risk.
PASS	Enter total number of providers that were in compliance with the AHCCCS appointment standards for maternity care.
FAIL	Enter total number of providers that were not in compliance with the AHCCCS appointment standards for maternity care.
COMPLIANCE PERCENTAGE	The percentage of providers that are compliant with the AHCCCS appointment standards for maternity care.

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
- 42 CFR 438.206
- ACOM Policy 415
- Attachment A, Appointment Availability Provider Report

ATTACHMENT A, APPOINTMENT AVAILABILITY PROVIDER REPORT

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

418 PROVIDER AND AFFILIATE ADVANCE REQUEST

EFFECTIVE DATE: 10/01/08, 10/01/12, 10/01/13

REVISION DATE: 01/31/08, 05/01/12, 08/15/13

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. The policy establishes the procedure for Contractor approval or notification to AHCCCS of provider and affiliate advances and loans; including advances and loans involving another fund or line of business within the Contractor's organization.

II. DEFINITIONS

ADVANCE	Includes but is not limited to payment to a provider by a Contractor which is based on an estimate of Received But Unpaid Claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the Contractor.
AFFILIATE (RELATED PARTY) TRANSACTIONS	Transactions with a party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by the Contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties" or "Affiliates" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
DAY	Calendar day unless otherwise specified.

PROVIDER Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions of A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. For the purposes of this policy, a provider shall be further defined as all individuals associated by the same Tax Identification Number, utilized for claiming purposes.

III. POLICY

A. INDIVIDUAL AND CUMULATIVE PROVIDER ADVANCES

The Contractor shall submit a written request for approval to the designated AHCCCS Operations and Compliance Officer for any individual or cumulative advances equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. Approval must be requested at least 10 days prior to disbursement of the funds. In extenuating circumstances, AHCCCS may waive the 10 day notification requirement. All requests for approval must be in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
   a. The provider(s) name(s) and AHCCCS Identification Number(s);
   b. The date the provider and Contractor initiated discussions relating to the need for the advance;
   c. The systemic organizational causes resulting in the need for an advance;
   d. The process that will be utilized to reconcile the funds against claims payments;
   e. The anticipated timeline for the project;
   f. The corrective action(s) that will be implemented to avoid future occurrences; and,
   g. The total advance amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.

2. A copy of the written communication that will serve as notification to the affected provider(s).

3. Upon completion of the advance(s), AHCCCS may request that the Contractor make available within three working days a listing of the payments to be advanced, organized by provider Tax Identification Number if multiple providers are affected, that includes the following:

   a. AHCCCS Member ID
   b. Date of Service
   c. Original AHCCCS Claim Number
   d. Date of Payment
   e. Amount Paid

f. Amount Advanced
g. Balance Due to/from the Provider

B. INDIVIDUAL AND CUMULATIVE PROVIDER LOANS

The Contractor shall submit written notification to the assigned AHCCCS Operations and Compliance Officer of any individual or cumulative loan equal to or in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. Approval must be requested at least 10 days prior to disbursement of the funds. In extenuating circumstances, AHCCCS may waive the 10 day notification requirement. All requests for approval must be in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
   a. The provider(s) name(s) and AHCCCS Identification Number(s);
   b. The date the provider and Contractor initiated discussions relating to the need for the loan;
   c. The systemic organizational causes resulting in the need for a loan;
   d. The process that will be utilized to reconcile the funds against claims payments;
   e. The anticipated timeline for the project;
   f. The corrective action(s) that will be implemented to avoid future occurrences; and,
   g. The total loan amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.

2. A copy of the written communication that will serve as notification to the affected provider(s).

3. Upon completion of the loan(s), AHCCCS may request that the Contractor make available within three working days a listing of the payments to be loaned, organized by provider Tax Identification Number if multiple providers are affected, that includes the following:
   a. AHCCCS Member ID
   b. Date of Service
   c. Original AHCCCS Claim Number
   d. Date of Payment
   e. Amount Paid
   f. Amount Loaned
   g. Balance Due to/from the Provider

C. ROUTINE/SCHEDULED ADVANCES TO PROVIDER AND ANY ADVANCES TO AFFILIATES

Routine/scheduled advances to providers as a result of contractual arrangements or **any** advance to an affiliate must be submitted to AHCCCS for prior approval. The request for approval must be submitted 30 days in advance of the effective date of the contractual arrangement or advance, and 30 days prior to any amendment to a contractual arrangement.

AHCCCS may request additional information or periodic reconciliations related to these advances.

D. AHCCCS RESPONSIBILITY AND AUTHORITY

AHCCCS reserves the right to evaluate and present the proposed advance with the affected providers(s) as part of the approval and/or notification process. Communication will be at the timing and discretion of AHCCCS.

The AHCCCS Division of Health Care Management (DHCM) will evaluate all advance and loan requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Contractor by electronic mail contingent upon receipt of all required information from the Contractor.

IV. REFERENCES

- Acute Care Contract Section D
- ALTCS/EPD Contract, Section D
- DCS/CMDP Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- A.R.S. §36-2901

419 – RESERVED

420 – RESERVED

421 – CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE RESIDENTIAL SETTINGS

EFFECTIVE DATE: 04/08/09, 11/01/12, 10/01/13, 10/01/15

REVISION DATE: 10/11/12, 08/29/13, 07/30/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to ALTCS/EPD and DES/DDD Contractors. This Policy is limited to and defines the relationship between a Nursing Facility (NF) and/or an Alternative Residential Setting (ARS) and a Contractor following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. This policy delineates how the Contractor, NF and ARS will collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

II. DEFINITIONS

ADD-ON	Generally refers to contract standards that a Contractor may have with a NF to establish criteria for additional payment to the Class 1, 2 or 3 levels determined by the Universal Assessment Tool (UAT).
ALTERNATIVE RESIDENTIAL SETTING (ARS)	Under the Home and Community Based Services (HCBS) program, members may receive certain services while they are living in an alternative HCBS setting. HCBS settings as defined in 9 A.A.C. 28 Article 1 and AMPM Chapter 1200, section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH) Adult Foster Care (AFC) Homes, Behavioral Health Residential facilities, and Behavioral Health Supportive Homes.
ANNIVERSARY DATE	The month the member is able to make an annual enrollment choice. The Anniversary Date in most situations is 12 months from the date the member was enrolled with the Contractor and annually thereafter. Only members in a GSA with more than one Contractor have a choice of Contractors.

BED HOLD DAY

A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and/or therapeutic leave.

1. Short Term Hospitalization Leave – This service may be authorized for members residing in a Nursing Facility (NF), Intermediate Care Facility for person with intellectual disabilities (ICF) or residential Treatment Center (RTC) that is licensed as a Behavioral Health Inpatient Facility when short-term hospitalization is medically necessary. The total number of days available for each member per year is limited to 12 days per contract year except as in #3 below.
2. Therapeutic Leave – If included in the member's care plan, this service may be authorized for members residing in an NF, ICF or RTC that is licensed as a Behavioral Health Inpatient Facility due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as a part of discharge planning. The total number of therapeutic leave days available for each member per year is limited to nine days per contract year except as in #3 below.

Members under 21 years of age may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per year.

NURSING FACILITY (NF)

A health care facility that is licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Contracted NFs are those facilities that have a contract with a Contractor. Non-contracted NFs are those facilities that do not have a contract with a Contractor.

ROOM AND BOARD (R&B)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.
SUBACUTE OR SPECIALTY CARE	Generally refers to contract standards that a Contractor may have with a NF to establish criteria for paying a rate higher than the Class 1, 2 and 3 levels determined by the UAT.
SHARE OF COST (SOC)	The amount an ALTCS member is required to pay toward the cost of long term care services.
UNIVERSAL ASSESSMENT TOOL (UAT)	A standardized tool that is used by Contractors to assess the acuity of NF residents and commonly used for ARS residents residing in Assisted Living Centers (ALC), Assisted Living Holmes (ALH) and Adult Foster Care (AFC) settings. The use of the Uniform Assessment Tool (UAT) is not intended to impact how Contractors determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management). This tool is located in Chapter 1600 of the AHCCCS Medical Policy Manual.

III. POLICY

A. MEMBER/RESIDENT OPTIONS WHEN A NF OR ARS CONTRACT IS TERMINATED

Affected members residing in a NF and/or ARS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available Contractor that is contracted with the facility, or move to a setting that is contracted with their current Contractor.

A meeting between the Contractor, NF and/or ARS and AHCCCS will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

The Contractor in collaboration with the NF and/or ARS and AHCCCS must develop a member/representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The Contractor must receive approval of their member/representative communication plan from the Division of Health Care

Management Operations Unit. The plan must be submitted to AHCCCS within five business days of the termination decision. All member communications must be consistent with guidelines found in ACOM Policy 404.

B. REIMBURSEMENT

1. Nursing Facilities

   The Contractor shall reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, the Contractor shall reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or the Contractor's previously contracted rates. Should AHCCCS reduce its fee schedule, the Contractor shall reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

   If the Contractor had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the Contractor shall apply those rates. Should AHCCCS adjust its fee schedule, then the Contractor will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Residential Settings

   The Contractor shall reimburse the ARS at the previously contracted rate. Should AHCCCS adjust its HCBS Fee Schedule rates, the Contractor will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

C. QUALITY OF CARE

In the event that a Contractor or other entity, such as Arizona Department of Health Services (ADHS) Licensure or AHCCCS identify instances where the overall quality of care delivered by an NF or ARS places residents in immediate jeopardy, the Contractor will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or ARS.

In some cases, ADHS or AHCCCS may require that the Contractor find new placements for members. In such cases, the Contractor shall work with the members/representative to identify an appropriate placement that meets the needs of the member. AHCCCS may require Contractors to increase monitoring of facilities identified as having health or safety issues until AHCCCS is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or ARS, the Contractor must notify AHCCCS of the situation. In these instances, the Contractor should review the

financial, health and safety status prior to placing a member in a placement owned by the same entity. In the event that a Contractor identifies a member specific quality of care concern, the Contractor shall identify that to the NF or ARS for resolution. The Contractor shall also report to external entities, and to AHCCCS as required by AMPM Chapter 900.

D. ADMISSIONS/DISCHARGES/READMISSIONS

1. NFs or ARSs are not required to accept new admissions of members who are enrolled with a non-contracted Contractor.

2. NFs are required to otherwise follow admission, readmission, transfer, and discharge rights as per 42 CFR 438.12.

3. The Contractor may authorize bedhold days up to the allowed limit (Short Term Hospitalization Leave – 12 days and Therapeutic – nine days) as required by Chapter 100 of the AMPM.

IV. REFERENCES

- ALTCS/EPD Contract, Section D
- DES/DDD Contract, Section D
- A.A.C. R9-28-204
- 42 CFR 438
- 42 CFR 483
- AMPM Chapter 100
- AMPM Chapter 900
- AMPM Chapter 1200
- AMPM Chapter 1600
- ACOM Policy 404

422 – RESERVED

423 – FINANCIAL RESPONSIBILITY FOR COURT ORDERED TREATMENT FOR DUI/DOMESTIC VIOLENCE OR OTHER CRIMINAL OFFENSES

EFFECTIVE DATE: 07/01/09, 09/01/13, 10/01/15

REVISION DATE: 08/17/09, 08/29/13, 10/01/13, 05/14/15, 08/01/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, and DES/DDD (DDD) Contractors. The purpose of this Policy is to provide clarification regarding the financial responsibility for the provision of specific mental health treatment/care when such treatment is ordered as a result of a judicial ruling.

II. DEFINITIONS

COURT-ORDERED ALCOHOL TREATMENT	Detoxification services or treatment provided according to A.R.S. Title 36, Chapter 18, Article 2.
DUI CLIENT	An individual who is ordered by the court to receive DUI screening, DUI education, or DUI treatment as a result of an arrest or conviction for a violation of A.R.S. §28-1381, §28-1382, or §28-1383.
DUI EDUCATION	A program in which a person participates in at least sixteen hours of classroom instruction relating to alcohol or other drugs.
DUI SCREENING	A preliminary interview and assessment of an offender to determine if the offender requires alcohol or other drug education or treatment. (A.R.S. §28-1301)
DUI SERVICES	DUI Screening, DUI education, or DUI treatment provided to an AHCCCS member.
DUI TREATMENT	A program consisting of at least twenty hours of participation in a group setting dealing with alcohol or other drugs in addition to the sixteen hours of education. (A.R.S. §28-1301)

III. POLICY

A. DRIVING UNDER THE INFLUENCE (DUI)

The Contractor is responsible for covering and reimbursing for services when the services are AHCCCS covered, medically necessary services described in Statute, Rule, Contract or Policy. A court order is not necessarily a substitute for the Contractor's obligation to determine the amount, duration and scope of medically necessary services. The Contractor should not assume that a court or administrative agency ordering DUI screening, education or treatment services is aware of the scope of AHCCCS covered services or of how medical necessity is defined for purposes of the AHCCCS program. Nevertheless, the Contractor may take into consideration, the medical information and factual findings of the court or administrative agency in making the Contractor's determination of medical necessity.

When a DUI screening, education or treatment is ordered by the court for a person who has been charged for driving under the influence pursuant to A.R.S. §36-2027, the cost of the screening, education and/or treatment is the responsibility of the county, city, or town whose court ordered the screening, education and/or treatment. See A.R.S. §36-2027 (E). The county, city or town is a source of third party liability for any court ordered evaluation and/or treatment services that are also AHCCCS covered services. Upon receipt of the claim, the Contractor should return it to the provider with directions to bill the responsible county, city or town.

B. DOMESTIC VIOLENCE OFFENDER TREATMENT

When a person is convicted of a misdemeanor domestic violence offense, pursuant to A.R.S. §13-3601, the sentencing judge must order the person to complete a domestic violence offender treatment program that is provided by a facility approved by the Department of Health Services or a probation department. Pursuant to A.R.S. §13-3601.01. A person who is ordered to complete a domestic violence offender treatment program must pay the cost of the program.

Although a judge may determine that court ordered domestic violence offender treatment (including educational classes to meet the requirements of the court order) is the financial responsibility of the offender under A.R.S. §13-3601.01. An AHCCCS member cannot be considered a legally responsible third party with respect to themselves. As a result, it is AHCCCS' expectation that the Contractor responsible for the provision of behavioral health services will provide domestic violence offender treatment when the service is deemed medically necessary. The member is not a source of first or third party liability as defined in A.A.C. R9-22-1001 when required prior authorization is obtained and/or the service is provided by an in-network provider, The Contractor must provide medically necessary services and ensure that the member's medical record includes documentation to justify the medical necessity for the services rendered.

C. COURT ORDERED TREATMENT FOR PERSONS ACCUSED OF OTHER CRIMES

Pursuant to A.R.S §36-2027, a court may order evaluation and treatment at an approved treatment facility of a person who is brought before the court and charged with a crime if:

1. It appears the person is an alcoholic, and
2. Such person chooses the evaluation and treatment procedures. The court cannot order the person to undergo treatment and evaluation for more than 30 days.

The cost of evaluation and treatment of an indigent patient treated pursuant to a court order under A.R.S. §36-2027 is the responsibility of the county, city, town or charter city whose court issued the order for evaluation.

When evaluation or treatment is ordered pursuant to this statute, the county, city, town or charter city whose court issued the order for evaluation is responsible for the cost of services to the extent ordered by the court. To the extent those services are also AHCCCS covered services and the Contractor receives a claim for the services, the Contractor may direct the provider to bill the appropriate county, city, town or charter city.

Financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of court-ordered evaluation is outlined in ACOM Policy 437.

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
- A.R.S §13-3601
- A.R.S §13-3601.01
- A.R.S §28-1381, §28-1382, §28-1383
- A.R.S §28-1301
- A.R.S Title 36, Chapter 18, Article 2
- A.R.S §36-2027
- A.R.S §36-2028
- A.A.C. R9-22-1001
- ACOM Policy 437

424 - VERIFICATION OF RECEIPT OF PAID SERVICES

EFFECTIVE DATE: 04/01/10, 06/01/15

REVISION DATE: 07/01/10, 10/28/10, 10/01/2012, 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE

I. PURPOSE

This Policy applies to the Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), DES/DDD (DDD) Contractors. The Contractor is responsible for verifying member receipt of paid services according to Federal and contractual requirements to identify potential service/claim fraud [42 CFR 455.20]. The Contractor is expected to perform periodic audits through member contact and to report the results of these audits to AHCCCS Division of Health Care Management (DHCM).

II. DEFINITIONS

VALIDATION Receipt of affirmative confirmation from the member (written or verbal).

III. POLICY

A. GENERAL REQUIREMENTS

1. The Contractor shall perform, at a minimum, quarterly audits to determine member receipt of paid services.

2. A Quarterly Verification of Services Audit Report, shall be due on January 15th; April 15th; July 15th; and October 15th; using the format in Attachment A, Quarterly Verification of Services Audit Report.

B. SAMPLING

1. The sampling shall be from claims with Dates of Services (DOS) from the reporting quarter and not more than 45 days from date of payment pursuant to 42 CFR 455.232 and 433.116(e). The report is due the 15th day after the end of the quarter that follows the reporting quarter as specified in Contract, Attachment F3, Contractor Chart of Deliverables. For example, the July 15th report would be for paid claims with DOS for January through March. Surveys can be performed at any point after claims have been paid.

2. Members who are surveyed shall have been enrolled with the Contractor during the period under review.

3. The sampling shall consist of claims that resulted in payment.

4. The sampling shall be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility, assisted living facility and in-home services).

5. The sample size shall be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an ALTCS/EPD Contractor with less than 2,000 members shall be 50 claims (the minimum sample size refers to completed surveys).

C. METHODOLOGY

1. The audit can be performed by mail, telephonically or in person (e.g., ALTCS case management on-site visits). Concurrent review will be allowed; however, if used it must be recorded and tied back to a successfully adjudicated claim.

2. Survey language should be in an easily understood language, including the description of services (e.g., x-ray, surgery, blood tests, counseling) when validating the receipt of paid services.

3. Individual survey results indicating that paid services may not have been received shall be referred to the Contractor's Fraud and Abuse department for review and on to the AHCCCS Office of the Inspector General (AHCCCS-OIG) department as appropriate.

D. REPORTING

1. The Contractor shall submit a report which includes the total number of surveys sent out, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS-OIG department for further review (Attachment A).

2. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the Contractor's Fraud and Abuse department and analysis and interventions where appropriate.

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

- 42 CFR 455.20
- 42 CFR 455.232
- 42 CFR 433.116(e)
- Attachment A, Quarterly Verification of Services Audit Report
- Contract, Section F, Attachment F3, Contractor Chart of Deliverables

ATTACHMENT A: QUARTERLY VERIFICATION OF SERVICES AUDIT REPORT

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

425 - SOCIAL NETWORKING

EFFECTIVE DATE: 02/01/10, 10/01/13, 03/01/15

REVISION DATE: 02/25/10, 01/01/11, 08/13/13, 02/19/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes the requirements for AHCCCS Contractors regarding Social Networking Activities.

II. DEFINITIONS

BROADCAST	Video, Audio, or text transmitted through Social Networking Applications, via internet, cellular or wireless network for display on any device (e.g. comments, blogs).
FRIENDS/FOLLOWERS	Persons who choose to interact through online social networks by creating accounts or pages and proactively connecting with others.
MARKETING	Any communication from a Contractor to an AHCCCS member not enrolled with that Contractor that can reasonably be interpreted as intended to influence enrollment in that particular Contractor, or to not enroll in, or to disenroll from, another Contractor.
SOCIAL NETWORKING ACTIVITIES	The use of Social Networking Applications, the development of Contractor-specific Social Networking Application sites/pages, and Broadcast activities.
SOCIAL NETWORKING APPLICATIONS	Web based services/platforms (excluding the Contractor's State mandated website content, member portal, and provider portal) for online collaboration that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services – collectively also referred to as social media (e.g. Facebook).

TAGS/TAGGING	Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.
USERNAME	An identifying pseudonym associating the author to messages or content generated.

III. POLICY

A. SOCIAL NETWORKING ACTIVITIES

The Contractor must comply with the requirements and restrictions outlined in this Policy for all Social Networking Activities.

The Contractor is responsible for ensuring that all materials used in Social Networking conform to the requirements for member information as outlined in ACOM Policy 404.

Social Networking for purposes of Marketing is prohibited.

The Contractor is responsible for continuous monitoring of its Social Networking Activities to ensure adherence to AHCCCS Policy including, but not limited to, marketing restrictions, member information guidelines, and adherence to HIPAA Privacy Rules and provisions regarding safeguarding of Protected Health Information (PHI). [42 CFR 438. 104, 42 CFR 438.101, 438.10, 45 CFR Parts 160, 162, and 164]

Contractor Social Networking Activities and materials do not require prior review or approval by AHCCCS. However, AHCCCS shall perform monitoring activities of the Contractor, including but not limited to, Contractor's oversight of its Social Networking Activities, to ensure ongoing compliance with this Policy. AHCCCS may perform audits as determined necessary.

The Contractor is not required to use Social Networking Applications or to partake in Social Networking Activities.

B. SOCIAL NETWORKING REQUIREMENTS

The Contractor shall adhere to the following requirements for Social Networking Activities when the Contractor participates in Social Networking activities:

1. All Social Networking Activities shall address programs and services of the AHCCCS program in support of the mission and delivery of services.

2. Member privacy measures taken regarding Social Networking shall ensure the security of Protected Health Information (PHI) and must adhere to all HIPAA Privacy Rules, AHCCCS policies and contractual requirements.

3. The Contractor shall designate a Social Networking Administrator who is responsible for policy development, implementation and oversight of all social networking activities. The Social Networking Administrator may have other responsibilities and may hold another position.

4. The Contractor must use all available security features to prevent fraud and unauthorized access.

5. All Social Networking connections must be initiated by the external user and not the Contractor.

6. All Social Networking Application sites and Broadcasts shall be clear, direct, professional, accurate, and presented in a well-organized manner. The Contractor should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.

7. The Contractor shall comply with copyright and intellectual property law and shall reference or cite sources appropriately.

8. The Contractor's presence on Social Networking Application sites must include an Avatar and/or a Username that clearly indicates what company is being represented. Use of the AHCCCS logo or State of Arizona seal is prohibited.

9. The Contractor shall develop an internal company policy, based on the requirements of this Policy, for the use of Social Networking and Broadcasts with regard to the AHCCCS lines of business. The Policy must include a statement of purpose/general information explaining how the Contractor uses Social Networking and Broadcasting and how the Contractor continuously monitors Social Networking Activities. The Contractor shall ensure employees receive instruction and/or training on the AHCCCS and Contractor's Social Networking policies before using Social Networking Applications and Broadcasts on behalf of the Contractor.

C. SOCIAL NETWORKING RESTRICTIONS

The Contractor shall adhere to the following restrictions regarding Social Networking Activities:

1. Social Networking Applications and Broadcasts for the purposes of marketing are prohibited.

2. The Contractor shall not solicit feedback from members via Social Networking Applications or Broadcasts.

3. External user-generated content (comments/posts) is not permitted unless the Contractor has an intermediary review process in place in which the Contractor ensures all postings are appropriate and are in compliance with this Policy.

4. The Contractor shall not post information, photos, videos, links/URLs or other items online that reflect negatively on any individual(s), its members, AHCCCS or the State.

5. The Contractor is prohibited from tagging photographic or video content and must promptly remove all tags placed by others upon discovery.

6. The Contractor shall not identify members by name, or post, share, or publish information, including a member photo, that may lead to the identification of a member.

7. The Contractor is prohibited from posting ads, whether targeted or general, on Social Networking Application sites.

8. No affiliate/referral links or banners are permitted. This includes links to other non-Medicaid lines of business that the Contractor or a parent company is engaged in. When using any Social Networking Application which may automatically generate such linkage, recommendation, or endorsement on side bars or pop-ups (e.g. Facebook), the Contractor's Social Networking Application page must contain a disclaimer message prominently displayed in the area under the Contractor's control stating that such **items, resources, and companies are NOT endorsed by the Contractor or AHCCCS.**

9. Use of materials that are inaccurate, misleading or that otherwise make misrepresentations is prohibited.

D. CONTRACTOR SUBMISSION REQUIREMENTS

The Contractor shall submit the following to the Designated Operations and Compliance Officer, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

1. Attachment A, Social Networking Attestation (within 90 days after the start of the Contract year)

2. A listing of all Social Networking Applications used in the contract year with associated URLs (within 90 days after the start of the Contract year and within 30 days of any changes)

3. The name and contact information of the Contractor's Social Networking Administrator (within 90 days after the start of the Contract year and within 30 days of any changes).

IV. REFERENCES

- Acute Care Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- ACOM Policy 404
- 42 CFR 438.10
- 42 CFR 438. 101
- 42 CFR 438. 104
- 45 CFR Parts 160, 162, and 164
- Attachment A, Social Networking Attestation

ATTACHMENT A, SOCIAL NETWORKING ATTESTATION

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

426 – CHILDREN'S REHABILITATIVE SERVICES REFERRALS, ENROLLMENT, AND COVERAGE GUIDELINES

EFFECTIVE DATE: 01/01/11, 10/01/13, 08/01/14, 10/01/15

REVISION DATE: 10/25/12, 02/07/13, 07/17/14, 09/17/15

STAFF RESPONSIBLE FOR POLICY: DHCM AND DMS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy defines the processes used to accept and process applications and referrals to the Children's Rehabilitative Services (CRS) program, CRS redeterminations, and delineates the responsibility for coverage and payment of CRS conditions as well as other services that are the responsibility of the respective Contractor.

II. DEFINITIONS

ACTIVE TREATMENT	Active Treatment means there is a current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22-1301).
CRS APPLICATION	A submitted form with additional documentation required by the AHCCCS DMS in order to make a determination whether an AHCCCS member is medically eligible for CRS.
CRS CONDITION	Pursuant to A.R.S. §36-2912, those covered conditions that are medically disabling or potentially disabling and which qualify for CRS medical eligibility as specified in A.A.C. R9-22-1303
REDETERMINATION	A decision made by the AHCCCS DMS regarding whether a member continues to meet the requirements in A.A.C. R9-22-1305

III. POLICY

The CRS Contractor provides covered services to individuals who have been confirmed as having a CRS condition requiring active treatment, as described in A.A.C. R9-22-1303 and AMPM Policy 330, who have been approved for the CRS program by the Division of Member

Services (DMS). AHCCCS may request, at any time, that the CRS Contractor submit medical documentation for the determination of continued eligibility. DMS is responsible for processing and responding to requests for CRS enrollment and will accept and process a referral and application in accordance with this Policy.

AHCCCS members under the age of 21 shall be enrolled into the CRS Program when the presence of a CRS condition requiring active treatment, as defined by AMPM Policy 330 and A.A.C. R9-22-1303, is confirmed through medical review by DMS. Applicants who are not enrolled in Title XIX/XXI cannot be enrolled in the CRS Program. Members are permitted to opt out of, or refuse enrollment into, the CRS program.

Regardless of the CRS Coverage Type, the CRS Contractor is responsible for care and services effective from the date of the member's enrollment into the CRS Program through the date of disenrollment and also during Prior Period Coverage (PPC) as noted in section D of this Policy.

Members, currently enrolled in the CRS Program, who were determined CRS eligible due to a covered medical condition which is no longer listed in A.A.C. R9-22-1303, may elect to remain enrolled in the CRS Program, providing they continue to meet medical criteria for the covered medical condition which was the basis for their initial enrollment.

The CRS Contractor shall pay for **all** medically necessary services related to the member's CRS condition as well as other covered services based on the member's CRS Coverage Type. The CRS coverage types are described below.

CRS COVERAGE TYPES:

1. CRS Fully Integrated

   This coverage type is applicable to members receiving all services from the CRS Contractor including acute care, behavioral health, and CRS-related services.

2. CRS Partially-Integrated – Acute

   This coverage type is applicable to American Indian (AI) members receiving all acute care and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA).

3. CRS Partially-Integrated – Behavioral Health (BH)

   This coverage type is applicable to CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute care services from the primary program of enrollment.

4. CRS Only

This coverage type is applicable to members receiving all CRS related services from the CRS Contractor, receiving acute care services from the primary program of enrollment, and receiving behavioral health services as follows:
a. CMDP and DDD AI members from a TRBHA
b. American Indian Health Program (AIHP) members from a T/RBHA
c. CRS only also includes ALTCS/EPD AI Fee-For-Service (FFS) members.

IV. PROCEDURE

A. REFERRAL/APPLICATION

1. Form Requirements
A CRS referral/application shall be submitted to DMS for a medical eligibility determination. A copy of the required CRS referral/application and instructions are available on the AHCCCS website at the following link: CRS Referral.
   a. The completed Application for Enrollment into AHCCCS CRS form may be faxed, mailed, or delivered in person to DMS as indicated on the AHCCCS website.
   b. Prior to submitting the completed CRS referral/application form, the Contractor shall discuss the referral and possible health plan change with the parent/ authorized representative.
   c. The following additional documentation is required with submission of the application:
      i. Documentation from a specialist who diagnosed the individual, stating the individual's diagnosis and the need for treatment; and
      ii. Diagnostic testing results that support the medical diagnosis.

2. Processing
   a. DMS will verify Title XIX/XXI enrollment.
   b. If further information is needed in order to make a determination of medical eligibility, DMS will contact the appropriate parties to request the information.

3. Enrollment
   a. Except as specified in 3(b) for newborns when the CRS application is received within the first 28 days of birth, DMS will enroll the applicant into the CRS Program, by coverage type, effective on the same date as the eligibility determination, including those applicants who may be hospitalized at the time of the CRS determination.
   b. DMS will enroll newborns retroactive to the date of birth when the CRS application is received within the first 28 days of birth.

4. Notifications
   a. When a determination is made, notification will be provided to the following parties:
      i. Applicant/authorized representative;
      ii. Referral source, if authorized; and
      iii. The current AHCCCS Contractor, if applicable.
   b. If approved for CRS enrollment, the CRS Contractor will also be notified.

DMS will provide information related to the CRS condition(s) that are identified during the eligibility determination process. It will be the responsibility of the CRS Contractor to ensure that the information provided by DMS is made available to the appropriate areas and staff within its organization who may need the information. It remains the responsibility of the CRS Contractor and the Acute Care Contractor to also appropriately transition the member utilizing established transition processes.

B. MEMBERS TURNING 21

Shortly before a member who is enrolled in the CRS Program turns 21 years of age, s/he is provided a one-time opportunity to remain enrolled with the CRS Contractor.

The month prior to the month the member will turn 21, the member will be notified of his/her opportunity to either continue enrollment with the CRS Contractor or enroll with another AHCCCS Contractor and will be informed of the process for doing so.

If a member does not timely notify the AHCCCS CRS Enrollment Unit to continue enrollment in the CRS Program, s/he will be disenrolled from the CRS Contractor at the end of his/her birth month and will be auto-enrolled with another AHCCCS Contractor.

The member will then be given a 30 day choice of Acute Care Contractor period.

If a member turning 21 years of age fails to timely notify the AHCCCS CRS Enrollment Unit to continue enrollment in the CRS Program, the member will not be permitted to reenroll with the CRS Program at a later date.

C. CONTRACTOR RESPONSIBILITIES FOR CRS SERVICES

AHCCCS members may elect to use his/her private insurance network (providers) or Medicare providers to obtain health care services, including those for treatment of the CRS condition. Contractor responsibilities for payment of services for treatment of the CRS condition, when a member uses private insurance or Medicare, are further outlined below.

1. CRS Contractor Responsibilities
   a. Members under 21 years of age who are determined to have a qualifying CRS condition will be enrolled with the CRS Contractor. The CRS Contractor is

responsible for payment for services provided to its enrolled members as outlined in the four CRS coverage types above and as set forth in AHCCCS rules and policy.

b. If a member enrolled with the CRS Contractor uses private insurance or Medicare for a CRS covered condition, then the CRS Contractor is the secondary payer responsible for all applicable deductibles and copayments and for application of the appropriate coordination of benefits activities for members as outlined in ACOM Policy 434.
c. When the member's private insurance or Medicare expires, does not cover the CRS condition, is exhausted for the CRS-covered conditions, or certain annual or lifetime limits are reached for the CRS-covered condition, the CRS Contractor is responsible for all covered CRS services.
d. If the member chooses to continue enrollment with the CRS Contractor upon reaching age 21, the CRS Contractor will continue to be responsible for payment of CRS conditions and other covered services as specified by the member's CRS coverage type.

2. AHCCCS non-CRS Contractor Responsibilities when the Member Opts out of CRS (Under 21)

Members who opt out of/or refuse enrollment with the CRS Program will be enrolled with another AHCCCS Contractor.

For members who opt out/refuse enrollment with the CRS Contractor, the AHCCCS Contractor with whom the member is enrolled for acute care services is not responsible for coverage of the CRS condition except when a member uses private insurance or Medicare for a CRS covered condition as discussed below.

a. Member has Third Party Coverage Benefits Available:
   i. If a member opts out/refuses enrollment with the CRS Contractor and uses private insurance or Medicare for treatment of the CRS condition, the AHCCCS Contractor with whom the member is enrolled for acute care services is responsible for all applicable deductibles and copayments remaining after payment by private insurance or Medicare.
b. Member has Exhausted Third Party Coverage Benefits:
   i. When the member's private insurance or Medicare does not make payment for treatment of the CRS condition, terminates, is exhausted for the CRS-covered condition, or when annual or lifetime limits are reached for the CRS covered condition, the AHCCCS Contractor with whom the member is enrolled for acute care services has no responsibility for coverage of the CRS condition.
   ii. Upon receipt of information that the member's private insurance or Medicare has terminated or has been exhausted with respect to the CRS covered condition, the AHCCCS Contractor with whom the member is enrolled for acute care services shall refer the member to DMS to evaluate the member for CRS eligibility.

In situations when the AHCCCS Contractor is not responsible for the CRS condition, the member may be billed by the provider as authorized by A.A.C. R9-22-702.

3. AHCCCS non-CRS Contractor Responsibilities (21 and Over)
   a. For members age 21 years or older, the AHCCCS Contractor with whom the member is enrolled for acute care services **IS** responsible for payment of services related to a CRS condition regardless of whether the member has private insurance or Medicare. The AHCCCS Contractor is the payor of last resort.

D. TERMINATION OF ENROLLMENT

DMS may terminate a member's enrollment with the CRS Contractor for the following reasons:

1. Member Loses Title XIX/XXI Eligibility
   a. If a member regains Title XIX/XXI eligibility within 12 months, the member will be re-enrolled with the CRS Contractor without a new referral/application being required.
   b. If AHCCCS eligibility is regained after 12 months, a new referral/application will be required for the CRS program.
   c. PPC with the CRS Contractor will only occur when a Title XIX CRS enrolled member loses eligibility and then regains eligibility within 12 months, resulting in re-enrollment with the CRS Contractor.

2. DMS Medical Eligibility Determination
   a. Member no longer meets the medical eligibility requirements for CRS.
   b. Member has completed treatment for the CRS condition(s).

3. Member/Authorized Representative Requests for Opt Out/Termination
   a. Members will be notified by DMS that any services related to the CRS condition will not be covered by another AHCCCS Contractor except when the member has private insurance or Medicare for the CRS condition in which case the non-CRS AHCCCS Contractor is responsible for payment of copayments and deductibles as outlined in this Policy, Section IV (C) (2).
   b. The member (or the member's parent, legal guardian, or representative when applicable), will be required to sign an acknowledgement of understanding that CRS-related services will not be provided by the non-CRS Contractor and that the member agrees to accept payment responsibility for CRS services except when the member's private insurance or Medicare makes payment for CRS services. In these circumstances, the non-CRS AHCCCS Contractor shall pay the member's copayments and deductibles as outlined in this Policy, Section IV(C)(2). Otherwise, the member shall be responsible for payment of services related to the CRS condition.

4. Member Transitions to ALTCS/EPD for members who are not ALTCS/EPD AI FFS members

5. Option to Disenroll After No Receipt of CRS Services for Three Years
   a. Starting in CYE15, during one designated time of the year determined by AHCCCS, AHCCCS will provide CRS Fully Integrated members who have been continuously enrolled in CRS and who have not received services for their CRS condition for three years, an option to disenroll from CRS.
   b. During this designated timeframe these Members will be allowed to choose an available Acute Care Contractor in their area.
   c. If it is later determined that the member needs care for a CRS condition, a CRS referral/application shall be submitted to DMS and evaluated for medical eligibility as described in this Policy.

E. NOTIFICATION OF CRS DISENROLLMENT

DMS will send written notice of CRS disenrollment to the member/authorized representative including a description of the member's hearing rights and information about the hearing process.

F. APPEAL OF CRS ELIGIBILITY DETERMINATIONS

A decision made by DMS to approve or deny a request for CRS enrollment, or to disenroll a CRS member, is subject to appeal under 9 A.A.C. 34.

G. REDETERMINATION

Continued eligibility for the CRS program shall be redetermined by verifying active treatment status of the CRS conditions as described in A.A.C. R9-22-1305 and as follows:

1. CRS Notification
   a. The CRS Contractor is responsible for notifying AHCCCS of CRS members no longer requiring active treatment for the CRS qualifying condition(s).
   b. The CRS Contractor shall transmit to AHCCCS, the Members with Completed Treatment Report, on at least a monthly basis, for any CRS member who has completed treatment.
   c. The above-referenced report must be sent no later than 15 days after the start of the month (reporting for the prior month) as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

2. AHCCCS Notification
   a. If AHCCCS determines that a CRS member is no longer medically eligible for CRS, AHCCCS shall provide the CRS member or authorized representative a written notice that informs the CRS member that AHCCCS is transitioning the CRS

member's enrollment to another AHCCCS Contractor according to A.A.C. R9-22-1306.

b. The member may appeal this determination under 9 A.A.C. 34.

III. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- DCS/CMDP Contract, Section D
- Contract, Section F, Attachment F3, Contractors Chart of Deliverables
- ACOM Policy 434
- AMPM Chapter 300
- 9 A.A.C 34
- A.A.C. R9-22-702
- A.A.C. R9-22-1301 et seq.

427 – RESERVED

428 - RESERVED

429 – DIRECT CARE WORKER TRAINING AND TESTING PROGRAM

EFFECTIVE DATE: 1/01/2012, 10/01/12, 10/01/14

REVISION DATE: 4/01/11, 12/08/11, 03/08/12, 09/13/12, 10/03/12, 09/04/14, 08/24/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to ALTCS/EPD and DES/DDD (DDD) Contractors and the Programs training and testing Direct Care Workers (DCW). This Policy sets forth minimum Program requirements and standards for Approved Direct Care Worker Training and Testing Programs to ensure uniformity of training Programs as well as to promote portability of testing records. In addition to other responsibilities, DCW Agencies, as the employer of the DCW, must ensure DCWs meet minimum competencies to provide quality care to ALTCS Members. DCW Agencies have the option to become an Approved Direct Care Worker Training and Testing Program or to delegate the responsibility of DCW training and testing to an Approved Direct Care Worker Training and Testing Program (See AMPM Policy 1240-A).

II. DEFINITIONS

APPROVED DIRECT CARE WORKER TRAINING AND TESTING PROGRAM ("APPROVED PROGRAM")	Program any entity that is approved by AHCCCS to provide training and testing of DCWs. These Approved Programs can be an AHCCCS registered agency that provides Direct Care Services, a private vocational program or an educational institution (e.g., high school, college or university).
ARIZONA STANDARDIZED DCW TEST	The test that an individual must pass to demonstrate the required knowledge and skills to become a qualified DCW.
CHALLENGE TEST	The standardized test that an individual with education similar to what is required for DCWs or work experiences similar to that performed by DCWs can request to take without having to complete the required DCW training.

CORRECTIVE ACTION PLAN (CAP)

A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

DIRECT CARE SERVICES

The services provided by Direct Care Workers are collectively known as Direct Care Services. There are three types of services within ALTCS that are provided by Direct Care Workers; these include Attendant Care, Personal Care, and Homemaker services.
See AMPM, Chapter 1200.

DIRECT CARE WORKER (DCW)

A person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed by DCW Agencies or, in the case of member-directed options, by ALTCS members. The DCW Agency or ALTCS member establishes DCW terms of employment. See AMPM, Chapter 1200, Policy 1240-A.

DIRECT CARE WORKER AGENCY

An agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care and Homemaker. The agency, by registering with AHCCCS, warrants that it has the ability, authority, skill, expertise and capacity to perform the services as specified in AHCCCS Policy.

PRINCIPLES OF CAREGIVING — A curriculum prepared under the guidance of the Direct Care Workforce Alliance and made available to the public at no cost. The curriculum consists of Caregiving Fundamentals and two modules:

1. Aging and Physical Disabilities, and
2. Developmental Disabilities.

The content of this curriculum addresses the DCW competencies; and will be updated periodically. Adopting the Principles of Caregiving curriculum satisfies the requirements for curriculum approval, but no guarantee is made that students completing the training will have all skills needed to provide services to a particular client. The curriculum is available on the AHCCCS website www.azahcccs.gov/dcw.

PRIVATE VOCATIONAL PROGRAM — An Approved Program that does not have an AHCCCS Provider ID for providing services or is a training Program that is subsidiary of a DCW agency. This can include private businesses. Individuals not established as a business organization cannot be a private vocational Program.

PROGRAM — An entity that is approved to provide the training and testing of DCWs as required by AMPM Chapter 1200. (Same as "Approved Direct Care Worker Training and Testing Program" and "Approved Program")

TRAINER — Individuals designated by an Approved Program and qualified to conduct training of DCWs. Trainers must have passed all the tests at the level required of Trainers for competencies they teach including, but not limited to, Caregiver Fundamentals, Aging and Physical Disabilities and/or Developmental Disabilities, have experience providing direct care and experience in teaching groups of adults.

III. POLICY

A. REQUIREMENTS FOR AN APPROVED DIRECT CARE WORKER TRAINING AND TESTING PROGRAM

Approved Direct Care Worker Training and Testing Programs (Approved Programs) must comply with all minimum Program requirements and standards outlined in this Policy for training and testing of DCWs. Only Approved Programs may administer the required

Arizona Standardized DCW test. Training and tests administered by an organization that is not an Approved Program are not valid.

1. Curriculum Standards
   a. An entity using the "Principles of Caregiving" is required to attest that it is utilizing these instructional materials during the initial application process. There is nothing that restricts an Approved Program or an entity seeking approval Program from including other training material.
   b. An entity not using the "Principles of Caregiving" must submit evidence that its training curriculum meets the competencies established for the "Principles of Caregiving".
   c. An Approved Program must routinely update their curriculum to align with updates posted to the AHCCCS website at www.azahcccs.gov/dcw.

2. Trainer Qualifications and Protocols
   An Approved Program is responsible to prepare and/or qualify (initially and ongoing) their trainers.

   An Approved Program must ensure each trainer:
   a. Has achieved a minimum score of 92% for the knowledge test(s) before the trainer begins teaching and a score of 100% for the skills test for any curriculum modules the trainer teaches. Approved Programs can train their own trainer, but the testing of a trainer must be administered by a trainer from another Approved Program. The same testing standards apply to trainers and DCWs (See III.A.3.). DCWs who become trainers are not required to retake the knowledge and skills tests if the original test scores were at or above the level required of a trainer. However, skills tests must be retaken because the skills-based testing requirements are more stringent for trainers than DCWs.
   b. Has substantive hands-on experience as a caregiver of at least one year. Experience must include providing personal care and working with relevant client populations, such as older adults or individuals with disabilities, including family members. If the trainer, employed by the Approved Program as a trainer prior to 10/01/2012, has passed both the knowledge and the skills tests but does not have the minimum one year of experience, the trainer must obtain at least 40 hours of hands-on experience. The trainer is not eligible to train until the hands-on experience requirements have been met.
   c. Has at least one year experience in teaching groups of adults (any field) or three months (100 plus hours) preparation to become an instructor in direct care. Preparation can include coaching, mentoring, co-teaching, and coursework.
   d. Conducts at least two DCW training classes per year.

An Approved Program must also ensure the following:

e. Individuals who are "experts" or licensed/certified on a training subject (e.g., Physical Therapist or Registered Nurse to train on body mechanics) may provide training related to their area of expertise in the absence of the qualified trainer. The Approved Program is responsible to ensure that "experts" used to provide training is capable/competent to conduct a portion of the training.
f. Trainers may have assistant trainers to assist with training. The trainer must be present for all training if the assistant trainer is not a qualified trainer.
g. Trainers who are also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per A.R.S. §32, Chapter 15 must meet all of the aforementioned requirements to become a qualified trainer outlined in this section.

3. Training and Testing Standards
   a. An Approved Program must have access to the necessary space to conduct training. The knowledge based aspect of training can be provided through a variety of approaches, including video and e-learning. Portions of the skills training can also be provided through video and e-learning techniques; however, there must be hands-on training of skills to ensure the student is able to appropriately perform the task (e.g., wheelchair to bed transfer).
   b. An Approved Program must have access to the basic necessary supplies and training equipment (e.g., wheelchair, hospital bed) to facilitate skills training and testing. Appropriate alternative supplies or training equipment may be used. A list of required and recommended supplies and equipment is available on the AHCCCS website (www.azahcccs.gov/dcw).
   c. An Approved Program must use standardized tests provided by AHCCCS. The Program may integrate the test (knowledge and skills) into the training Program. The testing may be split into smaller units. A "final" test is not required if the testing is conducted in this manner. The Program must ensure that all knowledge and skills testing documents and questions remain secured.
   d. If an individual is unable to take a written test they may request to take an oral knowledge test. If an oral knowledge test is provided it must be read from a prepared text in a neutral manner. An Approved Program may offer the tests to a student in a language other than English.
   e. A DCW agency may request the challenge test one time for an employee if they have education similar to what is required for DCWs or work experiences similar to that performed by DCWs. The DCW agency and the Approved Program administering the challenge test must verify and document the DCWs related educational and work experience. The challenge test cannot be repeated. A student who takes the challenge test and fails (either knowledge or skills tests or both) must be trained and, then, retake and pass the knowledge and skills tests in order to become a qualified DCW.
   f. Retesting is permitted if the student has been trained or is exempt from the training requirement (e.g., Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per A.R.S. §32, Chapter 15). If a knowledge test is failed, the student must

retake the entire test. If one or more skills are failed, only the failed skill(s) must be retested. Trainers shall provide additional training as needed before retesting. Retesting cannot occur the same day the failed tests were administered.

g. A DCW who is also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per A.R.S. §32, Chapter15 is exempt from the DCW training and testing requirements. This exemption allows the DCW agency the discretion to test and train their employees as determined necessary. **NOTE**: Trainers who are also a Registered Nurse, Licensed Practical Nurse or Certified Nursing Assistant per A.R.S §32, Chapter- 15 must meet all the requirements to become a qualified trainer (See III.A.2.), including the requirement to pass the knowledge and skills tests. They are permitted to take the tests and, then, retest if tests are failed without training.
h. A DCW with an initial hire date prior to 10/01/2012 is deemed to meet the training and testing requirements with the DCW agency(ies) they are currently employed. However, if the DCW becomes employed with another agency on or after 10/01/2012, the DCW must meet the training and testing requirements as outlined in this Policy and AMPM, Chapter 1200, Policy 1240-A.
i. Except as noted above (in paragraph 3.g), a DCW must have achieved a score of 80% for each knowledge test that the DCW completes and must pass all (100%) of the skills test for any curriculum modules the DCW completes.
j. All DCWs with an initial hire date on or after 10/01/2012 must meet the DCW training and testing requirements within 90 calendar days from date of hire. It is permissible for DCWs to provide care during the 90 day training period. In the event the DCWs 90 day training period has expired prior to the DCW receiving training and passing the knowledge and skills tests, the DCW must stop providing care until the training and testing requirements are met.
k. Test administration guidelines are available on the AHCCCS website www.azahcccs.gov/dcw.

4. Program Policy Standard
   a. An Approved Program must maintain polices for: training Program structure and process; validating/verification and sharing individual DCW and trainer test results; and testing process and maintaining test integrity,
   b. Policies must be reflective of the training and testing requirements.

5. Training and Testing Records
   a. An Approved Program shall maintain accurate and complete records of all training and testing. This includes but is not limited to names of trainers including the names of any individual experts used, schedules (dates and times), class rosters with evidence of student attendance (student and trainer signatures) and individual student records (test type, modules and results). Programs shall integrate the use of the AHCCCS DCW and trainer testing records online database into day to day business practices. The primary purpose of the online database is to serve as a tool to support the portability or transferability of DCW or trainer testing records from one employer to another employer. The database is available online

https://dcwrecords.azahcccs.gov complete with computer-based training modules, a frequently asked questions document and a User Guide under the "help" tab. Approved Programs shall:

i. Maintain a list of organizational users and notify AHCCCS when a user account must be terminated or suspended;
ii. Maintain and manage an employee listing of trainers who will be or have sent for training/testing including updating status changes of employees (hired, terminated, resigned) within 30 days of the status change;
iii. Utilize a standard form to obtain permission from current/prospective trainer employees to access testing records in the online database; and
iv. Report testing results for DCWs or trainers in the online database within 30 days of a testing event.

In the event testing records are not available in the online database, a hard copy form must be used for testing record verification. A current/former/prospective employer of a trainer shall share upon request and/or may solicit testing records using the *Verification of Direct Care Worker Testing* form. The *Verification of Direct Care Worker Testing* form is available on the AHCCCS website www.azahcccs.gov/dcw. The employer shall maintain copies of the verification testing forms provided to and/or requested from another trainer employer. Verification may also include an official transcript from an Approved Training and Testing Program of the test type(s), date(s), module(s), and score(s).c. Back up documentation shall be retained for a minimum period of six years. Back-up documentation includes the testing search authorization standard form and back-up documentation for any and all entered data in the online database or any data pertaining to training and testing of DCWs or trainers. The documentation can be retained in either an electronic or hard copy filing system.

b. Training and testing record requirements and responsibilities of DCW Agencies are found in AMPM, Chapter 1200, Policy 1240-A.

6. Continuing Education

a. Continuing Education requirements are the responsibility of the DCWs employer and not that of an Approved Program. See AMPM Chapter 1200, Policy 1240-A.

B. INITIAL PROGRAM APPROVAL

1. Application

a. The applying entity must submit a completed, signed and dated *Application for Approval for DCW Training and Testing* form to AHCCCS. The form is available on the AHCCCS website www.azahcccs.gov/dcw.
b. An entity that charges individual students for DCW training and testing must be licensed by the Arizona Board of Postsecondary Education A.R.S. §32.3001 et. seq. and A.A.C R4-39-103.

2. Review of Application
   The initial application review is a "paper review," with no planned onsite review. AHCCCS personnel will:
   a. Compare the application to the requirements.
   b. Request, as needed, additional documents from the applicant before making a final determination to approve an application.

3. Final Approval of Application and Notice
   a. A written notice of approval will be sent to the requesting entity by AHCCCS. The written notice will include the effective date of the approval.
   b. Training and testing of DCWs may begin no sooner than the date of Program approval.
   c. All Approved Programs will be listed at www.azahcccs.gov/dcw.

C. CONTINUING PROGRAM APPROVAL

After a DCW training and testing Program is approved by AHCCCS, an ALTCS Contractor will conduct a post-initial audit within 180 days of the initial Program approval. AHCCCS will coordinate with the Contractors to determine which Contractor shall conduct the year one audit and subsequent onsite annual audits. AHCCCS may perform audits in lieu of the Contractors. An onsite review of an Approved Program, outside of the audit cycle, may be performed at the discretion of AHCCCS, the Contractor, or the assigned auditing Contractor.

1. Year One Audit
   a. The post-initial audit is a desk audit and does not constitute an onsite visit. The post-initial audit occurs one time within 180 days of an Approved Program's initial approval. The Contractor shall provide at least a 30 day advance notice of a scheduled audit in order for the Approved Program to prepare for the audit.
   b. Information, documents and evidence to be provided by the Approved Program and reviewed by the auditor include, but are not limited to, policies and procedures, evidence of adequacy of training space and evidence of access to the necessary equipment and supplies to provide the skills training and testing and qualification of trainers. Additional documents must be available to the auditor upon request.

2. Onsite Audit
   a. The onsite audit occurs annually close to the anniversary of the year one audit. Auditors will visit the Approved Program's main training site, but the audit will be inclusive of all training sites.
   b. The Contractor shall provide at least a 30 day advance notice of a scheduled audit in order for the Approved Program to prepare for the audit.
   c. Information, documents and evidence to be provided by the Approved Program and reviewed by the Contractor include but are not limited to, policies and procedures, evidence of adequacy of training space, evidence of access to the necessary equipment and supplies to provide the skills training and testing, qualifications of

trainers, curriculum and training and testing records including training and testing records of individual students. Other documents must be made available to the Contractor upon request.

d. Upon request from the Contractor, the Approved Program will provide data such as rosters which reflect all individuals who were trained and tested for the audit period under review. A random sample of 50%, but no more than 10 individual training records will, be selected by the Contractor to evaluate compliance of DCW training and testing requirements. The sample selection shall not be selected from a sole training session, but shall be representative of training sessions from multiple training sites that have occurred throughout the audit period.

e. A record review to determine if the DCW providing services has met the training and testing requirements is not part of the process for continuing Program approval. The Contractor must review this type of information when monitoring a DCW agency to ensure a member's caregiver is a qualified DCW as required by AMPM Chapter 1200. For Approved Programs that also serve as a DCW agency, Contractors are encouraged to conduct their monitoring oversight of DCW services at the same time as the continuing Program approval review in an effort to reduce the administrative burden.

3. Notice of Audit Findings

a. The Contractor will issue a letter indicating the findings of the audit specifying whether the Program is compliant, is compliant but must address recommendations, or is granted a provisional approval pending corrective action. The completed report must be provided to the Approved Program within 30 days of completing the audit.

b. AHCCCS will update the Approved Programs listing with the audit findings to the AHCCCS website (www.azahcccs.gov/dcw) on a monthly basis.

c. The Contractor will promptly provide the full report to other Contractors upon request.

4. Provisional Approval Pending Corrective Action

a. If the Contractor determines the Approved Program is not compliant in one or more areas of the audit, the Approved Program will be granted provisional approval pending a CAP. The Contractor shall summarize the deficiencies noted in the audit report to assist the Approved Program in developing and implementing a CAP. Approved Programs with a provisional approval status are permitted to continue to provide training and testing of DCWs.

b. The Approved Program shall submit its CAP to the Contractor within 15 days of receipt of the audit findings and report. The CAP shall include a timeline for the deficiencies to be corrected, not to exceed 30 days from the CAP submission.

c. The Contractor has the discretion to require the Approved Program to submit evidence or documentation and/or conduct an on-site review to determine if the CAP was implemented successfully.

d. The Contractor shall send a notice updating the provisional Program approval status to the Approved Program and to AHCCCS. If the Contractor determines that the

Program remains out of compliance, 3.a. b. and c. will be performed an additional time.

e. If the Program fails to correct the deficiencies after having submitted two CAPs, the Contractor will timely notify AHCCCS of the deficiencies. AHCCCS will notify the Approved Program that the provisional approval has been denied and that it cannot operate an approved direct care worker training and testing Program.
f. A training and testing Program that has been denied continuing Program approval based on the findings from an audit is not permitted to submit a new application to become an Approved Program for a minimum of 90 days from the date of the notice advising the Program it is no longer an approved Program.

5. Disagreement with Audit Findings
   a. An Approved Program which disagrees with the audit findings may submit its disagreement to the auditing Contractor. Any disagreement submitted by the Approved Program must be received by the auditing Contractor no later than 15 days of receipt of the audit findings and report and must include evidence to support its position.
   b. The auditing Contractor will reconsider the results of the review based on the evidence submitted Program. The Contractor shall submit findings to the Program and AHCCCS within 30 days of receipt of the disagreement.
   c. In the event the Program is in disagreement with Contractor's reconsideration decision, the Program may request review by the AHCCCS Administration. The review request must be received no later than the date of the Contractor's reconsideration decision. The AHCCCS Administration will issue a determination specifying whether the Program continues to serve as an Approved DCW Training and Testing Program.
   d. AHCCCS will post the final results to the AHCCCS website and notify all Contractors in writing.

6. Audit findings and reports and other related documents shall be maintained by the Contractor that performs the audit for six years.

D. EXEMPTIONS

1. Educational Institution
   An educational institution (e.g., high school, college or university) is exempt from the initial and continuing Program approval requirements if it submits a signed copy of the *Application for Approval for DCW Training and Testing* form (Available on the AHCCCS website, www.azahcccs.gov/dcw) form attesting that its DCW training and testing Program meets the DCW competencies as established through the Principles of Caregiving. This form must be completed and submitted to AHCCCS for initial Program approval and annually thereafter.

2. Approved Programs licensed by the Arizona State Board for Private Postsecondary Education (AZPPSE)
   A Program licensed by the AZPPSE is exempt from the initial and continuing Program approval requirements if it submits a signed copy of the *Application for Approval for DCW Training and Testing* form (Available on the AHCCCS website, www.azahcccs.gov/dcw) form attesting that its DCW training and testing Program meets the DCW competencies as established through the Principles of Caregiving. This form must be completed and submitted to AHCCCS for initial Program approval and annually thereafter.

IV. REFERENCES

- ALTCS/EPD Contract, Section D
- DES/DDD Contract, Section D
- A.A.C. R4-39-103
- A.R.S. §32, Chapter15
- A.R.S. §32-3001
- AMPM Chapter 1200

430 – RESERVED

THE ALTCS MEMBER CHANGE REPORT USER GUIDE MAY BE ACCESSED AT THE FOLLOWING LINK: ALTCS MEMBER CHANGE REPORT USER GUIDE

431 – COPAYMENT

EFFECTIVE DATE: 04/01/12, 09/01/12, 06/01/13, 01/01/14

REVISION DATE: 09/15/12, 10/11/12, 05/29/13, 03/06/14, 08/27/14

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

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 outline the copayment requirements described in A.A.C. R9-22-711, including mandatory and optional copayment amounts for certain populations, and provide clarification on services and populations which are exempt from copayments. The copayments referenced in this Policy are only those copayments charged under AHCCCS, and do not apply to other copayments such as Medicare copayments.

II. DEFINITIONS

COPAYMENTS

A monetary amount that a member may be required to pay directly to a provider at the time a covered service is rendered. AHCCCS has two types of copayments:

1. *Mandatory* (also known as "hard"): Providers can deny services to members who do not pay the copayment.
2. *Optional* (also known as "nominal"): Providers are prohibited from denying the service when the member is unable to pay the copayment.

COPAYMENT LEVELS

Copayment requirements will be indicated via a member specific copayment level found in all AHCCCS eligibility verification processes other than Interactive Voice Response (IVR). Every member will be assigned a copayment level which will reflect whether they are exempt from copayments, subject to optional (nominal) copayments, or subject to mandatory (hard) copayments.

PROVIDER PREVENTABLE SERVICES

Services provided for a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in 42 CFR 447.26.

VISIT

All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.

III. POLICY

A. MANDATORY COPAYMENTS

Individuals eligible for AHCCCS through the Transitional Medical Assistance (TMA) program are subject to mandatory copayments for the services listed below.

TMA COPAYMENTS

SERVICE	COPAYMENT
Prescriptions (per drug)	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$4.00
Physical, Occupational and Speech Therapies	$3.00
Outpatient non-emergency or voluntary surgical procedures	$3.00

B. OPTIONAL (NON-MANDATORY) COPAYMENTS

Optional copayments are also referred to as nominal copayments. Individuals eligible for AHCCCS through the following programs are subject to Optional Copayments:

1. A caretaker relative eligible under A.A.C. R9-22-1427(A),
2. Young Adult Transitional Insurance (YATI) for young adults who were in foster care,
3. State Adoption Assistance for Special Needs Children,
4. Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
5. SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled,
6. Freedom To Work (FTW).

C. OPTIONAL (NON-MANDATORY) COPAYMENTS for members enrolled in the programs listed above are as follows:

SERVICE	COPAYMENT
Prescriptions (per drug)	$2.30
Physical, Occupational and Speech therapies	$2.30
Doctor or other provider outpatient office visits for evaluation and management	$3.40

D. MEMBERS AND SERVICES EXEMPTED FROM COPAYMENTS

Some populations and services are not subject to copays as outlined below:

1. Copayments are **not charged** to the following persons:
   a. Children under age 19
   b. People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
   c. Individuals through age 20 eligible to receive services from the Children's Rehabilitative System (CRS) program
   d. People who are acute care members and who are placed in nursing homes or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year.
   e. People who are enrolled in the Arizona Long Term Care System (ALTCS)
   f. People who are eligible for Medicare Savings Programs only
   g. People who receive hospice care
   h. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under Public Law 93-638, or urban Indian health programs
   i. Breast and Cervical Cancer Treatment Program (BCCTP) for Women
   j. An adult eligible under A.A.C. R9-22-1427(E)
   k. An individual with respect to whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care, without regard to age
   l. An individual with respect to whom adoption or foster care assistance is made available under Part E of Title IV of the Social Security Act, without regard to age.
   m. An individual who is pregnant and through the postpartum period following the pregnancy

2. When an Acute Care member meets the criteria for copay exemption as described in Section C. 1. d. and g. of this Policy, Contractors must notify Member Data Management Administration (MDMA). The Contractor must fax a completed copy of Attachment A,

AHCCCS Notification to Set Member's Copay Flag to Exempt to AHCCCS MDMA within five days of admission or services being provided.

3. Copayments are **not charged** for the following services:
   a. Hospitalizations,
   b. Emergency services,
   c. Family Planning services and supplies,
   d. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women,
   e. Services paid on a Fee-for-Service basis,
   f. Well visits,
   g. Preventive services,
   h. Provider preventable services.

E. COPAYMENT COLLECTION

Providers are responsible for billing members for the copayment amount at the time of service. This applies to members with optional copayments as well as members with mandatory copays.

1. Mandatory copayments permit providers to deny services to members who do not pay the copayment. Payments to providers will be reduced by the amount of a member's copayment obligation regardless of whether or not the provider successfully collects the mandatory copayment.

2. Optional copayments apply to AHCCCS members who are not required to make the mandatory copayments. When a member has an optional copayment, providers are prohibited from denying the service when the member is unable to pay the copayment. The provider's reimbursement cannot be reduced by the amount of the copayment for members with optional copayments if the member is unable to pay.

F. ENCOUNTER SUBMISSIONS

Refer to the AHCCCS Encounter Manual, Chapter 6 for more information on the reporting of copayments on encounter submissions.

G. COPAYMENT LIMITS

Members subject to copays will not be required to pay additional copayments once the total amount of copayments made is more than 5% of the gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December).

The AHCCCS Administration will track each member's specific copayment levels by service type to identify those members who have reached the 5% copayment limit.

1. With the exception of prescription drugs (where a copay is charged for each drug received), only **one** copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

H. COPAYMENT INFORMATION

For more information regarding copays, refer to the AHCCCS Copayments page on the AHCCCS website and ACOM Policy 201.

IV. REFERENCES

- Acute Care Contract, Section D
- ALTCS/DDD Contract, Section D
- ALTCS/EPD Contract, Section D
- BHS Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DDD Contract, Section D
- A.A.C. R9-22-711
- A.A.C. R9-22-1427
- 42 CFR 447.26
- Public Law 93-638
- AHCCCS Encounter Manual
- ACOM Policy 201
- Attachment A, AHCCCS Notification to Set Members Copay Flag to Exempt

ATTACHMENT A, AHCCCS NOTIFICATION TO SET MEMBERS COPAY FLAG TO EXEMPT

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

432 - BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

EFFECTIVE DATE: 07/01/12, 04/01/15, 10/01/15

REVISION DATE: 10/11/12, 04/02/15, 05/21/15, 07/30/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors for the purposes of benefit coordination and delineating financial responsibility for AHCCCS covered behavioral health services provided to AHCCCS members. This Policy also prescribes payment responsibility for physical health services that are provided to members who are also receiving behavioral health services. This Policy does not apply to services provided through Indian Health Services (IHS) or Tribally owned and/or operated facilities.

II. DEFINITIONS

ACUTE CARE CONTRACTOR A contracted managed care organization (also known as a health plan) that provides acute care physical health services to AHCCCS members in the acute care program who are Title XIX or Title XXI eligible. The Acute Care Contractor is also responsible for providing behavioral health services for its enrolled members who are treated by a Primary Care Provider (PCP) for anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). Effective October 1, 2015, Acute Care Contractors are also responsible for providing behavioral health services for dual eligible adult members with General Mental Health and/or Substance Abuse (GMH/SA) needs. For other acute care populations, behavioral health services are carved out and are provided through Tribal or Regional Behavioral Health Authorities.

ACUTE CARE HOSPITAL A general hospital that provides surgical services and emergency services.

AMERICAN INDIAN HEALTH PROGRAM (AIHP)

An acute care Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.

BEHAVIORAL HEALTH DIAGNOSIS

Behavioral health diagnoses can be located in Covered Behavioral Health Services Guide at http://www.azdhs.gov/bhs/covserv.htm and any amendments thereof due to ICD 10.

BEHAVIORAL HEALTH ENTITY

A Contractor or subcontractor to which the member is assigned for the provision of Behavioral Health services. Behavioral Health Entities are one of the following:

- Acute Care Contractor for adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs except for members who elect a TRBHA for behavioral health services
- Regional Behavioral Health Authority (RBHA);
- Integrated RBHA;
- Tribal Regional Behavioral Health Authority (T/RBHA);
- Children's Rehabilitative Services (CRS) Fully Integrated; and
- CRS Partially Integrated Behavioral Health.

CRS FULLY INTEGRATED

A coverage type which includes members who receive all services from the CRS Contractor including acute health, behavioral health and CRS-related services.

CRS ONLY

A coverage type which includes members who receive all CRS-related services from the CRS Contractor, who receive acute health services from the primary program of enrollment, and who receive behavioral health services as follows:

- CMDP and DDD American Indian (AI) members from a Tribal RBHA
- AIHP members from a T/RBHA

CRS Only also includes ALTCS/EPD AI Fee-For-Service (FFS) members.

CRS PARTIALLY-INTEGRATED-ACUTE	A coverage type which includes American Indian members who receive all acute health and CRS-related services from the CRS Contractor and who receive behavioral health services from a Tribal RBHA.
CRS PARTIALLY-INTEGRATED BEHAVIORAL HEALTH (BH)	A coverage type which includes CMDP or DDD members who receive all behavioral health and CRS-related services from the CRS Contractor and who receive acute health services from the primary program of enrollment.
ENROLLED ENTITY	The entity, which may be a Contractor or AHCCCS FFS, with which the member is enrolled for the provision of acute care services. • For members enrolled in Acute Care, the Enrolled Entity is the Acute Care Contractor. • For members enrolled in DDD, with or without CRS coverage and/or BH coverage, the Enrolled Entity is DDD. • For members enrolled in CMDP, with or without CRS coverage and/or BH coverage, the Enrolled Entity is CMDP. • For members with Serious Mental Illness with CRS coverage who do not elect the American Indian Health Program, the Enrolled Entity is CRS under the CRS Fully Integrated coverage type. • For members with Serious Mental Illness with CRS coverage who elect a TRBHA for behavioral health services, the Enrolled Entity is CRS under the CRS partially Integrated-Acute coverage type. • For members with Serious Mental Illness without CRS coverage who do not elect the American Indian Health Program, the Enrolled Entity is an Integrated RBHA. • For members with Serious Mental Illness without CRS coverage who elect a TRBHA for behavioral health services, the Enrolled Entity is either the Acute Care Contractor or AIHP. • For members who elect the American Indian Health Program, the Enrolled Entity is AIHP. • For members receiving all services from the CRS Contractor including acute health, behavioral health and CRS-related services, the Enrolled Entity is CRS under the Fully Integrated CRS coverage type.

ENROLLED ENTITY **CONTINUED**

- For American Indian members receiving all acute health and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal RBHA, the Enrolled Entity is CRS under the CRS partially Integrated-Acute coverage type.

INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)

An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.

PRIMARY CARE PROVIDER (PCP)

An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

PRINCIPAL DIAGNOSIS

The condition established after study to be chiefly responsible for occasioning the admission or care for the member, (as indicated by the Principal Diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim line).

The Principal Diagnosis should not be confused with the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

SERIOUS MENTAL ILLNESS (SMI)

A person 18 years of age or older who has been determined to have a serious mental illness as defined in A.R.S. §36-550.

TRIBAL/REGIONAL BEHAVIORAL HEALTH AUTHORITY (T/RBHA)	An organization under contract with the State of Arizona that administers covered behavioral health services for Title XIX and XXI members. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407, and A.A.C. R9-22-1201.

III. POLICY

The purpose of this Policy is to clarify payment responsibility of AHCCCS Contractors and ADHS/DBHS subcontracted T/RBHAs for physical and behavioral health services for specific circumstances. Payment for AHCCCS covered behavioral health and physical health services is determined by the Principal Diagnosis appearing on a claim, except in limited circumstances as described in Attachment A, Matrix of Financial Responsibility by Responsible Party.

As this policy is not intended to address **all** scenarios involving payment responsibility, refer to Contract, Section D, Program Requirements, for additional information regarding covered services.

A. GENERAL REQUIREMENTS REGARDING PAYMENT FOR PHYSICAL AND BEHAVIORAL HEALTH SERVICES

1. Regardless of setting, if physical health services are listed on a claim with a Principal Diagnosis of behavioral health, the Behavioral Health Entity is responsible for payment of covered physical health services as well as behavioral health services.

2. Regardless of setting, if behavioral health services are listed on a claim with a Principal Diagnosis of physical health, the Enrolled Entity is responsible for payment of covered behavioral health services as well as physical health services.

3. Payment responsibility for professional services associated with an inpatient stay is determined by the Principal Diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity which authorized the inpatient stay.

4. Payment for an emergency department facility claim of an acute care facility is the responsibility of the Enrolled Entity regardless of the Principal Diagnosis on

the facility claim. Payment responsibility for professional services associated with the emergency department visit is determined by the Principal Diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of notification of the emergency department visit.

5. AHCCCS Fee-For-Service (FFS) will be responsible for payment of claims for physical and behavioral health services that are provided by an IHS or a tribally owned and/or operated facility to Title XIX members whether enrolled in managed care or FFS.

In addition to identifying exceptions, Attachment A, Matrix of Financial Responsibility by Responsible Party also provides detail and clarification regarding payment responsibility in specific scenarios.

All AHCCCS services must be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712.60 et seq. Enrolled Entities and Behavioral Health Entities may enter into contracts with providers that delineate other payment terms, including responsibility for payment.

B. SPECIFIC CIRCUMSTANCES REGARDING PAYMENT FOR BEHAVIORAL HEALTH SERVICES

The Enrolled Entity is responsible for reimbursement of services associated with a Primary Care Provider (PCP) visit for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder including professional fees, related prescriptions, laboratory and other diagnostic tests. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AMPM Policy 310.

The Enrolled Entity is responsible for payment of medication management services provided by the PCP while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the Behavioral Health Entity. For purposes of medication management, it is not required that the PCP be the member's assigned PCP.

1. The Enrolled Entity must coordinate with the Behavioral Health Entity when both physical and behavioral health services are rendered during an inpatient stay and the Enrolled Entity is notified of the stay. Such coordination shall include,

but is not limited to, communication/collaboration of authorizations, determinations of medical necessity, and concurrent reviews.

2. When the Principal Diagnosis on an inpatient claim is a behavioral health diagnosis, the Behavioral Health Entity shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the member's Enrolled Entity authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis.

4. When the Enrolled Entity is AHCCCS FFS for AIHP members assigned to a TRBHA, AHCCCS FFS is responsible for payment of medically necessary transportation services (emergent and non-emergent) when the diagnosis code on the claim is unspecified (799.9 or its replacement code under ICD-10).

5. Payment of pre-petition screening and court ordered evaluation services is the fiscal responsibility of a county. For payment responsibility for other court ordered services refer to ACOM Policy 423 and ACOM Policy 437.

C. SPECIFIC CIRCUMSTANCES REGARDING PAYMENT FOR PHYSICAL HEALTH SERVICES – ARIZONA STATE HOSPITAL (AZSH)

The payment responsibilities of an Enrolled Entity described below for members residing in AzSH do not apply to CMDP because CMDP members are under the age of 18 and members residing in AzSH are 18 years and older.

1. AHCCCS enrolled members who are residing in the Arizona State Hospital (AzSH) and who require physical health services that are not provided by AzSH during their stay, will receive the services at the Maricopa Integrated Health Systems (MIHS) clinics and/or Maricopa Medical Center (MMC).
   a. The Enrolled Entity shall provide reimbursement for medically necessary physical health services under one of the two following arrangements:
      i. A contractual agreement with MIHS clinics including MMC and MIHS physicians, to provide all medically necessary services. MIHS will be assigned to provide primary care services for all members residing in AzSH.
      ii. In the absence of a contractual agreement, the enrolled entity shall be responsible for coordination of care, prior authorization processes, claims payments, and provider and member issues for all services delivered by MIHS. The Contractor shall provide a seamless and obstacle free process for the provision of services and payment.
   b. Emergency services for AzSH residents will be provided by the Maricopa Medical Center and shall be reimbursed by the Enrolled Entity regardless of prior authorization or notification.

c. Physical health related pharmacy services for AzSH residents will be provided by AzSH in consultation with the Enrolled Entity. The Enrolled Entity is responsible for such payment.

IV. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- Attachment A, Matrix of Financial Responsibility by Responsible Party
- ACOM Policy 423
- ACOM Policy 437
- A.A.C. R9-22-712.60 et seq.
- A.A.C. R9-22-1201
- A.R.S. Title 32 Chapter 13
- A.R.S. Title 32 Chapter 15
- A.R.S. Title 32 Chapter 17
- A.R.S. Title 32 Chapter 25
- A.R.S. §32-3401
- A.R.S. §32-3407
- A.R.S. §36-550
- A.R.S. §36-2901

ATTACHMENT A, MATRIX OF FINANCIAL RESPONSIBILITY BY RESPONSIBLE PARTY

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

433 – MEMBER IDENTIFICATION CARDS

EFFECTIVE DATE: 11/01/12, 10/01/13, 10/01/14, 10/01/15

REVISION DATE: 10/11/13, 03/07/13, 05/09/13, 08/01/13, 01/22/14, 05/21/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP) and DES/DDD (DDD) Contractors. This Policy establishes AHCCCS' expectations for its AHCCCS Contractors and their subcontractors regarding the development, approval and distribution of Member Identification Cards (ID Cards). These expectations apply for ID Cards for AHCCCS members served by AHCCCS Direct Contractors or their subcontractors.

This Policy outlines the following requirements:

- Member ID Card Program,
- Responsibility for reviewing and approving the ID Card design in compliance with this Policy,
- Timeframes for card distribution to members,
- Oversight of distribution timeframes,
- Format of AHCCCS Member Identification Cards.

II. DEFINITIONS

834 ENROLLMENT TRANSACTION FILE	A nightly transaction file provided by AHCCCS to its Contractors. The file identifies newly-enrolled members and changes to existing members.
BEHAVIORAL HEALTH ENTITY	A Contractor or subcontractor to which the member is assigned for the provision of Behavioral Health services. Behavioral Health Entities are one of the following: • Acute Care Contractor for adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs except for members who elect a TRBHA for behavioral health services; • Regional Behavioral Health Authority (RBHA); • Integrated RBHA; • Tribal Regional Behavioral Health Authority (TRBHA); • Children's Rehabilitative Services (CRS) Fully Integrated; and • CRS Partially Integrated Behavioral Health.

BUSINESS DAY	For the purposes of this Policy and for those Responsible Contractors issuing ID Cards as a result of an 834 Transaction file, a business day is considered to extend from 7:00 am in the morning to 7:00 am the following morning. If the next day is a weekend or a holiday, then the ending timeframe is extended to 7:00 am in the morning of the day following the weekend or holiday.
CARD HOLDER	A printed sheet enclosing the Member Identification Card used during the mailing to the member.
CRS FULLY INTEGRATED MEMBERS	Members receiving all services from the CRS Contractor including acute health, behavioral health and CRS-related services.
CRS ONLY	Members receiving all CRS-related services from the CRS Contractor, and receiving acute health services from the primary program of enrollment and behavioral health services as defined under the CRS contract YH14-0002, Section D, paragraph 3. The primary program of enrollment will issue ID Cards for CRS Only members.
CRS PARTIALLY-INTEGRATED – ACUTE MEMBERS	American Indian members receiving all acute health and CRS-related services from the CRS Contractor and receiving behavioral health services from a Tribal RBHA.
CRS PARTIALLY-INTEGRATED – BEHAVIORAL HEALTH	CMDP or DDD members receiving all behavioral health and CRS-related services from the CRS Contractor and receiving acute health services from the primary program of enrollment.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides directly, or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.
INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)	An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.

MEMBER IDENTIFICATION CARD	A Contractor-specific identification card that meets the formatting requirements outlined in this Policy and issued by the Responsible Contractor to each member. The ID Card is used by the member when presenting for Medicaid services.
NOTICE OF PRIVACY PRACTICES (NPPS)	A Notice available on the AHCCCS website that describes: 1. The uses and disclosures of Protected Health Information (PHI); 2. Patient rights concerning PHI; and 3. The AHCCCS legal duties pertaining to PHI. The Health Insurance Portability and Accountability Act (HIPAA), requires covered entities, such as AHCCCS and its Contractors to provide this Notice upon an individual's enrollment in the plan, within 60 days of a material change to the Notice, and upon request by any person. In addition, every three years a health plan also must notify individuals who are covered by the plan that the Notice of Privacy Practices is available, including how to obtain the Notice.
RESPONSIBLE CONTRACTOR (ID CARD PRODUCTION)	The Contractor with which the member is enrolled for their physical health services. Where there is more than one AHCCCS Contractor providing services to a member, the Responsible Contractor is the AHCCCS Direct Contractor or Program Subcontractor responsible for providing for a member's physical health care needs.

III. POLICY

A. GENERAL

The Responsible Contractor must produce and distribute Member Identification Cards to all members assigned to them. Moreover, the Responsible Contractor must produce and distribute cards to newly-enrolled members, and have a process for producing and distributing replacement Member Identification Cards to all of the Contractors' enrolled members. The cards must meet the formatting, timeliness and prior approval guidelines outlined in this Policy and in Attachment A of this Policy.

B. RESPONSIBILITY FOR PRODUCING MEMBER IDENTIFICATION CARDS

When a member is served by more than one AHCCCS Contractor, the Responsible Contractor shall be the Contractor responsible for providing for the member's physical health services.

The Responsible Contractors include:

- Acute Care Contractors,
- ALTCS/EPD Contractors,

- CRS Contractors: For Fully Integrated and Partially-Integrated – Acute members only and CMDP,
- Integrated RBHAs: For members diagnosed with Serious Mental Illness (SMI),
- DDD Acute Care Subcontractors: DDD delegates responsibility for acute care services and the responsibility of producing ID Cards through subcontracts with its Program Subcontractors.

Attachment A of this Policy consists of a table identifying the responsibilities and formatting requirements for AHCCCS Direct Contractors and their Program Subcontractors.

C. PROGRAM REQUIREMENTS

Responsible Contractors must have in place processes to ensure all members receive appropriate Member Identification Cards in a timely manner. Please see Attachment A to identify which of the following minimum requirements apply to a Responsible Contractor:

1. Members requiring Identification Cards must be identified as a result of the 834 Transaction File and the ID Cards must be produced and mailed in a timely manner. The Responsible Contractor must mail ID Cards to new members within twelve business days starting from the business day following AHCCCS making the 834 Transaction File available to the Contractor. In addition, when a member requests a replacement ID Card, the card must be mailed within five business days of the request.

2. AHCCCS Direct Contractors must ensure the timeliness standards are met. The Contractors must monitor the timeliness standards in this Policy for the ID Cards it issues directly, and any issued by its Program Subcontractors.

3. If the Responsible Contractor replaces all ID Cards with a new version, members must receive their new ID Card at least two calendar weeks prior to the card going into effect. When a Contractor initiates services in a new GSA, or for new Contractors initiating services in the State, AHCCCS' contract transition process will determine the timelines for issuing ID Cards.

4. A Responsible Contractor serving members dually-enrolled in Medicare and AHCCCS programs may elect to issue a combined Medicare/AHCCCS ID Card. The format for the combined cards must meet the Centers for Medicare and Medicaid Services (CMS) requirements for ID Cards and be approved by AHCCCS. To obtain AHCCCS approval, the Contractor must meet the minimum formatting requirements identified in Attachment A as applying to ID Cards for members dually-enrolled. For the requirement of an ID Number, the Contractor may adopt additional formatting features included in this Policy or prescribed by CMS so long as they do not conflict with this policy's minimum requirements.

D. FORMAT OF ID CARDS

Member Identification Cards must meet the format standards outlined in this Policy. Not all formatting standards apply to every Responsible Contractor, see Attachment A. The following formatting standards may apply:

1. The front of the ID Card must contain the approved color or black and white version of the AHCCCS logo. It can be no smaller than 1" long by .333" inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The approved logo is available from AHCCCS.

2. The Responsible Contractor must not edit or alter the approved logo, except as noted above.

3. The front of the ID Card must include the following text in the Arial font no smaller than 11 points :

   Arizona Health Care Cost Containment System

   The inclusion of "Arizona Health Care Cost Containment System within the approved AHCCCS logo does not fulfill this requirement.

4. The front of the ID Card must also identify the member's name in the Arial font no smaller than 8 points.

5. The front of the ID Card must also include the member's AHCCCS ID number in Arial font no smaller than 8 points.

   For ID Cards issued to members enrolled with CMDP, the card may use wording and an identification number adopted by CMDP.

6. The front of the ID Card must include the Responsible Contractor's name in Arial font no smaller than 8 points.

7. The front of the ID Card must include the Responsible Contractor's telephone number in Arial font no smaller than 8 points.

8. The front of the ID Card must include a contact telephone number for accessing services from the Behavioral Health Entity in Arial font no smaller than 8 points. The ID Card must clearly identify this number as the contact for behavioral health services. If the Responsible Contractor is also the Behavioral Health Entity for the member and services are accessed through one number, a separate behavioral health services phone number is not required.

9. The back of the ID Card or the card holder must include the following text in the Arial font no smaller than 7 points:

   Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit <insert appropriate website address>.

10. The back of the ID Card, or the card holder or an insert included in the card's mailing to the member if a card holder is not used, must contain the following text font no smaller than Arial 7 points:

    To help protect your identity and prevent fraud, AHCCCS is adding pictures to its on-line verification tool that providers use to verify your coverage. If you have an Arizona driver's license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.

11. The ID Card or card holder may include additional information identified as appropriate, subject to the approval requirements of this Policy. Possible items could include plan logos, contact information for contracted hospitals, or after-hours clinics.

12. Any new ID card mailing must also include the most recent version of the AHCCCS NPP.

E. APPROVAL OF MEMBER IDENTIFICATION CARDS AND OTHER COMPLIANCE REQUIREMENTS

A Member Identification Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items must be submitted and obtain prior approval by the appropriate party as outlined in the program requirements section of Attachment A. If the Responsible Contractor issues more than one version of an ID Card to its members, an example of each version must be submitted for approval. For those ID Cards requiring AHCCCS approval, the documents must be submitted to the designated AHCCCS Operations and Compliance Officer for approval at least 30 days prior to dissemination, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

ADHS/DBS and DDD must approve ID Cards and other member information for their subcontractors who are Responsible Contractors.

Any third party subcontracted to produce or distribute Member Identification Cards qualifies as an Administrative Services Subcontract. Direct AHCCCS Contractors must obtain approval prior to implementation of the subcontract, and include the subcontractor

in the *Annual Subcontractor Assignment and Evaluation Report* as outlined in ACOM Policy 438.

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
- 9 A.A.C. 22, Article 1
- ACOM Policy 438
- Attachment A, Table of Requirements
- Contract, Section F, Attachment F3, Contractor Chart of Deliverables

ATTACHMENT A, TABLE OF REQUIREMENTS

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

434 - COORDINATION OF BENEFITS AND THIRD-PARTY LIABILITY

EFFECTIVE DATE: 10/01/13, 06/01/15

REVISION DATE: 07/22/13, 05/07/15, 06/17/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. Federal law 42U.S.C.1396a(a)(25)(A) requires Medicaid to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid members. The purpose of this Policy is to delineate Contactors' requirements for Coordination of Benefit (COB) activities and Third Party Liability (TPL) recoveries.

II. DEFINITIONS

ABSENT PARENT	An individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child, as defined by A.A.C. R9-22-1001.
COORDINATION OF BENEFITS (COB)	The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
COPAYMENT	A monetary amount that at the member pays directly to a provider at the time covered services are rendered, as defined in A.A.C. R9-22 Article 7.
COST AVOIDANCE	To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C. R9-22 Article 10.
FEE FOR SERVICE (FFS):	A method of payment to registered providers on an amount-per-service basis.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.

POST-PAYMENT RECOVERY	Subsequent to payment of a service by a Contractor, efforts by that Contractor, to retrieve payment from a liable third-party. Pay and Chase is one type of post-payment recovery.
PROVIDER	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provision A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.
THIRD-PARTY	An individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan [42 CFR 433.136].
THIRD PARTY LIABILITY	The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

III. POLICY

AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall take reasonable measures to identify potentially legally liable Third-Party sources.

The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et seq., so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable Third-Party. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the federal regulations referenced above.

AHCCCS is not the payor of last resort when the following entities are the Third-Party:

1. Indian Health Services (IHS/638), contract health,
2. Title IV-E,
3. Arizona Early Intervention Program (AZEIP),
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300,
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 U.S.C. 300ff et seq., and

6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G.

The two methods used for Coordination of Benefits are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et seq., federal and state law, and AHCCCS Policy. See ACOM Policy 201 for Contractor cost sharing responsibilities for members covered by both Medicare and Medicaid. See ACOM Policy 426 for additional information regarding Contractor responsibilities for payment of services for treatment of a CRS condition when a member uses private insurance or Medicare.

A. COST AVOIDANCE - CONTRACTOR RESPONSIBILITY

The Contractor shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. However, there are limited circumstances when cost avoidance is prohibited and the Contractor must apply post-payment recovery processes as described in Section: *Post-Payment Recovery – Pay and Chase* below.

NOTE: Claims for inpatient stay for labor, delivery and postpartum care including professional fees when there is no global OB package must be cost avoided.

For purposes of cost avoidance, establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities the Contractor shall be subject to sanctions.

When the Contractor cost avoids a claim the following payment provisions apply:

1. Claims from Providers **CONTRACTED** with a Contractor. Unless a subcontract with the provider specifies otherwise, the Contractor shall pay the lesser of Calculation A or Calculation B:

   Calculation A,
   The Primary Insurance Paid Amount minus the Primary Insurance rate (i.e. the member's copayment, coinsurance, and deductible required under the Primary Insurance)

   Calculation B,
   The Primary Insurance Paid amount minus the Contractor's Contracted Rate

2. Claims from Providers **NOT CONTRACTED** with a Contractor. The Contractor shall pay the lesser of Calculation A or Calculation B:

Calculation A,
The Primary Insurance Paid amount minus the Primary Insurance Rate (i.e., the member's copayment, coinsurance, and deductible required under the Primary Insurance)

Calculation B,
The Primary Insurance Paid Amount minus the AHCCCS Capped-Fee-For-Service Schedule

Examples:

SCENARIO 1	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $45 Primary Paid $30	
Contractor Payment to **Contracted Provider** in this example	**$15** This is calculated from the lesser of: ($45 - $30 = $15) vs. ($55 - $30 = $25)
Contractor Payment to **Non-Contracted Provider** in this example	**$15** This is calculated from the lesser of: ($45 - $30 = $15) vs. ($50 - $30 = $20)
SCENARIO 2	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $60 Primary Paid $40	
Contractor Payment to **Contracted Provider** in this example	**$15** This is calculated from lesser of: ($60 - $40 = $20) vs. ($55 - $40 = $15)
Contractor Payment to **Non-Contracted Provider** in this example	**$10** This is calculated from the lesser of: ($60 - $40 = $20) vs. ($50 - $40 = $10)
SCENARIO 3	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $70 Primary Paid $60	
Contractor Payment to **Contracted Provider** in this example	**$0** This is calculated from the lesser of: ($70 - $60 = $10) vs. ($55 - $60 = No Additional Payment)
Contractor Payment to **Non-Contracted Provider** in this example	**$0** This is calculated from the lesser of: ($70 - $60 = $10) vs. ($50 - $60 = No Additional Payment)

B. POST-PAYMENT RECOVERY - CONTRACTOR RESPONSIBILITY

If the probable existence of a third-party's liability cannot be established or if Post-Payment Recovery is required, the Contractor must adjudicate the claim and then utilize Post-Payment Recovery processes which include: *Pay and Chase*, *Retroactive Recoveries Involving Commercial Insurance Payor Sources*, and *Other Third-Party Liability Recoveries*.

1. Pay and Chase

   The Contractor shall pay the full amount of the claim according to the AHCCCS Capped-Fee-For-Service Schedule or the contracted rate **and then** seek reimbursement from any Third-Party if the claim is for the following:
   a. Prenatal care for pregnant women, including services which are part of a global OB Package
   b. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program; or
   c. Services covered by third-party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

2. Retroactive Recoveries Involving Commercial Insurance Payor Sources

   a. <u>Tagging</u>
      For a period of two years from the date of service, the Contractor shall engage in retroactive recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the Contractor must seek recovery from the commercial insurance. The Contractor is prohibited from recouping payments from providers or requiring the involvement of providers in any way, unless the provider was paid in full from both the Contractor and the commercial insurance.

      The Contractor has two years from the date of service to recover payments for a particular claim, or to identify (tag) claims having a reasonable expectation of recovery using a process to be developed by AHCCCS. A reasonable expectation of recovery is established when the Contractor has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment. If AHCCCS determines that a Contractor is tagging claims that do not meet these requirements, AHCCCS may impose sanctions. After two years from the date of service, AHCCCS will direct recovery efforts for any claims not tagged by the Contractor.

Although Contractors are responsible for recovery efforts for tagged claims irrespective of the two year time period, AHCCCS may, on a case by case basis, elect to direct recovery efforts for claims which are tagged by the Contractor. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the Contractor.

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

b. Encounter Adjustments - Flagging

Although all encounters related to the Contractor's retroactive recovery efforts outlined above must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the Contractor is prohibited from requesting adjustments from, or adjusting related payments to, providers.

Instead, the Contractor must submit an external replacement file (via an AHCCCS-approved vendor using a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project.

In order to submit an external replacement file, the Contractor must contact the AHCCCS Encounter Unit at the completion of the recovery project for a list of approved AHCCCS vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Encounters will not be adjusted when recoveries occur as a result of AHCCCS' efforts. AHCCCS will instead flag all encounters that are impacted by retroactive commercial insurance recoveries and will develop and maintain a database to store recovery payments.

Utilizing the data from the replacement file submitted by the Contractor, and the database used to store AHCCCS' recoveries, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments when appropriate.

3. Other Third-Party Liability Recoveries

The Contractor shall identify the existence of other potentially liable third parties through a variety of methods, including referrals and data mining related to the following:

- Motor vehicle cases
- Other casualty cases
- Tortfeasors
- Restitution recoveries

- Workers' compensation cases

Upon the identification of a potentially liable third-party via referrals or data mining as described below, the Contractor shall, within 10 business days, report the potentially liable third parties to AHCCCS' TPL Contractor for determination of a mass tort case, total plan case, or joint case. AHCCCS' TPL Contractor will refer total plan cases to the Contractor to be processed in accordance with AHCCCS, State, and Federal laws and policies. The Contractor shall report total plan case settlement information to AHCCCS, utilizing Attachment A, the AHCCCS-approved casualty recovery Total Plan Case Settlement Notification Form, within 10 business days from the settlement date or in a monthly file approved by the AHCCCS TPL Administrator and as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

a. Referrals
Third-party liability referrals may be received by the Contractor from a variety of sources including, attorneys, insurance companies, members, and providers.

b. Data Mining
The Contractor shall engage in data mining through the use of trauma code edits to identify claims which indicate specific ICD-9, or replacement codes under ICD-10, that are consistent with injuries that may be covered by liable third parties.

The ICD-9 diagnosis codes to be identified include:

- Codes for Injury and Poisoning: 800-999.9 (excluding 994.6); and
- External Causes of Injury and Poisoning codes: E000-E999.

A listing of ICD-10 trauma codes are identified in Attachment B, Trauma Code ICD-10 List.

C. CONTRACTOR DISCOVERY AND REPORTING OF A LIABLE THIRD-PARTY

1. Discovery and Reporting of a Liable Third-Party

If the Contractor discovers the probable existence of a liable Third-Party that is not known to AHCCCS, or identifies any change in coverage, the Contractor must report the information to the AHCCCS TPL Contractor within 10 days of discovery as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

2. Reporting Cost Avoidance and Recovery Activity

The Contractor must submit quarterly updates regarding cost avoidance/recovery activity as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables and the AHCCCS Program Integrity Reporting Guide.

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 201
- ACOM Policy 408
- ACOM Policy 426
- A.A.C. R9-22-1001
- A.A.C. R9-22, Article 7
- A.A.C. R9-22, Article 10
- A.R.S. §36-2901
- A.R.S. §36-2903
- A.R.S. §36-2923
- 42 CFR 400 Subpart G
- 42 CFR 433.135, et.seq
- 42 CFR 433.136
- Deficit Reduction Act of 2005 (Public Law 109-171)
- AHCCCS Program Integrity Reporting Guide
- Attachment A, Total Plan Case Settlement Notification Form
- Attachment B, Trauma Code ICD-10 List

ATTACHMENT A, TOTAL PLAN CASE SETTLEMENT NOTIFICATION FORM

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, TRAUMA CODE ICD-10 LIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

435 - TELEPHONE PERFORMANCE STANDARDS MEASUREMENT AND REPORTING

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

REVISION DATE: 06/06/13, 07/22/13, 12/19/13, 12/29/14

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This requirement applies to Acute Care, ADHS/BHS, CRS, and DCS/CMDP Contractors. This Policy establishes a Contractor reporting requirement and format regarding the Contractor's telephonic performance measures for member and provider telephone calls to the Contractor.

II. DEFINITIONS

AVERAGE SPEED OF ANSWER (ASOA)	The average on line wait time in seconds that the member/provider waits from the moment the call is connected in the Contractor's phone switch until the call is picked up by a Contractor's representative or Interactive Voice Recognition System (IVR).
DAILY FIRST CONTACT CALL RESOLUTION RATE (DFCCR)	The number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed, divided by the Total number of calls received in the 24-hour period.
MONTHLY AVERAGE ABANDONMENT RATE (MAAR)	This is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.
MONTHLY AVERAGE SERVICE LEVEL (MASL)	The total of the month's calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).
MONTHLY FIRST CONTACT CALL RESOLUTION RATE (MFCCR)	The sum of the DFCCRs divided by the number of days in the reporting period.

III. POLICY

A. GENERAL REQUIREMENT

The Contractor is required to meet the following Telephone Performance Standards for member and provider calls:

1. The ASOA must be 45 seconds or less

2. The MAAR must be five percent or less

3. The MFCCR must be 70 percent or better, and

4. The MASL must be 75 percent or better.

BHS shall develop and oversee a process, including receiving regular reports, to ensure that its subcontractors meet and maintain established telephone performance standards. All reported data is subject to AHCCCS validation.

B. QUARTERLY REPORTING

On the 15th of each month following the reporting quarter (or the first business day following the 15th if it appears on a weekend or State Holiday) Acute Care, CRS, and CMDP Contractors only must submit the quarterly Telephone Performance Measures Report to the Contractor's designated Operations and Compliance Officer in the Operations Unit of the Division of Health Care Management. The Report will cover the Contractor's performance during the previous quarter and an additional prior nine month period. For example on April 15th, the Contractor will report member and provider telephone performance for January through March and the prior nine months.

The Report will include Attachment A, Telephone Performance Measures Template, of this Policy to document the ASOA, MAAR, MFCCR, and MASL as described in this Policy. The Contractor must separately document performance for calls of the following types:

1. Member Calls

2. Provider Calls

In addition, the Contractor will document the number of days in a month one or more of the standards were not met by type of call. If a current month's number of days where the standard was not met was more than two standard deviations greater than the average of the previous nine months, the Contractor must provide an explanation of why the increase occurred, and summarize the steps it is taking to reduce the non-compliant calls.

The Contractor must also include in the Report, Attachment B, Centralized Telephone Line Down Time Template, of this Policy to report the down time for its centralized telephone lines, the dates of the occurrences, and the length of time they were out of service.

NOTE: The Contractor must complete separate templates for each month of the quarter.

IV. REFERENCES

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- CRS Contract, Section D
- DCS/CMDP, Contract, Section D
- Attachment A, Telephone Performance Measures Template
- Attachment B, Centralized Telephone Line Down Time Template

ATTACHMENT A, TELEPHONE PERFORMANCE MEASURES TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, CENTRALIZED TELEPHONE LINE DOWN TIME TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

436 – NETWORK STANDARDS

EFFECTIVE DATE: 10/01/13, 01/01/14, 10/01/15

REVISION DATE: 10/01/13, 12/19/13, 09/17/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. The Contractor shall develop and maintain a provider network that is sufficient to provide all covered services to AHCCCS members [42 CFR 438.206(b)(1)]. This Policy establishes Contractor network standards for Hospitals, Primary Care Providers (PCP), Dentists, Pharmacies, DD Group Homes, Nursing Facilities (NF), and Assisted Living Facilities (ALF), by county and GSA, and across all service areas for In Home Care Service standards. If established network standards cannot be met, it must be explained in the Network Development and Management Plan. See ACOM Policy 415.

II. DEFINITIONS

ADULT FOSTER CARE (AFC)HOME	An ALTCS approved ALF that provides room and board supervision and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members. For the purposes of this policy, an AFC is defined as a facility licensed to operate using the AHCCCS provider type 50 “Adult Foster Care”.
ASSISTED LIVING CENTER (ALC)	An ALF that provides resident rooms or residential units and services to 11 or more residents. For the purposes of this policy, an ALC is defined as a facility licensed to operate using the AHCCCS provider type 49 “Assisted Living Center”.
ASSISTED LIVING FACILITY (ALF)	Residential care facilities licensed by the Arizona Department of Health Services that are licensed to provide personal care or directed care services as defined in the 9 A.A.C.10 Article 8. ALFs are designed for ALTCS members who are physically or functionally unable to live in their own home, but do not need the care intensity of a nursing facility. Three types of ALFs are relevant to this policy, ALC, Assisted Living Homes and AFC Homes.

ASSISTED LIVING HOME (ALH)	An ALF that provides resident rooms and services to ten or fewer residents. For the purposes of this policy, an ALH is defined as a facility licensed to operate using the AHCCCS provider type 36 "Assisted Living Home".
DENTIST	A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. §32-11-2 and 3. For the purposes of compliance with this policy, Dentists are further identified as providers in the Contractor's network and licensed using the AHCCCS provider type 07.
DISTRICT	A Service District is a section of Maricopa or Pima County defined by zip code for purposes of establishing and measuring minimum network standards for Hospitals, DD Group Homes, Nursing Facilities and Assisted Living Facilities. See "GSA, County and District Definitions" below.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1. See "GSA, County and District Definitions" below.
GROUP HOME FOR PERSONS WITH DEVELOPMENTAL DISABILITIES	A residential setting for not more than six persons with developmental disabilities, regulated by the Arizona Department of Economic Security and operating under Arizona Revised Statutes Title 36, Chapter 5.1, Articles 2 and 3. For the purposes of this policy, a DD Group Home is defined as a facility licensed to operate using the AHCCCS provider type 25 "Group Home (Developmentally Disabled)".
HOSPITAL	For the purposes of this Policy, a hospital is a defined as a facility licensed to operate using the AHCCCS provider type 02 "Hospital". For Maricopa and Pima Counties, a Contractor must hold a contract with specific hospitals identified in this policy for the purpose of establishing minimum network standards. To meet this policy's requirements for hospitals outside of Maricopa and Pima Counties, a Contractor may obtain contracts with a hospital or with physicians with admission and treatment privileges (including hospitalists).

IN HOME CARE SERVICES	For the purposes of this Policy, In Home Care Services are defined as Home and Community Based "Critical Services" under ACOM Policy 413. These are Attendant Care, Personal Care, Homemaking, and Respite Care.
INTEGRATED REGIONAL BEHAVIORAL HEALTH AUTHORITY (INTEGRATED RBHA)	An organization that provides behavioral health services to AHCCCS members who are Title XIX or Title XXI eligible, other than adult members dually enrolled in Medicaid and Medicare with General Mental Health and Substance Abuse needs and American Indians who choose a TRBHA. The Integrated RBHA also provides physical health services for AHCCCS members determined to have a Serious Mental Illness, with the exception of American Indians who choose AIHP.
NURSING FACILITY (NF)	For the purposes of this Policy, a Nursing Facility is a health care institution licensed to operate using the AHCCCS provider type 22 "Nursing Home".
PHARMACY	A facility regulated by the State Board of Pharmacy and operating under A.R.S. §32-18-2 and 3. For the purposes of compliance with this policy, a Pharmacy is a provider in the Contractor's network licensed using the AHCCCS provider type 03 "Pharmacy".
PROVIDER AFFILIATION TRANSMISSION (PAT) FILE	A data file submitted quarterly by the Contractor using the format established in the AHCCCS Provider Affiliation Transmission User Manual found at: http://www.azahcccs.gov/commercial/Downloads/OperationsReporting/PATManual.pdf. The PAT File is used to measure each Contractor's network for compliance with this policy using the provider's location. As a result, Contractors must follow the PAT file guidelines and report the physical address and zip code where its providers perform the services measured under this Policy.

PRIMARY CARE PHYSICIAN A healthcare practitioner responsible for the management of a member's health care. For the purposes of compliance with this Policy, a PCP is considered to consist of the following provider types:

1. Provider type 08 "Physician" and 31 "Osteopath", with the specialty codes:
   a. 050-Family Practice,
   b. 055-General Practice,
   c. 060-Internal Medicine,
   d. 089-Obsterician and Gynecologist,
   e. 091-Obstetrician or
   f. 150-Pediatrician.
2. Provider type 19 "Registered Nurse Practitioner" with the specialty codes:
   a. 095-Women's HC/OB-GYN NP,
   b. 084-RN Family Nurse Practitioner or
   c. 87-RN Pediatric Nurse Practitioner.
3. Provider type, 18 "Physician Assistant" with the specialty code:
   a. 798 – Physician's Assistant.

GSA, COUNTY AND DISTRICT DEFINITIONS

1. AHCCCS has adopted definitions for GSAs and assigned the following numerical definitions under its Acute Care, ALTCS/EPD, ALTCS/DDD, and CRS programs:

The split zip codes assignments are as follows:

COUNTY	GSA (ACUTE CARE, CMDP AND CRS)	GSA (ALTCS/EPD AND DDD)
APACHE, COCONINO, MOHAVE, NAVAJO	04	44
COCHISE, GRAHAM, GREENLEE	14	46
GILA, PINAL	08	40
LA PAZ, YUMA	02	42
MARICOPA	12	52
PIMA, SANTA CRUZ	10	50
YAVAPAI	06	48

2. Split zip codes occur in some counties. Split zip codes are those which straddle two different counties. Enrollment for members residing in these zip codes is based upon the county and GSA to which the entire zip code has been assigned by AHCCCS. The Contractor shall be responsible for ensuring that all members residing in the zip code that is assigned to the county in which it is contracted to provide services are fully able to access care.

ZIP CODE	SPLIT BETWEEN THESE COUNTIES	COUNTY ASSIGNED TO
85140	Pinal and Maricopa	Maricopa
85120	Pinal and Maricopa	Maricopa
85142	Pinal and Maricopa	Maricopa
85192	Gila and Pinal	*Graham
85342	Yavapai and Maricopa	Maricopa
85390	Yavapai and Maricopa	Maricopa
85643	Graham and Cochise	Cochise
85645	Pima and Santa Cruz	Santa Cruz
85943	Apache and Navajo	Navajo
86336	Coconino and Yavapai	Yavapai
86351	Coconino and Yavapai	Coconino
86434	Mohave and Yavapai	Mohave
86340	Coconino and Yavapai	Yavapai
85143	Pinal and Maricopa	Maricopa

*County was reassigned 10/1/15- see county re-assignment as shown in the table below

The following zip codes have been re-assigned outside of their originally assigned counties:

ZIP CODE	ORIGINAL COUNTY ASSIGNED	COUNTY RE-ASSIGNMENT 10/1/15
85192	Gila and Pinal	Graham
85542	Gila	Graham
85550	Gila	Graham

3. For purposes of this Policy, Maricopa and Pima Counties are further subdivided into districts. Below is the definition of these districts:

a. <u>Maricopa County</u>

MARICOPA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Phoenix	85022, 85023, 85024, 85027, 85029, 85032, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331
DISTRICT 2	Carefree, Cave Creek, Fountain Hills, Scottsdale	85250, 85251, 85255, 85256, 85257, 85258, 85259, 85260, 85262, 85263, 85264, 85268

MARICOPA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 3	Phoenix	85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, 85051, 85253
DISTRICT 4	Phoenix	85003, 85004, 85006, 85007, 85008, 85009, 85025, 85034, 85040, 85041, 85042, 85044, 85045, 85048
DISTRICT 5	Buckeye, Goodyear, Phoenix, Tolleson and Gila Bend	85031, 85033, 85035, 85037, 85043, 85322, 85323, 85326, 85338, 85339, 85353, 85337
DISTRICT 6	Glendale	85301, 85302, 85303, 85304, 85305, 85306, 85308, 85310
DISTRICT 7	El Mirage, Peoria, Sun City, Sun City West, Surprise and Wickenburg	85275, 85307, 85309, 85335, 85340, 85342, 85345, 85351, 85355, 85361, 85363, 85373, 85374, 85375, 85379, 85381, 85382, 85383, 85387, 85388, 85390, 85395, 85396
DISTRICT 8	Mesa, Tempe	85120, 85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282
DISTRICT 9	Chandler, Tempe, Gilbert, Queen Creek, Sun Lakes	85140, 85142, 85143, 85222, 85224, 85225, 85226, 85233, 85234, 85242, 85243, 85248, 85249, 85283, 85284, 85296 85297

b. <u>Pima County</u>

PIMA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 1	Northwest	85321, 85653, 85658, 85701, 85704, 85705, 85737, 85739, 85741, 85742, 85743, 85745, 85755

PIMA DISTRICT	DESCRIPTION	ZIP CODES
DISTRICT 2	Northeast	85619, 85702, 85712, 85715, 85716, 85718, 85719, 85749, 85750
DISTRICT 3	Southwest	85601, 85614, 85622, 85629, 85713, 85714, 85723, 85724, 85735, 85736, 85746, 85757
DISTRICT 4	Southeast	85641, 85706, 85708, 85710, 85711, 85730, 85747, 85748

III. POLICY

A. MARICOPA AND PIMA COUNTY NETWORK REQUIREMENTS

1. PCP and Pharmacy Services

   In Maricopa and Pima counties, Acute Care, CMDP, ALTCS/EPD, and CRS Contractors, and Contractors who provide acute care services overseen by DES/DDD and ADHS/DBHS must have a network that is able to provide PCP and pharmacy services so that 90% of members do not need to travel more than 15 minutes or 10 miles from their residence, unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). If outpatient specialty services (OB, family planning, and pediatrics) are not included in the primary care provider contract, at least one subcontract is required for each of these specialties within the established time and distance standard.

2. Dental Services

   Acute Care, CMDP, and CRS Contractors, and Contractors who provide acute care services overseen by DES/DDD and ADHS/DBHS must have a network that provides dental services so that 90% of members do not need to travel more than 15 minutes or 10 miles from their residence.

3. Minimum Hospital Standards

   In Maricopa and Pima counties, Acute Care, CMDP, ALTCS/EPD, and CRS Contractors, and Contractors who provide acute care services overseen by DES/DDD and ADHS/DBHS must have contracts with a sufficient number of the specified hospitals in the district groupings outlined below. The requirements identified below are a minimum; the Contractor may supplement these facilities with other hospitals from those listed in the table, or additional hospitals available in these counties.

a. Maricopa County Hospital Requirements

MARICOPA DISTRICT	POSSIBLE HOSPITALS	HOSPITAL ZIP CODE	MINIMUM NUMBER OF CONTRACTS REQUIRED
DISTRICT 1	John C. Lincoln Hospital Deer Valley Hospital	85027	**1 in District 1 or 2**
	Paradise Valley Hospital	85032	
	Mayo Clinic Hospital	85054	
DISTRICT 2	Scottsdale Healthcare – Osborn	85251	
	Scottsdale Healthcare – Thompson Peak	85255	
	Scottsdale Healthcare – Shea	85260	
DISTRICT 3	St. Joseph's Hospital and Medical Center	85013	**1 in District 3 or 4**
	Phoenix Baptist Hospital	85015	
	John C. Lincoln Hospital – North Mountain Hospital	85020	
DISTRICT 4	Banner Good Samaritan Medical Center	85006	
	Maricopa Medical Center	85008	
	St. Luke's Medical Center	85006	
MARICOPA DISTRICT	**POSSIBLE HOSPITALS**	**HOSPITAL ZIP CODE**	**MINIMUM NUMBER OF CONTRACTS REQUIRED**
DISTRICT 5	Maryvale Hospital	85031	**1 in District 5, 6 or 7**
	Banner Estrella Medical Center	85037	
DISTRICT 6	Banner Thunderbird Medical Center	85306	
	Arrowhead Hospital	85308	
DISTRICT 7	Banner Boswell Medical Center	85351	
	Banner Del E. Webb Medical Center	85375	
	West Valley Hospital	85395	

MARICOPA DISTRICT	POSSIBLE HOSPITALS	HOSPITAL ZIP CODE	MINIMUM NUMBER OF CONTRACTS REQUIRED
DISTRICT 8	Arizona Regional Medical Center – Apache Junction	85201	1 in District 8 or 9
	Banner Desert Medical Center	85202	
	Banner Baywood Medical Center	85206	
	Mountain Vista Medical Center	85209	
	Tempe St. Luke's Hospital	85281	
DISTRICT 9	Chandler Regional Medical Center	85224	
	Banner Ironwood Medical Center	85140	
	Banner Gateway Medical Center	85234	
	Mercy Gilbert Medical Center	85297	

b. <u>Pima County Hospital Requirements</u>

PIMA DISTRICT	POSSIBLE HOSPITALS	HOSPITAL ZIP CODE	MINIMUM NUMBER OF CONTRACTS REQUIRED
DISTRICT 1	Northwest Medical Center	85741	1 in District 1 or 2
	Carondelet St. Mary's Hospital	85745	
	Oro Valley Hospital	85755	
DISTRICT 2	University of Arizona Medical Center - University Campus	85724	
	Tucson Medical Center	85712	
DISTRICT 3	University of Arizona Medical Center - South Campus	85713	1 in District 3 or 4
DISTRICT 4	Carondelet St. Joseph's Hospital	85711	

4. Minimum DD Group Home, Nursing Facility, Assisted Living Center and Assisted Living Home/Adult Foster Care Home Standards

   In Maricopa and Pima counties, the ALTCS/DDD Contractor must have contracts with a sufficient number of DD Group Homes, and ALTCS/EPD and ALTCS/DDD Contractors must have contracts with a minimum number of Nursing Facilities, ALCs and a combination of ALH or AFC providers in each district as identified in the tables below.

   a. <u>Maricopa County DD Group Home, Nursing Facility, Assisted Living Center and Assisted Living Home/Adult Foster Care Home Requirements</u>

MARICOPA DISTRICT	DD GROUP HOMES	NF		ALC		ALH/AFC	
REQUIREMENT APPLIES TO:	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*
DISTRICT 1	95	4	0	4	0	30	0
DISTRICT 2	7	6	0	2	0	5	0
DISTRICT 3	50	8	0	6	0	17	0
DISTRICT 4	22	5	0	2	0	7	0
DISTRICT 5	21	2	0	0	0	13	0
DISTRICT 6	104	3	0	4	0	25	0
DISTRICT 7	32	8	0	10	0	21	0
DISTRICT 8	61	8	0	10	0	26	0
DISTRICT 9	63	4	0	4	0	21	0
WITHIN ARIZONA, BUT SERVING THE COUNTY	0	0	1	0	1	0	1

b. Pima County DD Group Home, Nursing Facility, Assisted Living Center and Assisted Living Home/Adult Foster Care Home Requirements

PIMA DISTRICT	DD GROUP HOMES	NF		ALC		ALH/AFC	
REQUIREMENT APPLIES TO:	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*	*ALTCS / EPD*	*ALTCS / DDD*
DISTRICT 1	11	3	0	1	0	20	0
DISTRICT 2	50	8	0	2	0	12	0
DISTRICT 3	9	2	0	1	0	9	0
DISTRICT 4	87	1	0	2	0	35	0
WITHIN ARIZONA, BUT SERVING THE COUNTY	0	0	1	0	1	0	1

B. STANDARDS FOR ALL OTHER GSA/COUNTIES

Contractors serving the GSAs and counties outside of Maricopa and Pima Counties must document a sufficient network to meet the medical service needs of its members based upon the following tables. The tables detail the minimum network standards in each GSA for each type of AHCCCS Contractor. The Tables are organized by GSA, by provider type, and line of business. Network requirements include minimum contracts within a specific city or group of cities, contracts within specified distances to specific cities, or minimum contracts within a county. In certain instances, locations outside of the GSA's boundary have been identified. This is to allow members to access services in the most geographically convenient location possible and to prevent members from traveling much greater distances to obtain care, but at the same time accommodate network availability in each county.

In addition, outside of Maricopa and Pima Counties, Contractors may meet the minimum network standards for hospitals by obtaining contracts with hospitals or physicians with admission and treatment privileges, including the use of hospitalists. If using one or more physician or hospitalist to meet these standards, the Contractor must identify each provider as outlined in Attachment A, Minimum Network Requirements Verification Template.

For example, for Contractors serving La Paz and Yuma Counties, an Acute Care or ALTCS/EPD Contractor, ADHS/DBHS's Integrated RBHA, the CRS Contractor and DES/DDD's Acute Care Subcontractors will need contracts with a minimum of one Hospital, PCP, Dentist and Pharmacy in Parker, Arizona. Additionally, the ALTCS/EPD Contractors will need a contract with at least one ALC, ALH or AFC within a 1 hour drive of Parker. ALTCS/DDD will also need at least one contract with a DD Group Home within La Paz County, and a contract with a Nursing Facility, and an ALC, ALH or AFC within Arizona to serve members in La Paz County.

[See Tables Below]

1. **La Paz and Yuma Counties**

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Blythe, CA	1	1	1	1	0	0	0	0	0
Lake Havasu City	1	1	1	1	0	0	0	0	0
Parker	1	1	1	1	0	0	0	1 within 1 hr.	0
Yuma City	1	1	1	1	0	4	0	0	0
San Luis	0	1	1	1	0	0	0	0	0
Somerton	0	1	0	1	0	0	0	0	0
Quartzite	0	0	0	0	0	1 within 1 hr.	0	0	0
Wellton	0	1	0	0	0	0	0	0	0
Within La Paz County	0	0	0	0	1	0	0	0	0
Within Yuma County	0	0	0	0	20	0	0	11	0
Within Arizona, but serving these counties	0	0	0	0	0	0	1	0	1

2. **Apache, Coconino, Mohave and Navajo Counties**

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ /DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Bullhead City	1	1	1	1	0	1	0	0	0
Flagstaff	1	1	1	1	0	2	0	0	0
Gallup, NM	1	1	1	1	0	0	0	0	0
Kanab, UT	1	0	0	0	0	0	0	0	0
Kingman	1	1	1	1	0	2	0	0	0
Lake Havasu City	1	1	1	1	0	2	0	0	0
Needles, CA	1	0	0	0	0	0	0	0	0
Page	1	1	1	1	0	0	0	1	0
Payson	1	1	1	1	0	0	0	0	0
Show Low	1	0	0	0	0	0	0	0	0
Show Low, Pinetop ***or*** Lakeside	0	1	1	1	0	1	0	0	0

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Springerville	1	0	0	0	0	0	0	0	0
Springerville ***or*** Eager	0	1	1	1	0	0	0	0	0
St. George, UT	1	0	0	0	0	0	0	0	0
St. George, UT ***or*** Mesquite, NV	0	1	1	1	0	0	0	0	0
Winslow	1	1	1	1	0	1	0	0	0
Colorado City, Hilldale ***or*** Kanab, UT	0	1	1	1	0	0	0	0	0
Fort Mohave	0	1	0	1	0	0	0	0	0
Holbrook	0	1	1	1	0	0	0	0	0
Snowflake ***or*** Taylor	0	1	1	1	0	0	0	0	0
Sedona	0	1	1	1	0	1	0	0	0
St. Johns	0	1	1	1	0	1 within 1.5 hrs	0	0	0
Williams	0	1	1	1	0	0	0	0	0

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Vernon	0	0	0	0	0	0	0	1	0
Within Apache County	0	0	0	0	28	0	0	0	0
Within Coconino County	0	0	0	0	47	0	0	5*	0
Within Mohave County	0	0	0	0	16	0	0	28	0
Within Navajo County	0	0	0	0	22	0	0	5	0
Within Arizona, but serving these counties	0	0	0	0	0	0	1	0	1

* The Contractor must be contracted with 5 additional ALH, ALC or AFCs beyond those required for specific cities in this County.

3. Yavapai County

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Cottonwood	1	1	1	1	0	1	0	0	0
Flagstaff	1	0	0	0	0	0	0	0	0
Prescott	1	1	1	1	0	3	0	0	0
Prescott Valley	0	1	1	1	0	1	0	0	0
Ash Fork ***or*** Seligman	0	1	1	0	0	0	0	0	0
Camp Verde	0	1	1	1	0	1	0	0	0
Sedona	0	1	1	1	0	1	0	0	0
Within Yavapai County	0	0	0	0	50	0	0	25	0
Within Maricopa County ***or*** Wickenburg	1	1	1	1	0	0	0	0	0
Within Arizona, but serving the county	0	0	0	0	0	0	1	0	1

4. Gila and Pinal Counties

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/ AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Casa Grande	1	1	1	1	0	1 plus 2 additional facilities within 1 hour of Casa Grande	0	0	0
Globe	1	0	0	0	0	0	0	0	0
Globe, Miami ***or*** Claypool	0	1	1	1	0	2	0	1	0
San Tan Valley	1	0	0	0	0	0	0	0	0
Payson	1	1	1	1	0	2	0	1	0
Apache Junction	0	1	1	1	0	0	0	0	0
Coolidge ***or*** Florence	0	1	1	1	0	0	0	0	0
Eloy	0	1	1	0	0	0	0	0	0
Kearney	0	1	1	1	0	0	0	0	0

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC /AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Mammoth, San Manuel ***or*** Oracle	0	1	1	1	0	0	0	0	0
Mesa, Gilbert ***or*** Queen Creek	0	1	1	1	0	0	0	0	0
Florence	0	0	0	0	0	3 facilities within 1 hour of Florence	0	0	0
Oracle	0	0	0	0	0	3 facilities within 1 hour of Oracle	0	0	0
Within Gila County	0	0	0	0	14	0	0	1*	0
Within Pinal County	0	0	0	0	41	0	0	17	0
Within Arizona, but serving these counties	0	0	0	0	0	0	1	0	1

* The Contractor must be contracted with one additional ALH, ALC or AFC beyond those required for specific cities in this County.

5. **Pima and Santa Cruz Counties**

See above for the requirements for Pima County.

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC /AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Nogales	1	1	1	1	0	1	0	0	0
Within Santa Cruz County	0	0	0	0	5	0	0	3	0
Within Arizona, but serving these counties	0	0	0	0	0	0	1	0	1

6. **Cochise, Graham and Greenlee Counties**

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Benson	1	1	0	1	0	1	0	0	0
Benson ***or*** Wilcox	0	0	1	0	0	0	0	0	0
Bisbee	1	1	1	1	0	0	0	0	0
Douglas	1	1	1	1	0	1	0	0	0
Safford	1	1	1	0	0	1	0	0	0
Safford ***or*** Thatcher	0	0	0	1	0	1	0	0	0
Sierra Vista	1	1	1	1	0	2	0	0	0
Tucson	1	0	0	0	0	0	0	0	0
Wilcox	1	1	0	1	0	1	0	0	0
Morenci ***or*** Clifton	0	1	1	1	0	0	0	0	0
Morenci	0	0	0	0	0	1 within 1.5 hours of Morenci	0	1 within 1.5 hours of Morenci	0

MINIMUM NETWORK REQUIREMENT	HOSPITAL	PCPS	DENTIST	PHARMACY	DD GROUP HOMES	NF		ALH/ALC/AFC	
REQUIREMENT APPLIES TO:	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ACUTE, ALTCS/EPD, INTEGRATED RBHA, CRS, DDD ACUTE SUBCONTRACTORS*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*	*ALTCS/ EPD*	*ALTCS/ DDD*
Within Cochise County	0	0	0	0	22	0	0	1	0
Within Graham County	0	0	0	0	5	0	0	3	0
Within Arizona, but serving these counties	0	0	0	0	0	0	1	0	1

C. STATEWIDE IN HOME CARE NETWORK STANDARDS

ALTCS/EPD and ALTCS/DDD Contractors must also comply with network standards for the following critical in home care services, Attendant Care, Personal Care, Homemaking, and Respite Care. All Contractors must ensure that the total gap hours represent no more than 0.05% of critical services scheduled in a given month as reported in its monthly Gap in Services Log. See ACOM Policy 413, Attachment A for details of this process.

D. NETWORK OVERSIGHT REQUIREMENTS

The Acute Care, CMDP, ALTCS/EPD, ALTCS/DDD and the CRS Contractors will take steps to ensure these networks standards are maintained. If established network standards cannot be met, the Contractor must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; Periodic Network Reporting Requirements as required by ACOM Policy 415.

DES/DDD, for its acute care subcontractors and ADHS/DBHS, for its Integrated RBHA are similarly expected to review their subcontractors for compliance with this Policy. DES/DDD and ADHS/DBHS must report to AHCCCS their subcontractors' gaps and short and long-term interventions and address them in their annual Network Development and Management Plans.

Additionally, Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, and DES/DDD Contractors must conduct an analysis of their compliance with the applicable standards each quarter using their Provider Affiliation Transmission (PAT) and the Gap in Services Log; this must be submitted at the same time as the PAT submission each quarter on October 15, January 15, April 15 and July 15. The analysis shall be reported using the Attachment A, Minimum Network Requirements Verification Template. DES/DDD must report its compliance with the standards identified as applying to its ALTCS/DDD provider network, and additionally provide separate attachments for each of its subcontracted health plans that provide acute care services measured under these standards.

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
- ACOM 413
- ACOM 415
- Provider Affiliation Transmission User Manual
- Attachment A, Minimum Network Requirements Verification Template

ATTACHMENT A, MINIMUM NETWORK REQUIREMENTS VERIFICATION TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

437 – FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT-ORDERED EVALUATION

EFFECTIVE DATE: 05/01/13, 10/01/15

REVISION DATE: 08/29/13, 01/16/14, 05/14/15, 08/01/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS and DES/DDD Contractors. The purpose of this Policy is to provide clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation.

II. DEFINITIONS

COURT-ORDERED EVALUATION	The proceedings and related services described in A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4).
COURT-ORDERED TREATMENT	The proceedings and related services described in A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5).
MEDICALLY NECESSARY BEHAVIORAL HEALTH SERVICES	Those behavioral health services necessary, in the judgment of a qualified medical practitioner, to treat an existing behavioral health condition or illness and/or to prevent the patient from potentially harming himself or others.
PREPETITION SCREENING	The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services pursuant to A.R.S. §36-501.33.

III. POLICY

Contractors subject to this Policy are responsible for providing medically necessary, covered behavioral health services to enrollees including services provided pursuant to court order under A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5).

As a matter of State law (A.R.S. §36-545.04), the cost of services provided as part of a legal proceeding under A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4) (Court-Ordered Evaluation) is the financial responsibility of the county in which the individual resided or was found.

However, the county's liability for the cost of screening and evaluation services (and any treatment services provided during screening and evaluation) ends when a petition for court ordered treatment is filed with the court, when an individual decides to seek treatment on a voluntary basis, the statutory 72 hour timeframe expires pursuant to A.R.S. §36-530 or when the individual is released from an inpatient setting, whichever occurs first.

The Contractor is responsible for payment for medically necessary, covered behavioral health services when a member decides to seek treatment on a voluntary basis, when the statutory 72 hour timeframe expires or when the member is released from an inpatient setting (unless there is some source of payment other than the county such as private insurance or Medicare). This includes inpatient and other covered services provided pending a hearing on court-ordered treatment.

The Contractor must accept and process timely claim submissions for medically necessary services for all TXIX enrolled members receiving Court Ordered Evaluation (COE) services in an inpatient setting for time periods that are not the county responsibility. This includes claims with dates of service prior to the effective date of this Policy that meet timeliness of claims submission and payment as outlined in contract and ACOM Policy 203.

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
- A.R.S. §36-501.33
- A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4)
- A.R.S. §36-530
- A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5)
- A.R.S. §36-545.04
- ACOM Policy 203

438 – ADMINISTRATIVE SERVICES SUBCONTRACTOR EVALUATION

EFFECTIVE DATE: 10/01/14, 06/01/15

REVISION DATE: 05/07/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes guidelines and requirements for Contractors entering into Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying AHCCCS of subcontractor non-compliance and corrective action plans.

II. DEFINITIONS

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 Health Authorities and the Integrated Regional Behavioral Health Authority.

Providers are not Administrative Services Subcontractors.

CHANGE IN ORGANIZATIONAL STRUCTURE

Any of the following:

- Merger
- Acquisition
- Reorganization
- Change in Articles of Incorporation
- Joint Venture
- Change in Ownership
- State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature
- Change of MSA Subcontractor (to the extent management of all or substantially all plan functions has been delegated

CHANGE IN ORGANIZATIONAL STRUCTURE **CONTINUED**	• To meet AHCCCS contractual requirements).
	• Other applicable changes which may cause:
	  o A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)
	  o Changes in critical member information, including the website, member or provider handbook and member ID card
	  o A change in legal entity name

MANAGEMENT SERVICE AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
PROVIDER	Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

III. POLICY

A. APPROVAL OF SUBCONTRACTS

All Administrative Services Subcontracts shall be submitted to the AHCCCS Division of Health Care Management for prior approval as noted below and as specified in Attachment F3, Contractor Chart of Deliverables. Additionally, ADHS/DBHS and DDD shall adhere to requirements outlined in numbers 6 and 7 below.

1. A copy of the proposed subcontract agreement must be submitted with Attachment A, Administrative Services Subcontract Checklist, of this Policy.

2. The Contractor must retain the authority to direct and prioritize any delegated contract requirements.

3. The Contractor must require that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS (e.g. Telephone Performance Standards as outlined in ACOM Policy 435).

4. The CRS Contractor must ensure the integration of acute care, behavioral health, and specialty services within the key functional areas identified in Section D of the AHCCCS Medicaid Contract.

5. A Change in Organizational Structure of an Administrative Services Subcontractor requires prior approval of AHCCCS. The Contractor is to follow the process for the review and approval of new subcontracts as defined in this Policy. Additionally, if

the Change in Organizational Structure is related to the Contractor's Management Service Agreement (MSA), to the extent management of all or substantially all plan functions has been delegated to meet AHCCCS contractual requirements, the Contractor must submit the proposed change for prior approval as further outlined in ACOM Policy 317.

6. ADHS/DBHS shall:
   a. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the Public including any RFP amendments.
   b. Submit final, signed copies of each contract which it enters into with subcontractors and Tribal subcontractors and any subsequent amendments within 30 days of signature date.
   c. Ensure its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes.
   d. Ensure subcontractors have a process to accept and manage provider inquiries, complaints, and requests for information that are received outside the claim dispute process.

7. DDD shall:
   a. Upon request, submit copies of RFPs at the time they are formally issued to the Public including any RFP amendments.
   b. Submit final, signed copies of each contract which it enters into with subcontractors and any subsequent amendments within 30 days of signature date.
   c. Ensure its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes.

B. SUBCONTRACTOR MONITORING AND REPORTING

The Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject the subcontractor to a formal review at least annually (42 CFR 438.230). If at any time during the period of the Administrative Service Subcontract, the subcontractor is found to be in non-compliance, the Contractor shall notify AHCCCS within 30 days of the discovery as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

1. The notification shall include the following:
   a. Subcontractor's name,
   b. Delegated duties and responsibilities,
   c. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern,
   d. The scope and estimated impact of the change upon members,
   e. The length of time that the subcontractor has been in non-compliance,
   f. The Contractor's Corrective Action Plan (CAP) that will be implemented to bring the Administrative Services Subcontractor into compliance,
   g. Sanction actions that may be taken because of the non-compliance.

2. AHCCCS reserves the right to request follow-up on any open CAPs.

3. The results of a CAP shall be communicated to AHCCCS upon closure of the CAP.

4. ADHS/DBHS or an independent external agent shall conduct an Operational Review of each T/RBHA subcontractor according to Section D of the AHCCCS Medicaid Contract.

C. ADMINISTRATIVE SERVICES SUBCONTRACTOR EVALUATION REPORT

The Contractor must submit the completed annual Administrative Services Subcontractor Evaluation Report (Attachment B, Administrative Services Subcontractor Evaluation Report Template), within 90 days of the start of the contract year as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

The Administrative Services Subcontractor Evaluation Report shall include the following.

1. Subcontractor's name,

2. Delegated duties and responsibilities,

3. Most recent formal review date of the duties, responsibilities and financial position of the subcontractor,

4. A comprehensive summary of the evaluation of the performance (operational and financial) of the subcontractor, including the type of audit performed. The full report shall be made available upon request from AHCCCS.

5. Next scheduled formal review date.

6. All identified areas of deficiency; including, but not limited to:
   a. Those which affect member services; and/or
   b. Those which cause a quality of care concern.

7. CAP Information:
   a. Any Corrective action plans that occurred since the last Administrative Services Subcontractor Evaluation Report;
   b. CAPs resulting from the annual formal review; and
   c. Date reported to AHCCCS.

8. Current status of CAPs.

D. ADDITIONAL REQUIREMENTS

1. All Administrative Services Subcontracts must reference and require compliance with the AHCCCS Minimum Subcontract Provisions available on the AHCCCS website at the following link: Minimum Subcontract Provisions.

2. In the event of a modification to the AHCCCS Minimum Subcontract Provisions the Contractor shall issue a notification and amend Administrative Services Subcontracts as specified in Contract and ACOM Policy 416.

3. All Administrative Services Subcontracts must reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in contract and 42 CFR 455.101 through 106, 42 CFR 436 and SMDL09-001. Administrative Services Subcontractors shall disclose to AHCCCS-OIG the identity of any excluded person.

4. All Administrative Services Subcontracts entered into by the Contractor are subject to review and approval by AHCCCS.

5. All Administrative Services Subcontracts for services rendered to Medicaid recipients shall incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.

6. The Contractor shall maintain a fully executed original or electronic copy of all Administrative Services Subcontracts, which shall be accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.

7. The Contractor shall ensure that all member communications furnished by the Administrative Services Subcontractor include the Contractor's name.

8. Before entering into an Administrative Services Subcontract the Contractor must evaluate the prospective Administrative Services Subcontractor's ability to perform the delegated duties.

9. In the event the Contractor terminates a subcontract, the Contractor must ensure compliance with all aspects of the AHCCCS Medicaid Contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

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
- Attachment A, Administrative Services Subcontract Checklist
- Attachment B, Administrative Services Subcontractor Evaluation Report Template
- AHCCCS Minimum Subcontract Provisions
- A.R.S. §36-2901
- 42 CFR 438.230
- 42 CFR 455.101 through 106
- 42 CFR 436
- SMDL09-001
- ACOM Policy 317
- ACOM Policy 416
- ACOM Policy 435

ATTACHMENT A, ADMINISTRATIVE SERVICES SUBCONTRACT CHECKLIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

ATTACHMENT B, ADMINISTRATIVE SERVICES SUBCONTRACTOR EVALUATION REPORT TEMPLATE

SEE THE ACOM WEBPAGE FOR ATTACHMENT B OF THIS POLICY

439 – MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: 10/01/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

I. PURPOSE

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy establishes guidelines for AHCCCS Contractors regarding the identification and assessment of material changes to a Contractor's provider network and business operations and the approval process for such changes.

II. DEFINITIONS

ADMINISTRATIVE SERVICES SUBCONTRACTS

An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:

a. Claims processing, including pharmacy claims,
b. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization),
c. Management Service Agreements,
d. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,
e. DDD acute care and behavioral health subcontractors,
f. ADHS/DBHS subcontracted Tribal/Regional Behavioral Health Authorities and the Integrated Regional Behavioral Health Authority.

Providers are not Administrative Services Subcontractors.

DELEGATED AGREEMENT

A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.

GEOGRAPHICAL SERVICE AREA (GSA)

An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care services to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.

MANAGEMENT SERVICES AGREEMENT

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

MATERIAL CHANGE TO BUSINESS OPERATIONS	Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.
MATERIAL CHANGE TO THE PROVIDER NETWORK	Any change that affects, or can reasonably be foreseen to affect, the Contractors' ability to meet the performance and/or provider network standards as required in contract including, but not limited to, any change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.
PROVIDER GROUP	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

III. POLICY

The Contractor must have efficient and effective business operations and provider networks to ensure that performance and provider network standards are met to support an individual's needs as well as the needs of the membership as a whole [42 CFR 438.207]. Changes to business operations or to the provider network must be evaluated for the impact to members and providers. Implementation must be planned to ensure continuity of care to members.

A. IDENTIFYING A PROVIDER NETWORK AND/OR BUSINESS OPERATIONS MATERIAL CHANGE

1. The Contractor is responsible for evaluating all business operational and provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the provider network or business operations.

2. For changes impacting members and/or providers regarding the provider network and/or business operations the Contractor must:
   a. Establish criteria and/or methodology for determining the impact of the change to members and providers.
   b. Evaluate the impact of the change to its membership and provider network, by GSA and as a whole, utilizing the established criteria and/or methodology established under III (A)(2)(a.) above.
   c. Determine, based on the evaluation results, if the change meets the definition of a material change as outlined in this Policy and determine if it complies with Contract and Policy requirements.

d. Maintain documentation of evaluation of all provider network and business operations changes.

3. Provider Network changes may include, but are not limited to, changes in services, geographic service areas, payments or eligibility of a new population. Changes may also include the addition or change in:
   a. Pharmacy Benefit Manager (PBM),
   b. Dental Benefit Manager,
   c. Transportation Vendor,
   d. Provider Contracts (e.g. Hospital, Nursing Facility, assisting living facility, primary care or specialty providers),
   e. Lab Contracts, and
   f. Any other delegated agreements.

4. Business Operations changes may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Changes may also include the addition or change in:
   a. Pharmacy Benefit Manager (PBM),
   b. Dental Benefit Manager,
   c. Transportation vendor,
   d. Claims Processing system,
   e. System changes and upgrades,
   f. Member ID Card vendor,
   g. Call center system,
   h. Management Service Agreement (MSA), and
   i. Any other Administrative Services Subcontract.

5. AHCCCS may request and review documentation of established methodology, criteria, and evaluation results for all provider network and business operations changes.

6. For all changes which have a member impact, but are determined by the Contractor not to be a material change, the Contractor is required to provide member notification as outlined in ACOM Policy 404.

7. The Contractor must request in writing, prior approval of a material change to the provider network and/or business operations in accordance with this Policy.
   a. A material change in the provider network and/or business operations requires a 30 day advance written notice from the Contractor to members and providers [42 CFR 438.10(f)(4)].
   b. Additionally, when appropriate, the Contractor must make a good faith effort to give written notice to enrollees within 15 days after receipt or issuance of a provider termination notice, to each member who received their primary care

from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)].

8. A material change to operations may **also** constitute a material change to the provider network.

B. CONTRACTOR REPORTING REQUIREMENTS

1. The Contractor must request, in writing, prior approval of a material change to the provider network or business operations to the designated Operations and Compliance Officer at a minimum of 60 days prior to the expected implementation date of the change, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. A request for approval shall include a detailed description of the proposed change and all requirements outlined above and summarized in Attachment A, Provider Network/Business Operations Material Change Plan Checklist.

2. 2. The Contractor must request prior approval, in writing, of a material change that involves major system changes and upgrades to the Contractor's information system that affects claims processing, payment or other major business component to the designated Operations and Compliance Officer at a minimum of six months prior to implementation, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables. A request for approval must include a system change plan that includes a timeline, milestones and outlines adequate testing to be completed before implementation.

3. In the event of an unexpected change that is likely to cause or may reasonably be foreseen to cause a material change to the provider network and/or business operations, the Contractor must submit written notification to AHCCCS no later than one business day of the change. Notification must be submitted to the designated Operations and Compliance Officer, as specified in Contract, Section F, Attachment F3, Contractor Chart of Deliverables.

4. AHCCCS will review and respond to the Contractor within 30 days of the submission. Incomplete submissions will not be approved and additional information may be requested. The approval process will be expedited for emergency situations.

5. The Contractor may be required to provide periodic updates on the status of the change or implementation.

6. The Contractor may be required to conduct meetings with providers and/or members to provide general information, technical assistance or address issues related to changes to business operations, changes in policy, reimbursement matters, prior authorizations and other matters as identified or requested by AHCCCS.

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
- Attachment A, Provider Network/Business Operations Material Change Plan Checklist
- 9 A.A.C. 22, Article 1
- 42 CFR 438.10(f)(4)
- 42 CFR 438.10(f)(5)
- 42 CFR 438.207
- ACOM Policy 404

ATTACHMENT A, PROVIDER NETWORK AND/OR BUSINESS OPERATIONS CHANGES PLAN CHECKLIST

SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY

440 – MANAGED CARE EXPIRATION OR TERMINATION OF CONTRACT

EFFECTIVE DATE: 01/01/2016

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

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 set forth Contractor requirements and responsibilities when the Contract between AHCCCS and the Contractor expires (contract expiration) or is terminated by either AHCCCS or the Contractor (contract termination).

II. DEFINITIONS

CONTRACT	A written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29.
CONTRACT EXPIRATION	The ending of the Contract pursuant to its terms without any action by a party to the agreement.
CONTRACT TERMINATION	The cancellation of the Contract, in whole or part (e.g. by GSA), as a result of an action taken by AHCCCS or the Contractor.
INCURRED BUT NOT REPORTED (IBNR)	The liability for services rendered for which claims have not been received.

III. POLICY

The Contractor is required to adhere to certain notification requirements and comply with specific responsibilities as outlined in Contract and this Policy in the event of contract expiration or contract termination. Upon determination of Contract Expiration/Termination, AHCCCS will provide notice to the Contractor outlining the Contractor's operational and reporting requirements for the Contract Expiration/Termination transition period as described below.

In either instance, Contract Expiration or Contract Termination, the Contractor is required to develop and submit a Plan to AHCCCS for prior approval as described in Section D. The Plan shall clearly present the Contractor's process for ensuring compliance with all contractual responsibilities through the transition period, regardless of whether a Contract

expires or is terminated. Contractors are responsible to assist AHCCCS in the transition of members.

A. CONTRACTOR NON-RENEWAL - GENERAL NOTIFICATIONS

1. If the Contractor elects not to renew the Contract, the Contractor must provide AHCCCS with at least a 180 day advance written notice prior to the Non-Renewal of the current Contract.

2. After receipt of the Contractor's notification of intent not to renew, AHCCCS will issue written notice to the Contractor specifying :
   a. The effective date of termination,
   b. The Contractor's operational and reporting requirements, and
   c. Timelines for submission of deliverables.

B. AHCCCS NON-RENEWAL - GENERAL NOTIFICATIONS

If AHCCCS elects not to renew the Contract, AHCCCS will provide written notice prior to the Non-renewal of the current Contract.

C. CONTRACT TERMINATIONS BY AHCCCS- GENERAL NOTIFICATIONS

1. AHCCCS may initiate termination actions for reasons, including but not limited to:
   a. A Contractor's notification of or refusal to sign a contract amendment,
   b. Substantial failure to provide medically necessary services that the Contractor is required to provide under law or the terms of its contract to its enrolled members,
   c. Failure to meet AHCCCS Financial Viability Standards,
   d. Material deficiencies in the Contractor's provider network,
   e. Failure to meet quality of care and quality management requirements,
   f. Failure to comply with contract provisions or applicable state and federal laws or regulations, or
   g. For convenience, as stipulated in Contract.

2. In the event AHCCCS initiates a Termination for Convenience action, pursuant to the Contract Terms and Conditions, AHCCCS will provide written notice of the termination at least 90 days before the effective date of the termination. The notice will include the effective date of the termination and the Contractor's operational and reporting requirements.

3. In the event AHCCCS initiates a termination action of a Contract for failure to meet the requirements of Federal Law or the Contract AHCCCS will provide the Contractor with notice of intent to terminate, the reason for termination and hearing rights (42 CFR 438.710).

a. In the event the Contractor does not contest the intent to terminate the contract, AHCCCS will notify the Contractor in writing of:
   i. The effective date of termination,
   ii. The Contractor's operational and reporting requirements, and
   iii. Timelines for submission of deliverables.
b. In the event the Contractor files a request for a hearing to challenge the intent to terminate and the termination is upheld through the Administrative Hearing process, AHCCCS will notify the Contractor in writing of:
   i. The effective date of termination,
   ii. The Contractor's operational and reporting requirements, and
   iii. Timelines for submission of deliverables.

4. AHCCCS will provide CMS with written notice no later than 30 days after the date of Contract termination, in accordance with 42 CFR 438.724.

D. GENERAL CONTRACTOR RESPONSIBILITIES

For Contract expirations and terminations, the Contractor shall adhere to the following:

1. Produce reports timely and perform all responsibilities through the dates specified in the AHCCCS notification,

2. Comply with all terms of the Contract including, but not limited to, the provision of all management and administrative services throughout the transition,

3. Maintain adequate staffing to perform all required functions as specified in Contract,

4. Designate an individual as Contract Transition Coordinator who shall ensure the continuance of Contractor performance, operations, and member transitions through a time determined by AHCCCS, and provide this individual's contact information with submission of the Contract Expiration or Termination Plan,

5. Participate in any meetings, workgroups, trainings or other activities scheduled by AHCCCS related to the transition of members, to support a seamless transition,

6. Be responsible for payment of all outstanding obligations for medical care rendered to members,

7. Be responsible for the provision of a monthly claims aging report including IBNR amounts (as outlined in the AHCCCS Notification),

8. Be responsible for the provision of Quarterly and Audited Financial Statements up to the date specified by AHCCCS,

9. Be responsible for the provision of encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed,

10. Cooperate with reinsurance audit activities on prior Contract years,

11. Cooperate with AHCCCS to complete and finalize any open and pending reconciliations,

12. Be responsible for the submission of Quality Management and Medical Management reports as required by contract, as appropriate, to provide information on services rendered up to the date of contract expiration or termination including Quality Of Care (QOC) concern reporting and investigations based on the date of service,

13. Be responsible for participation in and closing out Performance Measures and Performance Improvement Projects as required,

14. Provide a monthly accounting and disposition of Member Grievances and Claim Disputes as outlined in the AHCCCS Notification,

15. Be responsible for the retention, preservation, and availability of all records, including, but not limited to those records related to grievances, litigation, claims settlement and those covered under HIPAA, as required in Contract,

16. Be responsible for the completion of existing third-party liability cases or making any necessary arrangements to transfer the cases to AHCCCS' authorized Third Party Liability (TPL) Contractor,

17. Be responsible for the following activities pertaining to member services and transitions:
    a. Continue to serve enrolled members and provide all medically necessary covered services until the transition of all members is complete as specified by AHCCCS,
    b. Conduct all member transition activities in accordance with AHCCCS requirements,
    c. Cooperate with Contractor(s) which are receiving members, to support seamless transition of all member services,
    d. Transfer member data to Contractors(s) which are receiving members using a file format and dates for transfer of member data specified by AHCCCS,
    e. The cost, if any, of reproducing and forwarding medical records.

18. Return to AHCCCS any funds advanced to the Contractor for coverage of members for periods subsequent to the date of termination within 30 days of the Contract termination, and

19. Make available all data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under the contract to AHCCCS within 30 days following expiration or termination of the Contract or such other period as specified by AHCCCS.

For Contract terminations, the Contractor shall, in addition to the above requirements:

1. Be liable for costs incurred by AHCCCS in re-procuring materials or services under the Contract.

2. Be liable for costs associated with the transition of its members to a different Contractor.

E. CONTRACT EXPIRATION OR TERMINATION PLAN

1. The Contractor shall submit a Contract Expiration or Termination Plan to AHCCCS, Division of Healthcare Management (DHCM) for approval. The plan must be submitted to the designated Operations and Compliance Officer, within 30 days of AHCCCS' expiration/termination notice to the Contractor.

2. The Contract Expiration or Termination Plan must include, but is not limited to, the following:
   a. A description of the Contractor's process for ensuring compliance with all responsibilities delineated in the Contract including retention of sufficient staff to conduct business operations through the time period specified by AHCCCS,
   b. The designation of a Contract Transition Coordinator,
   c. Timeline for submission of all required deliverables for the term specified by AHCCCS,
   d. Communications to all subcontractors and members related to the Contract expiration/termination, including a timeline for notification,
   e. The method for transferring member data and disposition of any related medical records, and
   f. A Member Transition plan to support a seamless transition of members including but not limited to members with:
      i. Significant medical or behavioral health conditions such as, a high-risk pregnancy or pregnancy within the last trimester, Serious Mental Illness (SMI), the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.,
      ii. Ongoing services such as daily in home care, behavioral health services, dialysis, pharmacy, medical supplies, transportation, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition,

iii. Conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth,
iv. Prior authorized services including but not limited to scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, nursing home admission or Home and Community Based (HCBS) Placements,
v. Continuing prescriptions, Durable Medical Equipment (DME) and medically necessary transportation orders,
vi. Significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, ventilator services, and
vii. High needs/high costs.

g. In addition, the Member Transition Plan shall also support a seamless transition for those members who present ongoing concerns to State and Federal entities and/or the media.

F. RELEASE OF CONTRACTOR REQUIREMENTS AFTER CONTRACT EXPIRATION OR TERMINATION

The Contractor shall remain responsible for all activities associated with the Contract expiration or termination until official written release from AHCCCS has been granted.

1. The Contractor shall submit to AHCCCS, DHCM a written request for release.

2. AHCCCS will provide an official written release upon satisfaction of activities associated with the Contract expiration or termination including, but not limited to, the following:
   a. Audited Financial Statements inclusive of a balance sheet,
   b. Payment of all outstanding medical obligations for medical care rendered to members,
   c. Encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed,
   d. Reinsurance audit activities on prior contract years,
   e. Finalization of any open or pending reconciliations, and
   f. Performance Bond or Bond Substitute.

IV. REFERENCES

- Acute Care Contract, Section D and E
- ADHS/DBHS Contract, Section D and E
- ALTCS/EPD Contract, Section D and E
- CRS Contract, Section D and E
- DCS/CMDP Contract, Section D and E
- DES/DDD Contract, Section D and E

- A.R.S. Title 36, Chapter 29
- Balanced Budget Act of 1997
- 42 CFR 438.700 et seq.
- 45 CFR 164.530(j)(2)