100 - AHCCCS CONTRACTOR OPERATIONS MANUAL OVERVIEW

EFFECTIVE DATES: 07/01/05, 10/01/12, 11/01/14, 10/01/15, 07/01/16, 03/15/17

REVISION DATES: 10/25/06, 06/01/11, 09/12/12, 10/02/14, 12/29/14, 08/24/15, 01/05/17

I. PURPOSE

This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP, DES DDD, and RBHA 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

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). 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.

ACUTE CARE SERVICES
Medically necessary services that are covered for AHCCCS members and which are provided through contractual agreements with managed Care Contractors or on a Fee-For-Service (FFS) basis through AHCCCS.

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 subcontractors.
f. Providers are not Administrative Services Subcontractors.

AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.
AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.
AHCCCS POLICY COMMITTEE (APC)	A committee comprised of Agency Management and subject matter experts within AHCCCS and stakeholder representatives that review new and revised Policies.
AHCCCS REGISTERED PROVIDER	A contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS covered services to members.
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, state and local government services, public accommodations, commercial facilities, transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as "Rules." AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.
ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)	The department established pursuant to A.R.S. §8-451 to protect children and to perform the following: 1. Investigate reports of abuse and neglect. 2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect. 3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations. 4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF DEVELOPMENTAL DISABILITIES (ADES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for licensure/certification of facilities that specifically serve individuals with a developmental/intellectual disability, contracting with providers that serve individuals with developmental disabilities, and providing services for eligible Arizona residents with a developmental/ intellectual disability. AHCCCS contracts with ADES to serve eligible individuals with a developmental/ intellectual disability.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS Program which delivers long-term, acute, behavioral health care and case management services, as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with Developmental Disabilities (DD), through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	The Laws of the State of Arizona.
ALTCS MEMBER CHANGE REPORT USER GUIDE	A user guide that provides a tutorial for the process of reporting to AHCCCS when a change needs to be made on a long term care member's eligibility or enrollment record via the electronic Member Change Report (eMCR).
BEHAVIORAL HEALTH FACILITY	Refers to a behavioral health inpatient facility, a behavioral health residential facility, a substance abuse transitional facility, a behavioral health specialized transitional facility, an outpatient treatment center that provides only behavioral health services, or a behavioral health supportive home as outlined in A.A.C. R9-10.

BEHAVIORAL HEALTH INPATIENT FACILITY

A health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

1. Have a limited or reduced ability to meet the individual's basic physical needs,
2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality,
3. Be a danger to self,
4. Be a danger to others,
5. Be persistently, acutely, disabled as outlined in A.R.S. §36-501, or
6. Be gravely disabled.

BEHAVIORAL HEALTH PROFESSIONAL

As specified in A.A.C. R9-10-101, an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

a. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; or
b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101.;
c. A psychiatrist as defined in A.R.S. §36-501;
d. A psychologist as defined in A.R.S. §32-2061;
e. A physician;
f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
g. A behavior analyst as defined in A.R.S. §32-2091; or
h. A registered nurse.

CARE MANAGEMENT

A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.

CASE MANAGEMENT

A collaborative process which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

An organization within the United States Department of Health and Human Services which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.

CHILDREN'S REHABILITATIVE SERVICES (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS related services as specified in 9 A.A.C.22.
CLAIMS DASHBOARD GUIDE	A guide designed to assist the Contractor in submitting a monthly report to address claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for specific requirements.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
COMPREHENSIVE MEDICAL AND DENTAL PLAN (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.
CONTRACTOR	An organization, or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)	A comprehensive child health program of prevention, treatment, correction, and improvement of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical, oral and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396 d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

GRIEVANCE GUIDE	A guide that provides instructions to the Contractors on how to complete the Grievance System Report for submission to and review by the Division of Health Care Management (DHCM), as required by contract.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.
KIDSCARE	Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income at or below 133% and 200%of the Federal Poverty Level (FPL).
MANAGED CARE ORGANIZATION (MCO)	A health care delivery system consisting of affiliated and/or owned hospitals, physicians and others which provide a wide range of coordinated health services; an umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of physicians and hospitals.
MEDICALLY NECESSARY	As defined in A.A.C. R9-22.101. Medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.
NON-TITLE XIX/XXI MEMBER OR NON-TITLE XIX/XXI PERSON	An individual who needs or may be at risk of needing covered health-related services, but does not meet federal and State requirements for Title XIX or Title XXI eligibility.
NON-TITLE XIX/XXI SMI MEMBER	A Non-Title XIX/XXI member who has met the criteria to be designated as Seriously Mentally Ill.

PROVIDER AFFILIATION TRANSMISSION (PAT) USER MANUAL	Every quarter the Contractors are required to submit information about each individual provider within their network as specified in Contract. Each Contractor is responsible for submitting true and valid information.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.
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.
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. R9-22-201.
SERIOUS MENTAL ILLNESS (SMI)	A condition as defined in A.R.S. §36-550 and determined in a person 18 years of age or older.
SERVICE PLAN	A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."

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.

TITLE XIX

Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves Title XIX of the social security act which is also referred to Members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which include those populations 42 U.S.C. 1396 a (a)(10)(A).

TITLE XXI

Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.

III. POLICY

A. MANUAL CONTENT

The ACOM consists of four chapters, identified below. Each Chapter contains individual Policies and corresponding Policy Attachment(s). The Policy Attachments are considered Policy requirements and are provided in the appropriate format (e.g. Microsoft Word, Microsoft Excel, etc.) as necessary for ease of use.

CHAPTER 100 ADMINISTRATION

Contains the Manual Overview and policies pertaining to business plan and organization.

CHAPTER 200 CLAIMS

Contains policies pertaining to claim adjudication and reimbursement.

CHAPTER 300 FINANCIAL	Contains policies pertaining to financial information or data, including reconciliation and reporting.
CHAPTER 400 OPERATIONS	Contains policies pertaining to Contractor operations such as; member information, coordination of care, and network management.

The Contractor is responsible for complying with the requirements set forth within the ACOM and is responsible for ensuring that its subcontractors are notified when modifications are made to the ACOM. Upon adoption by AHCCCS, updates to the ACOM are made available to Contractors on the AHCCCS Contractor Operations Manual (ACOM) area of the AHCCCS website.

B. THE DIVISION OF HEALTH CARE MANAGEMENT (DHCM)

DHCM, in conjunction with other divisions within AHCCCS, is responsible for the formulation of ACOM Policies. ACOM Policies are developed and/or revised in order to maintain a consistent, uniform approach and to ensure the following:

1. Consistency with statutes and rules and contractual requirements,
2. Regular review,
3. Timely communication of updates, and
4. Reduction of duplication and inconsistencies.

New or revised Policies can stem from a variety of sources including, but not limited to, federal or state legislation, contractual requirements, internal operational changes, and requests for written guidelines in a particular area. Policy modifications are assessed for a financial impact and the need for input/comments from external parties (e.g. health plans, state agencies, stakeholders, CMS).

C. AHCCCS POLICY COMMITTEE

The AHCCCS Policy Committee (APC) is comprised of AHCCCS management and subject matter experts and stakeholder representation including member, advocate and Tribal representatives.

APC reviews policies within the ACOM related to Contractor operations and the AMPM regarding medical policy. In addition, other policies are reviewed as designated by the Director, Deputy Director, or the head of divisions/offices. Policies are reviewed to ensure compliance with the guidelines set forth by the Centers for Medicare and Medicaid (CMS), Federal and/or State Citations, and are in the best interest of the State. In addition, new policies and substantive modifications to existing policies and are reviewed by the committee.

In the event of an expedited review request, AHCCCS Executive Management may approve policy changes. APC determines if the proposed policy changes are substantial and require a Public Comment review period prior to final publication.

D. TRIBAL CONSULTATION NOTIFICATION/PUBLIC COMMENT

All Policies and related materials that have been opened for review and revisions will be posted to the AHCCCS Web Site within the AMPM Tribal Consultation Notification/Public Comment location. This page allows for both Tribal members and the general public to review and submit comments regarding changes that are being presented. The policy will be open for not more than 45 days unless otherwise stipulated. Due to extreme circumstances there will be on occasion the need to provide an expedited time period that will be not less than two weeks and will be noted if utilized. The comment deadline will be specified on each document. Comments must be limited only to policies that are currently open and listed on the site.

AHCCCS will review all comments submitted; however, will not be responding to any submissions. When the open period has concluded, the Policies will be removed from the page and review of all comments will be done.

To receive a notification when policies are available for comment, Tribal members, Contractors and the general public are encouraged to subscribe to Constant Contact in order to receive timely notifications.

E. PUBLISHED POLICIES

At the conclusion of the Tribal Consultation Notification/Public Comment period, comments are reviewed and policies are finalized and published to the AHCCCS website. An overview of changes can be found within the ACOM Revision Memo. AHCCCS has instituted Constant Contact to communicate updates regarding the ACOM. In order to be notified of updates it is the Contractor's responsibility to subscribe to Constant Contact in order to receive timely updates.

Updates to the ACOM webpage occur as-needed but, are typically published at the beginning of each month.

F. OTHER AHCCCS GUIDES AND MANUALS

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

- AHCCCS ALTCS Member Change Report User Guide
- AHCCCS Covered Behavioral Health Services Guide
- AHCCCS Claims Dashboard Reporting Guide
- AHCCCS Contractor Operations Manual (ACOM)

- AHCCCS Eligibility Policy Manual
- AHCCCS Encounter Manual
- AHCCCS Fee-For-Service Provider Manual
- AHCCCS Financial Reporting Guides
- AHCCCS Grievance and Appeal System Reporting Guide
- AHCCCS Guide to Languages in Notices of Action (NOA)
- AHCCCS Medical Policy Manual (AMPM)
- AHCCCS Minimum Subcontract Provisions
- AHCCCS Operations Reporting Guidelines
- AHCCCS Program Integrity Reporting Guide
- AHCCCS Provider Affiliation Transmission (PAT) Manual
- AHCCCS Public Notices and Opportunities for Public Comment
- AHCCCS Reinsurance Policy Manual
- AHCCCS State Plan
- AHCCCS Technical Interface Guidelines
- Arizona Administrative Code (A.A.C.)
- Arizona Revised Statutes (A.R.S.)
- Arizona Section 1115 Waiver
- Code of Federal Regulations (CFR)
- Medicare D-SNP Agreements (MIPPA Agreements)