





DFSM Tribal ALTCS

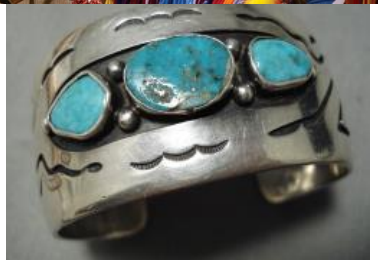
1st Quarter Case Management Supervisor Meeting

Thursday, January 27th, 2022

AHCCCS
Arizona Health Care Cost Containment System

WELCOME TO ALL!

Agenda Overview



- **Byron Wesley :** Opening Prayer
- **Rachel Hunter**: Welcome
- **Kevin Hoy:** Discharge Best Practices, PCSP Check-In, PCSP Ideas
- **Soni Fisher:** CES - adding a new CA160 Date in PMMIS;
  CES – submitting CES packets when >80% CES
- **Cheryl Begay:** Payor of Last Resort
- **Vanessa Torrez:** Tribal ALTCS PA Data Overview
- **Closing**

Meeting Reminders

- Please mute your computer's microphone and/or phone when not speaking.
- Use the chat feature to add in comments/questions.
- Ask questions after the speaker has finished.
- Sit back, listen in and enjoy the meeting!
- This meeting will be recorded.

POLICY & PROJECT UPDATES

Rachel Hunter-Tribal ALTCS Administrator

AHCCCS
Arizona Health Care Cost Containment System

Policy Updates

AMPM – Approved and Published

1620-F Tribal ALTCS Fee-For-Service Standards

Effective 01/20/22

AMPM – Provided Updates to APC

810 Fee-For-Service Utilization Management

820 Fee-For-Service Prior Authorization Requirements

AMPM – Currently Under Review

1620-D Placement Service Planning Standard

1620-E Service Plan Monitoring and Reassessment Standard

1240-E Habilitation Services

Tribal ALTCS IGA Status

Current Inter-governmental Agreements (IGA) with the six tribes will expire on June 30, 2022. Draft IGAs were sent to all seven Tribes in November 2021. Currently IGA will expire on June 30, 2022.

- Review the IGA with Tribal Leadership
- Submit questions for the Listening Session prior to meeting.
- Point of Contact on Tribal side will provide an update to Tribal ALTCS Administrator on a bi-weekly basis.
- Once all parties agree on the draft IGA, a copy without the watermark will be sent to the Tribal ALTCS Program for signatures.

GOAL: Implement a new IGA prior to July 01, 2022.

Tribal ALTCS IGA

Case Management is the process through which appropriate and cost effective medical and medically related social and behavioral health services and supports are identified.

- Planned, obtained and monitored for individuals eligible for Arizona Long Term Care System (ALTCS) services.
- ALTCS member shall receive Case Management services as specified in AMPM Chapter 1600 and provided by a qualified Case Manager.
- Process involves review and assessment of the member's strengths, preferences, service, and support needs with the member/Health Care Decision Maker, Designated Representative, and the Planning Team.

Tribal ALTCS IGA

The review should result in an individualized, mutually agreed upon, appropriate and cost effective PCSP that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting. In serving ALTCS members, the Case Manager shall promote the values of:

- Dignity
- Independence
- Individuality
- Privacy
- Choice
- Self-determination
- Adhere to the guiding principles specified in AMPM policies

Tribal ALTCS IGA

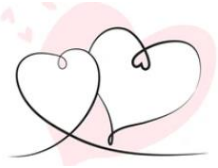
IGA Section 4

Provider Network: The Tribe will refer Members to AHCCCS-registered providers, including Indian Health Services and Tribally-owned/operated 638 system providers.

ALTCS Health plan will develop a provider network within their tribal communities to meet the unique needs of members with a focus on accessibility of services for aging members and members with:

- Disabilities
- Cultural Preferences
- Individual Health Care Needs
- Accessibility of network sufficiency supports choice in individualized member care and availability of services.

Ice Breaker – Valentine's Day

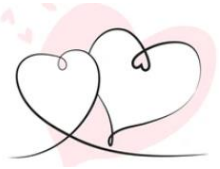


Ice Breaker – Valentine's Day

As you can see, our Icebreaker for this meeting is centered around Valentine's Day since it's the next upcoming holiday.

We will have three games related to Valentine's Day, and the winners will receive a $10 gift card from Sonic.

Our first game will be a word scramble puzzle game. For everyone who has signed in, we will have Soni send out the Word Search puzzle. We'll give you a few minutes to print it or you can complete it electronically. Please write your name and the Tribal ALTCS Program you are with at the top. We'll provide the hidden words on the screen, give you three minutes to circle as many words as you can and when the time is up, the first person to email the completed puzzle to Kevin Hoy, with the most correct circled words will win the game. You can take a snapshot of the puzzle and email it to Kevin, you can scan/email it to Kevin, or whatever works for you.



Ice Breaker – Valentine's Day

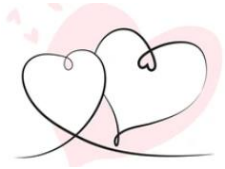
Okay, the puzzle has been emailed to everyone who was logged in at the start of the meeting. We'll give you five minutes to locate it in your email, print it and return to this meeting. Once we reveal the words on the screen, we'll give you three minutes to find as many words as possible: 1) Get Ready, 2) Get Set, and 3) Let's GO!!!

FEBRUARY	ROMANCE	FLOWERS
BOUQUET	CHOCOLATE	ADMIRER
CARDS	CUPID	LOVE
ENVELOPE	VALENTINE	CANDY
SWEETIE	KISS	HEART

Ice Breaker – Valentine's Day

Our next game is to do with Romantic movie titles. We will provide the year the movie came out and a portion of the name. You will type the full name of the movie title in the chat box. We'll record who was the first person to type in the movie title correctly. The person who guesses the most correct movie titles will win this game.

Get your romantic thinking cap on and 1) Get Ready, 2) Get Set, and 3) Here we Go....



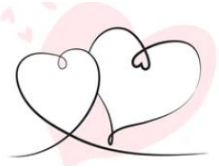
Ice Breaker – Valentine's Day

1953: ROMAN _____	Correct Answer: ROMAN **HOLIDAY**
1934: IT HAPPENED___ NIGHT	Correct Answer: IT HAPPENED **ONE** NIGHT
1999: NOTTING ___	Correct Answer: NOTTING **HILL**
2018: CRAZY ____ ASIANS	Correct Answer: CRAZY **RICH** ASIANS
1987: THE PRINCESS _____	Correct Answer: THE PRINCESS **BRIDE**
1999: RUNAWAY ____	Correct Answer: RUNAWAY **BRIDE**
1989: SAY _____	Correct Answer: SAY **ANYTHING**
2003: LOVE _____	Correct Answer: LOVE **ACTUALLY**
2004: __ FIRST DATES	Correct Answer: **50** FIRST DATES
1993: SLEEPLESS IN _____	Correct Answer: SLEEPLESS IN **SEATTLE**
1995: WHILE YOU WERE _____	Correct Answer: WHILE YOU WERE **SLEEPING**
1998: YOU'VE GOT ____	Correct Answer: YOU'VE GOT **MAIL**
1961: BREAKFAST AT _____	Correct Answer: BREAKFAST AT **TIFFANY'S**
1995: READY TO _____	Correct Answer: READY TO **EXHALE**
1996: _____ MCGUIRE	Correct Answer: **JERRY** MCGUIRE
2010: VALENTINE'S ___	Correct Answer: VALENTINE'S **DAY**
2004: THE NOTE___	Correct Answer: THE NOTE**BOOK**

Ice Breaker – Valentine's Day

Our last game is to do with famous quotes from romantic movies. We will provide the year the movie came out, and quote from the movie. You will type the full name of the Movie in the chat box. We'll record who was the first one to type in the answer correctly. The person who guesses the most movie titles correctly will win this game.

Get your romantic thinking cap on and 1) Get Ready, 2) Get Set, and 3) Here we Go....



Ice Breaker – Valentine's Day

1999: *"Look, I guarantee there'll be tough times. I guarantee that at some point, one or both of us is gonna want to get out of this thing. But I also guarantee that if I don't ask you to be mine, I'll regret it for the rest of my life, because I know, in my heart, you're the only one for me."*

Correct Answer: **RUNAWAY BRIDE**

1997: *"I'm The King of the World."*

Correct Answer: **TITANIC**

1939: *"Frankly, my dear, I don't give a damn."*

Correct Answer: **GONE WITH THE WIND**

1999: *"Don't forget: I'm also just a girl, standing in front of a boy, asking him to love her."*

Correct Answer: **NOTTING HILL**

1999: *"When you realize you want to spend the rest of your life with somebody, you want the rest of your life to start as soon as possible."*

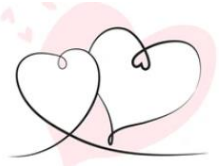
Correct Answer: **WHEN HARRY MET SALLY**

1996: *"You Complete Me." "You had me at Hello!"*

Correct Answer: **JERRY MCGUIRE**

1997: *"You make me want to be a better man."*

Correct Answer: **AS GOOD AS IT GETS**



Ice Breaker – Valentine's Day

2005: *"I wish I knew how to quit you."*

Correct Answer: **BROKEBACK MOUNTAIN**

1942: *"Here's looking at you, kid."*

Correct Answer: **CASABLANCA**

1997: *"Choose Me. Marry Me. Let me make you happy."*

Correct Answer: **MY BEST FRIEND'S WEDDING**

1995: "I've come here with no expectations, only to profess, now that I am at liberty to do so, that my heart is, and always will be, yours.."

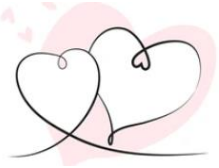
Correct Answer: **SENSE AND SENSIBILITY**

1990: *"I'm gonna treat you so nice, you're never gonna let me go."*

Correct Answer: **PRETTY WOMAN**

1996: *"Why do you want to marry me, anyhow?" "So I can kiss you anytime I want."*

Correct Answer: **SWEET HOME ALABAMA**



Ice Breaker – Valentine's Day

Thank you for participating in our Icebreaker







Discharge Planning Best Practices

PCPS Check-In

Kevin Hoy, Tribal ALTCS Manager

AHCCCS
Arizona Health Care Cost Containment System

Discharge Planning Best Practices

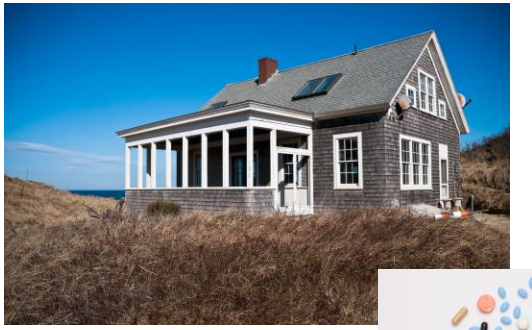
- Begin Discharge Planning Upon Admission (and/or shortly thereafter)
- Exchange contact information with facility DC team -Nurse, Physician, Tech etc.
- Form a Planning Team-Ensure member/Health Care Decision Maker, Designated Representative are involved (this maybe the responsibility of the facility to lead)
- Meet with planning team to determine level of care and expected DC date
- Request daily updates from facility DC facility team
- Identify step down and/or next level placement option(s)
- Ensure transportation is arranged (with a secondary option)
- Inform planning team which CM staff will provide coverage for Holidays, weekends etc.

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1020.pdf

Important Considerations

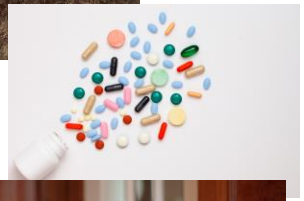
Where will the member be going?

- Home
- Returning to SNF or ALF
- Inpatient Rehabilitation Center
- Long-term acute care hospital



Medication Reconciliation/Review:

- Change in member's medications
- Prescription(s) need to be filled at local pharmacy/family pick up
- Bridge amount of meds given upon DC



Has an apt been scheduled with member's PCP? Counselor? PT?

- Does the discharge summary give aftercare providers enough information, did the member, Health Care Decision Maker, Designated Representative, aftercare providers etc. receive a copy upon/prior to DC?

Suggestions for members and their families or advocates

Source: ***How a Hospital Discharge Plan Helps AHCCCS Members Return to Good Health***

- Ask about the progress of your discharge plan
- Contact your care/case manager and/or hospital social worker for help if your questions are not answered.
- Make sure you fully understand the discharge plan BEFORE you sign it.
- ALWAYS obtain a copy of the discharge plan before you leave the hospital.
- During the follow-up call you'll receive 3 days after discharge, be prepared to ask questions and talk about any problems you are having.

https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischargeFlyer.pdf

How a Hospital Discharge Plan Helps AHCCCS Members Return to Good Health

AHCCCS
Arizona Health Care Cost Containment System
OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS

How A Hospital Discharge Plan Helps AHCCCS Members Return To Good Health

Discharge planning begins as soon as you are admitted to the hospital.
It helps your health care providers coordinate your treatment and helps you make a smooth return to your community and your regular routine.

Discharge planning ensures that the member/guardian/designated representative:

1. Participates in the discharge planning process,
2. Understands the written discharge plan, instructions and recommendations, and
3. Is provided resources, referrals and possible interventions to meet the member's needs after discharge.

Discharge planning begins upon admission and is updated periodically during the inpatient stay to ensure a safe, timely and effective discharge. It applies to short-term and long-term hospital and institutional stays and includes:

1. A follow-up appointment with the primary care doctor (PCP) and/or specialist within seven (7) days;
2. Safe and clinically appropriate placement, and community support services;
3. Communication of the member's treatment plan and medical history across all involved providers;
4. Prescription medications and medical equipment;
5. Nursing services and therapies, if appropriate;
6. Hospice and End of Life Care related services such as Advance Care Planning, if appropriate;
7. Practical supports such as housekeeping and shopping provided by a member of the family, if appropriate;
8. Referral to appropriate community resources;
9. Referral to the Contractor Disease Management or contractor care management (if needed);
10. A post-discharge follow-up call to the member within three (3) days of discharge to confirm the member's well-being and the progress of the discharge plan;
11. Additional follow-up actions as needed based on the member's needs.

Suggestions for members and their families or advocates

- **Ask about the progress of your discharge plan.**
- **Contact your care/case manager and/or hospital social worker for help if your questions are not answered.**
- **Make sure you fully understand the discharge plan BEFORE you sign it.**
- **ALWAYS obtain a copy of the discharge plan before you leave the hospital.**
- **During the follow-up call you'll receive 3 days after discharge, be prepared to ask questions and talk about any problems you are having.**

The Arizona Health Care Cost Containment System (AHCCCS) is committed to ensuring the availability of timely, quality health care. If you know of an AHCCCS member who is unable to access health services, or if you have a concern about the quality of care, please call your AHCCCS health care plan's Member Services number. If your concern is not resolved, please call AHCCCS Clinical Resolution Unit at 602-364-4558, or 1-800-867-5308.

AHCCCS Health Plan Contacts

AHCCCS ACUTE CARE/INTEGRATED HEALTH PLANS	
Arizona Complete Health - Complete Care Plan Customer Service 1-888-788-4408 www.azcompletehealth.com/completecare	**Mercy Care** Customer Service 1-800-624-3879 www.mercycareaz.org
Care 1st Health Plan Customer Service 1-866-560-4042 www.care1staz.com	**Molina Complete Care** Customer Service 1-800-424-5891 www.mcofaz.com
Banner – University Family Care Customer Service 1-800-582-8686 www.bannerufc.com/acc	**United Healthcare Community Plan** Customer Service 1-800-348-4058 www.uhccommunityplan.com
Health Choice Arizona Customer Services 1-800-322-8670 www.healthchoiceaz.com	**Mercy Care Department of Child Safety Comprehensive Health Plan** Customer Service 1-833-711-0776 mercycareaz.org/members/chp-members

AHCCCS CLINICAL RESOLUTION UNIT (JACOB'S LAW AHCCCS CLINICAL RESOLUTION UNIT (JACOB'S LAW – FOSTER/KINSHIP/ADOPTIVE)
602-364-4558 or 800-867-5808 DCS@azahcccs.gov

LONG TERM CARE HEALTH PLANS (PROGRAM CONTRACTORS)	
Banner – University Family Care LTC Customer Service 1-833-318-4146 www.bannerufc.com	**Mercy Care LTC** Customer Services 1-800-624-3879 www.mercycareaz.org
United Healthcare LTC Customer Service 1-800-293-3740 www.uhccommunityplan.com	**Department of Economic Security/ Division of Developmental Disabilities (DES/DDD)** Customer Service 1-844-770-9500 www.azdes.gov/ddd/

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) HEALTH PLANS		
Arizona Complete Health - Complete Care Plan RBHA Customer Service 1-888-788-4408 www.azcompletehealth.com/completecare	**Mercy Care RBHA** Customer Service 1-800-564-5465 www.mercycareaz.org	**Health Choice Arizona RBHA** Customer Services 1-800-322-8670 www.healthchoiceaz.com

https://www.azahcccs.gov/AHCCCS/Downloads/HospitalDischargeFlyer.pdf

We are not alone!

COVID Considerations

Type of Facility:	Banner-University Medical Center-Short Term Acute Care (FY2020)
DC Nurse/Staff	?
Total Staffed Beds:	746
Total Patient Revenue:	$4,299,998,937
Total Discharges:	31,617/86 Daily
Total Patient Days:	187,034

PCSP Assessment Check-in

Completion Time Comparison: June to December.

Innovative methods to decrease overall time in completing a PCSP assessment?

Use of mobile devices or other technologies to complete the PSCP assessment?

Any PCSP Improvement Ideas







- **Adding CES CA160 into PMMIS**
- **Submitting CES Packets to AHCCCS/Tribal ALTCS**

Soni Fisher, Tribal ALTCS CM Coordinator

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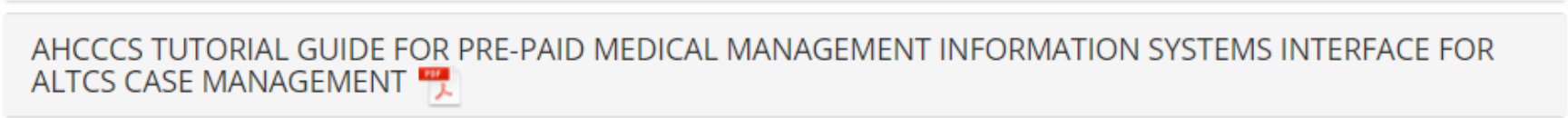
Arizona Health Care Cost Containment System

Adding a "NEW" CES onto CA160

- https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html



- https://www.azahcccs.gov/PlansProviders/Downloads/AHCCCSTutorialGuideForPMMISInterfaceForALTCSCM.pdf

Adding a "NEW" CES onto CA160

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

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AHCCCS TUTORIAL GUIDE FOR PRE-PAID MEDICAL MANAGEMENT INFORMATION SYSTEMS INTERFACE FOR ALTCS CASE MANAGEMENT

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 cannot 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:

Adding a "NEW" CES onto CA160

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.

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(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.**

Adding a "NEW" CES onto CA160

Critical CES Dates that must be entered into PMMIS CA160 CES:

- Date of the current PCSP Review XX/XX/202X

- Date(s) HCBS Rates changes on AHCCCS website:
  - 10/01/202X (every year)
  - 01/01/202X (every year)
  - 07/01/202X (occasionally)

The new Gross Institutional Cost corresponding with the rate change date must be used.

The new HCBS Unit Cost corresponding with the rate change date must be used.

When to submit a "NEW" >80% CES Overcost Packet to AHCCCS

- If the new CA160 percentage reflects >81%-99%, then a new >80% CES Overcost Packet must be submitted to AHCCCS for approval, IF:
  - There is **no** prior approved >80% CES Overcost Letter in the case file (dated within the past 12 months), then a new CES >80% CES Overcost Packet must be submitted to AHCCCS for approval.
  - The prior approved >80% CES Overcost Letter has expired (dated more than 12 months prior to the current date, regardless of percentage), then a new >80% CES Overcost packet must be submitted to AHCCCS for approval.
  - The current approved >80% CES Overcost Letter (dated within past 12 months) in the case file percentage is less than the current CA160, then a new >80% CES Overcost Packet must be submitted to AHCCCS for approval.

When a "NEW" >80% CES Overcost Packet is not required to be submitted to AHCCCS

- Exception: If there is a current approved >80% CES Overcost Letter in the case file (dated within the past 12 months), which reflects a higher CES Overcost percentage than the current CA160, then a new CES Packet is not required to be submitted to AHCCCS.

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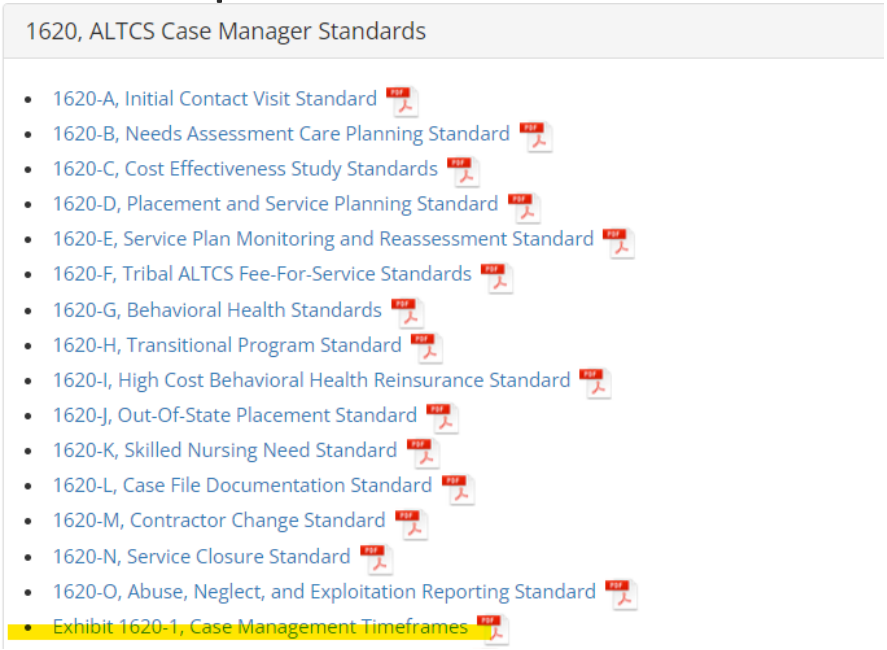
- https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1620-1.pdf



1620, ALTCS Case Manager Standards

- 1620-A, Initial Contact Visit Standard
- 1620-B, Needs Assessment Care Planning Standard
- 1620-C, Cost Effectiveness Study Standards
- 1620-D, Placement and Service Planning Standard
- 1620-E, Service Plan Monitoring and Reassessment Standard
- 1620-F, Tribal ALTCS Fee-For-Service Standards
- 1620-G, Behavioral Health Standards
- 1620-H, Transitional Program Standard
- 1620-I, High Cost Behavioral Health Reinsurance Standard
- 1620-J, Out-Of-State Placement Standard
- 1620-K, Skilled Nursing Need Standard
- 1620-L, Case File Documentation Standard
- 1620-M, Contractor Change Standard
- 1620-N, Service Closure Standard
- 1620-O, Abuse, Neglect, and Exploitation Reporting Standard
- Exhibit 1620-1, Case Management Timeframes

Policy 1620-1

AHCCCS Arizona Health Care Cost Containment System

AHCCCS MEDICAL POLICY MANUAL

EXHIBIT 1620-1, CASE MANAGEMENT TIMEFRAMES

INITIAL CONTACT/VISIT	TIMEFRAME
Initial Contact (Case Manager [CM] or designee)	Within seven business days of enrollment
Initial on-site visit	Within 12 business days of enrollment
Initial service start-up	Within 30 days of enrollment
CASE FILE UPDATES	**TIMEFRAME**
Initial Cost Effective Study (CES)	Prior to placement/services
Initial CES, when services are in place at time of enrollment	Within 12 business days of enrollment
CES update	Prior to placement change to Home and Community Based Services (HCBS) **and** annually for all HCBS members, **and** when there is a change in the member's condition, authorized services, and or rates
CES when no discharge potential	No updates required, CES will reflect "NONE"
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS) ENTRIES	**TIMEFRAME**
CES/CA160	Within 10 business days of date of action
Placement/CA161	Within 10 business days of date of action
Service Plan/CA165 (Tribal ALTCS only)	Within five business days of date of action
REASSESSMENT VISITS *(Includes service plan review and signature)*	**TIMEFRAME**
HCBS member	At least every 90 days
Nursing facility member	At least every 180 days

Effective Dates: 01/01/11, 05/01/12, 01/01/16, 10/01/17, 09/15/21
Approval Dates: 01/01/16, 05/01/12, 01/01/11, 07/25/17, 08/04/21

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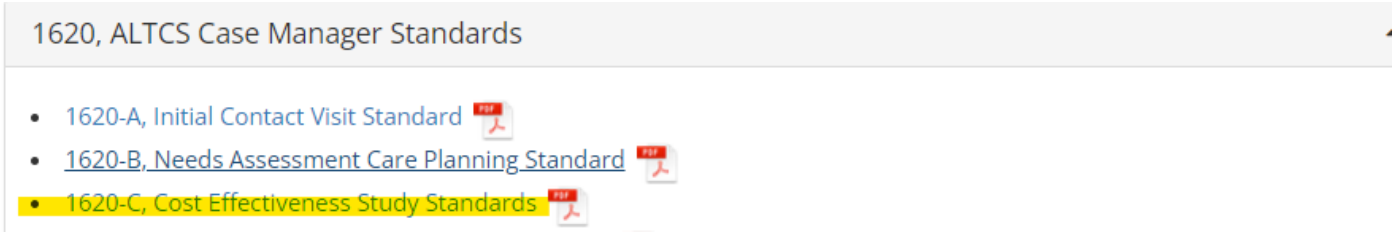
- https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1620C.pdf



Policy 1620-C

III. POLICY

A. REQUIREMENTS FOR A COST EFFECTIVENESS STUDY

Services provided under Title XIX shall be cost effective whether the placement is in an institutional facility or a Home and Community Based (HCB) setting. Placement in a HCB setting is considered appropriate if the cost of HCBS for a specific member does not exceed 100% of the net cost of institutional care for that member, is the least restrictive setting and HCBS will meet the member's needs.

1. A Cost Effectiveness Study (CES) shall be completed for all Arizona Long Term Care System (ALTCS) and Tribal ALTCS members who are Elderly and/or have a Physical Disability (E/PD) in a HCB setting and for those E/PD members currently placed in an institutional setting who have discharge potential. The timeframes for completion of the CES can be found in AMPM Chapter 1600, Exhibit 1620-1.

2. The Contractor's Annual Case Management Plan shall describe a process used by the Contractor that evaluates the net cost of institutional care that meets the requirements of this policy. This process shall include:
   a. Calculation on institutional costs stratified for levels of care and specialized needs,
   b. Annual re-assessment and adjustment of the institutional rates based upon changes in costs associated with the assessed levels of care and specialized needs, and
   c. Implementation of processes consistent with this policy, for determination and evaluation of CES for each member and processes for resolution of cases where the net HCBS cost exceeds the net cost of institutional care.

3. A CES shall be completed for members with developmental disabilities under the following circumstances:
   a. Every three months for a member whose service costs exceed 80% of the cost of the appropriate institutional setting for the member,
   b. When the service costs of a member whose service costs previously exceeded 80% of the cost of the appropriate institutional setting are subsequently reduced to below 80%, and/or

   c. When discharge is contemplated for any member residing in an Intermediate Care Facility (ICF).

4. The net cost of institutional care for each member takes into consideration the specific member's assessed Level of Care, the institutional rate appropriate for that Level of Care and the amount of the specific member's "CES Share of Cost."
   a. If the member has needs that would necessitate a specialized rate in an institutional setting (for example, Alzheimer's or behavioral unit, residential treatment center, extensive respiratory care), this cost shall be used in calculating the cost effectiveness of HCBS,
   b. The "CES Share of Cost" is the amount the Division of Member Services/ Arizona Long Term Care System (DMS/ALTCS) eligibility has determined, based on the member's income and expenses, that member would have to pay monthly **IF** member was placed in a nursing home,
   c. The net Medicaid cost of institutional care is calculated by subtracting the monthly CES Share of Cost amount for the member from the monthly nursing facility cost based on the specific member's level of care or other needs. The result is called the Net Institutional Cost,
   d. If the member has been assessed by the DMS/ALTCS unit, to have an actual Share of Cost that shall be paid in HCBS, that amount is deducted from the total monthly cost of the HCB services the member needs. The result is called the "Net HCBS Cost",
   e. If the Net HCBS Cost is more than the Net Institutional Cost, then home care services at that level are not "cost effective" and cannot be provided unless the HCBS costs are expected to decrease to less than the cost of institutional care within six months of the current CES date. At that time, the member shall be issued a Notice of Adverse Benefit Determination (NOA) that explains any decision to not provide services at the level requested/needed by the member/representative and given an opportunity to file an appeal if member does not agree with the decision, and
   f. The portion of HCBS that are cost effective can be provided if the member/representative still desires HCBS placement and is willing to accept that level of services and to assume the potential risks of remaining at home without all the care that has been assessed as needed. The Case Manager shall complete a Managed Risk Agreement with the member/representative to document this situation.

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Example of CES>100%

Total Nursing Home Cost		$4920.10
CES Share of Cost	–	$726.90
Net Institutional Cost	=	**$4193.20**
Services Member Needs		
40 hours of Attendant Care per week		$2924.00
12 Nursing visits per month	+	$1341.60
Net HCBS Cost	=	**$4265.60**
$4265.60 divided by $4193.20 = 102% Requested HCBS are not cost effective		

g. If the member in the previous example requested all the services that could cost effectively be provided, the Case Manager should determine which services are priorities for the member and recalculate the CES. For example:

Total Nursing Home Cost		$4920.10
CES Share of Cost	–	$ 726.90
Net Institutional Cost	=	**$4193.20**
Services that can cost effectively be provided		
40 hours of Attendant Care		$2924.00
11 Nursing visits per month	+	$1144.00
Net Home Services Cost	=	**$4068.00**
$4068.00 divided by $4193.20 = 97% Requested HCB services are cost effective		

h. Existing HCBS units cannot be reduced if there is an increased cost of services incurred to fill a service gap (for example, if personal care and homemaker services are provided to substitute for a gap in attendant care services).

5. When the cost of HCBS exceeds 80% of the cost of institutional care:
   a. Contractor Case Managers shall provide written justification of services to their administration for approval, and
   b. Tribal ALTCS Case Managers shall provide written justification of services to the AHCCCS/Division of Fee-for-Service Management (DFSM)/Tribal ALTCS Unit as a request for approval.

6. When the cost of HCBS exceeds 100% of the cost of institutional care, but the cost is expected to drop below 100% within the next six months because of an anticipated change in the member's needs:
   a. A Contractor's administration may approve the HCBS costs. Justification and the approval shall be documented in the case file, and
   b. Tribal ALTCS Case Managers shall provide written justification of services to the DFSM/Tribal ALTCS Unit as a request for approval.

7. If the cost of HCBS is expected to exceed 100% of net institutional cost for more than six months, the Case Manager shall advise the member of the cost effectiveness limitations of the program and discuss other options.
   a. The Case Manager shall either reduce or not initiate any Title XIX service costs in excess of 100%. Contractors or Tribal ALTCS Program may review individual cases with the appropriate AHCCCS unit (DHCM or DFSM) before the decision to deny or reduce services is made. A NOA shall be issued to the member regarding any decision to deny, reduce, limit or terminate requested services.
   b. If the member chooses to remain in their own home even though the Contractor or Tribal ALTCS Program cannot provide all of the services which have been assessed as medically necessary (including those ordered by the member's Primary Care Provider [PCP]), a Managed Risk Agreement/contract should be written. This agreement should document the services that the Contractor or Tribal ALTCS Program can cost effectively provide, the placement/service options offered to the member, the member's choices with regard to those options, the risks associated with potential gaps in service and any plans the member has to address those risks (for example, volunteer services or paying privately for services). The member/Health Care Decision Maker signature on the agreement documents acknowledgement of the service limitations and risks,
   c. The cost of HCBS services that will be retroactively approved during prior period coverage enrollment cannot exceed 100% of the cost of institutionalization for that member, and
   d. The CES shall be updated when there is a change in placement to HCBS or there is a change in services that would potentially place the member's costs at greater than 80% of institutional cost.

8. A CES may be completed indicating "None" for HCBS services needed under the following circumstances:
   a. Members residing in nursing facility who have no potential for HCBS placement (Placement/Reason code: Q/05). Documentation in the member's case notes is required to justify the lack of discharge potential and that the nursing facility is the most appropriate placement,
   b. Members receiving hospice services only (Placement/Reason code: 10). Members receiving other Long Term Care (LTC) services in combination with hospice shall have a CES completed in accordance with other CES policy explained in this section,
   c. Members residing in a nursing facility because the cost of HCBS would exceed 100% of institutional costs (Placement/Reason code: Q/01), or
   d. Members with Acute Care Only status (Placement/Reason code: D/04, D/11 or D/12).

9. CES data shall be entered into the Client Assessment Tracking System (CATS) system within 10 business days of the date the action took place (for example, initial on-site visit to determine service needs, placement changes or significant increase in cost of services). Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS

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website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

a. If the initial CES entered in the CATS system also reflects the assessment of the cost effectiveness of HCBS services provided in the Prior Period Coverage (PPC), a comment to that effect shall be added to the case file or system notes if comments are entered in CATS. If the services entered on the initial CES do not reflect those provided during the PPC, a separate hard copy CES shall be completed to demonstrate that PPC services were cost effective and this CES shall be maintained in the case file.

Refer to the Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management on the AHCCCS website, for information on the codes and procedures for entering CES data into the CATS system (CA160 screen).

10. HCBS that shall be included in the CES:
    a. Adult day health,
    b. Attendant care. In addition, if the member chooses to utilize their spouse as the paid caregiver for these services, the spouse shall not be authorized for more than 40 hours of services in a seven-day period. Refer to AMPM Policy1240 for more information on this limitation,
    c. Habilitation,
    d. Private Duty Nursing,
    e. Home delivered meals,
    f. Homemaker services,
    g. Personal care,
    h. Respite, if provided in a repeated pattern, such as weekly,
    i. Emergency alert systems,
    j. Behavioral health alternative residential settings, and
    k. Alternative HCBS settings

11. Services which are not to be included in a CES include:
    a. Hospice services,
    b. Customized DME items,
    c. Physical, speech, occupational and/or respiratory therapies,
    d. Medical supplies and pharmaceuticals,
    e. Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support),
    f. Home modification,
    g. Community Transition Services,
    h. Member and/or Direct Care Worker (DCW) Training, authorized as part of a member directed service option,
    i. Home Health Nursing/Home Health Aide,
    j. Regularly scheduled medically necessary transportation, and
    k. Behavioral management (behavioral health personal care, family support and peer support).

12. If the member receives ALTCS-covered HCBS, which are paid for by another funding source, including but not limited to Medicare, tribal entities, or private insurance, a CES shall be completed. The CES shall be completed indicating the services received, but with no unit cost paid by the Contractor or AHCCCS/DFSM for Tribal ALTCS members.

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In this example below, can anyone tell me if a CES should have been submitted to AHCCCS for approval, and why?

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ I _______________ CMP - COST-EFFECTIVENESS STUDY               14:10:50
                                                                          LT02L110

CES DATE: 01/01/2021  ASSESS DATE: _________
NAME:                                        AHCCCS ID:
WORKER ID:            CURR CSMGR:            LATEST ACN:

 LOC:    INST GRS COST: $     5434.50 SOC: $      698.90 NET COST: $     4735.60
         HCBS GRS COST: $     3856.64 SOC: $        0.00 NET COST: $     3856.64
SERVICE    UNIT          MONTH 1        MONTH 2        MONTH 3    AVG COST
 CODE MOD  COST    UNITS  COST    UNITS  COST    UNITS  COST       PER MONTH
S5125 __      5.24  744   3898.56  720   3772.80  744   3898.56     3856.64
_____ __ _________ ____ _________ ____ _________ ____ _________ _________
_____ __ _________ ____ _________ ____ _________ ____ _________ _________
_____ __ _________ ____ _________ ____ _________ ____ _________ _________
_____ __ _________ ____ _________ ____ _________ ____ _________ _________
_____ __ _________ ____ _________ ____ _________ ____ _________ _________

                    COMMENTS: N  CUR PLACEMENT: H DATE: 12/08/2017 REASON: 13
HCBS PRCNT :  81%   SSI PRCNT: ____
```

So if you guessed that the HCBS Percentage at 81% would require a >80% CES Overcost Packet be submitted to AHCCCS for approval, you would be correct.

Unfortunately, there was no >80% CES Overcost packet received for this member.

In spot checking several cases we have found that there are several member cases that are appearing just like this, where the HCBS Percentage exceeds 80%, but no >80% CES Overcost Packet was ever received by AHCCCS.

Supervisor's need to be checking their Case Manager's cases to verify that any CA160 CES Overcost that has a percentage of 81%-99% has a >80% CES Overcost Packet submitted to AHCCCS for approval, if it meets the criteria as outlined previously in this training.

This is important, especially when the >80% CES Overcost function is eventually transferred to the Tribal ALTCS Supervisor's to approve.

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In this example below, can anyone tell me what is wrong with it?

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ I _____ CMP - COST-EFFECTIVENESS STUDY                         14:25:34
                                                                          LT02L110

CES DATE: 10/01/2021  ASSESS DATE:
NAME:                                                                 :
WORKER ID:              CURR CSMGR:                                   :

 LOC:    INST GRS COST: $      6926.40 SOC: $       417.20 NET COST: $      6509.20
         HCBS GRS COST: $      4974.51 SOC: $         0.00 NET COST: $      4974.51
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST   UNITS   COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 U4      5.24   896   4695.04  992   5198.08  960   5030.40      4974.51
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________

                  COMMENTS: N  CUR PLACEMENT: H DATE: 11/06/2015 REASON: 13
HCBS PRCNT :   76%  SSI PRCNT: ____
```

Incorrect

So if you look at the CES Date, what was the HCBS Unit Cost on this date? It should have been $5.62 and if recalculated, this CES would be >80% and therefore **would require a CES packet be submitted to AHCCCS for approval**.

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ C _____ CMP - COST-EFFECTIVENESS STUDY                         14:27:38
                                                                          LT02L110

CES DATE: 10/01/2021  ASSESS DATE: _____
NAME:                                                    AHCCCS ID:
WORKER ID:              CURR CSMGR:

 LOC:    INST GRS COST: $      6926.40                          NET COST: $      6509.20
         HCBS GRS COST: $      5335.25 SOC: $         0.00 NET COST: $      5335.25
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST   UNITS   COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 U4      5.62   896   5035.52  992   5575.04  960   5395.20      5335.25
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________
_____ __ _________ ____ _________ ____ _________ ____ _________  _________

                  COMMENTS: N  CUR PLACEMENT: H DATE: 11/06/2015 REASON: 13
HCBS PRCNT :   82%  SSI PRCNT: ____
```

Correct

Policy 1620-C

In this example below, can anyone tell me what is wrong with it?

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ C _____ CMP - COST-EFFECTIVENESS STUDY                         14:49:27
                                                                          LT02L110

CES DATE: 10/01/2021  ASSESS DATE: _
NAME:
WORKER ID:              CURR CSMGR:

 LOC:    INST GRS COST: $     5825.70 SOC: $        0.00 NET COST: $     5825.70
         HCBS GRS COST: $     2748.20 SOC: $        0.00 NET COST: $     2748.20
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST    UNITS  COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 __      4.53   600   2718.00  620   2808.60  600   2718.00      2748.20
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________

                  COMMENTS: N  CUR PLACEMENT: H DATE: 08/10/2021 REASON: 13
HCBS PRCNT :   47%  SSI PRCNT: ____
```

Incorrect

So if you look at the CES Date, what was the HCBS Unit Cost on this date was $5.62 and if recalculated, this CES would not be >80% and therefore would not require a CES packet be submitted to AHCCCS for approval, but it is obviously incorrect and if audited, this would be a ding on the Program.

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ C _____ CMP - COST-EFFECTIVENESS STUDY                         14:54:39
                                                                          LT02L110

CES DATE: 10/01/2021  ASSESS DA
NAME:                                                    S ID:
WORKER ID:              CURR CSMGR                       ACN:

 LOC:    INST GRS COST: $     5825.70 SOC: $        0.00 NET COST: $     5825.70
         HCBS GRS COST: $     3409.47 SOC: $        0.00 NET COST: $     3409.47
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST    UNITS  COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 __      5.62   600   3372.00  620   3484.40  600   3372.00      3409.47
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________

                  COMMENTS: N  CUR PLACEMENT: H DATE: 08/10/2021 REASON: 13
HCBS PRCNT :   59%  SSI PRCNT: ____
```

Correct

Policy 1620-C

In this example below, can anyone tell me what is wrong with it?

```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ C _______________ CMP - COST-EFFECTIVENESS STUDY               16:03:06
                                                                          LT02L110
CES DATE: 10/01/2021  ASSESS DATE: ____
NAME:
WORKER ID:              CURR CSMGR.

 LOC:    INST GRS COST: $     5825.70 SOC: $        0.00 NET COST: $     5825.70
         HCBS GRS COST: $     4918.61 SOC: $        0.00 NET COST: $     4918.61
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST    UNITS  COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 __      5.24    960  5030.40  896   4695.04  960   5030.40      4918.61
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________

                    COMMENTS: Y  CUR PLACEMENT: H DATE: 03/07/2007 REASON: 13
HCBS PRCNT :  84%   SSI PRCNT: ____
```

Incorrect

So based upon the HCBS percentage of 84%, this member should have a >80% CES Overcost Packet submitted to AHCCCS for approval, but nothing was received in AHCCCS.

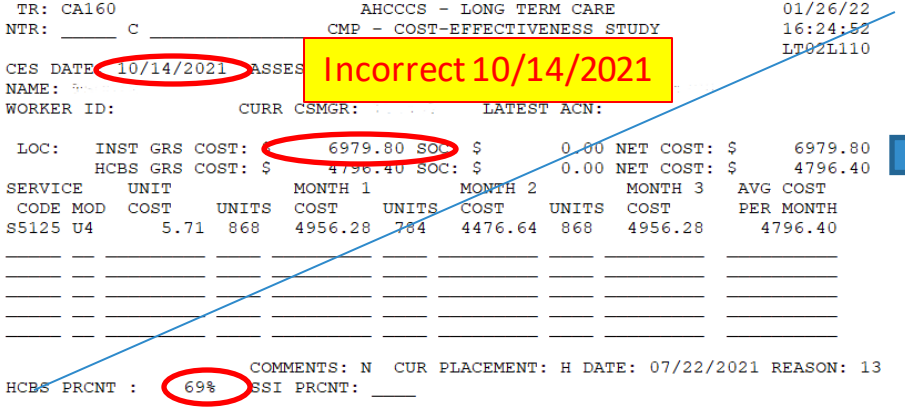
If you look at the CES Date, the HCBS Unit Cost on this date should have been $5.62 and if recalculated, this CES would been even greater than 84%. The HCBS Percentage should have been 91% and would have required a CES packet be submitted to AHCCCS for approval, but again nothing was received in AHCCCS.

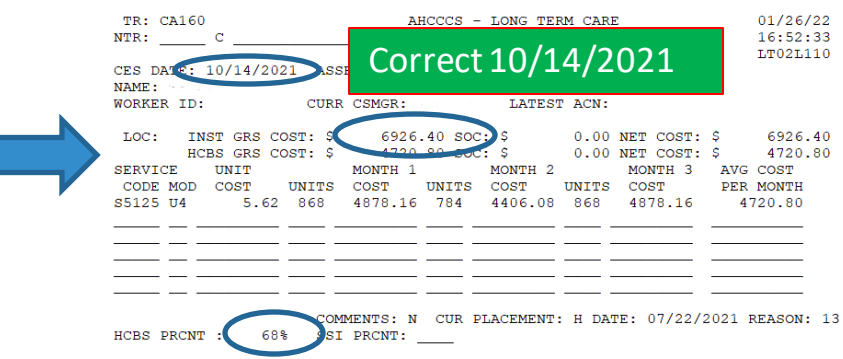
```
 TR: CA160                        AHCCCS - LONG TERM CARE                  01/26/22
NTR: _____ C _______________ CMP - COST-EFFECTIVENESS STUDY               16:06:27
                                                                          LT02L110
CES DATE: 10/01/2021  ASSESS DATE: ____
NAME:
WORKER ID:              CURR CSMGR.

 LOC:    INST GRS COST: $     5825.70 SOC: $        0.00 NET COST: $     5825.70
         HCBS GRS COST: $     5275.31 SOC: $        0.00 NET COST: $     5275.31
SERVICE     UNIT          MONTH 1         MONTH 2         MONTH 3    AVG COST
 CODE MOD   COST    UNITS  COST    UNITS   COST    UNITS   COST       PER MONTH
S5125 __      5.62    960  5395.20  896   5035.52  960   5395.20      5275.31
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________
_____ __ _________ ____ _________ ____ _________ ____ _________ _____________

                    COMMENTS: Y  CUR PLACEMENT: H DATE: 03/07/2007 REASON: 13
HCBS PRCNT :  91%   SSI PRCNT: ____
```

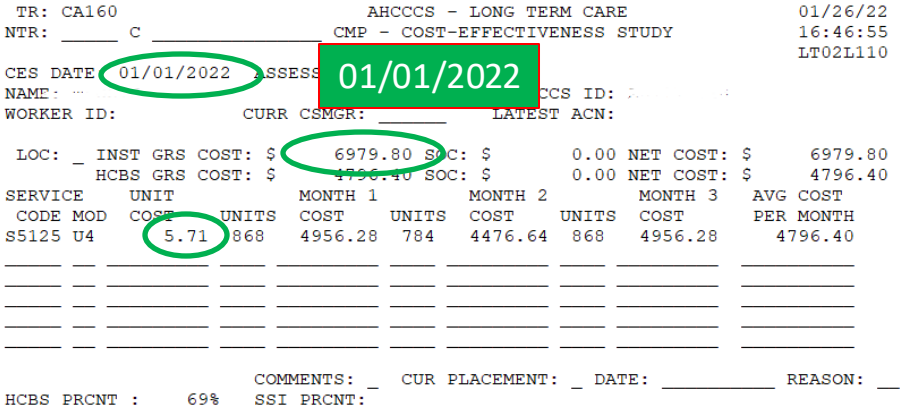
Correct

Policy 1620-C

In this example below, can anyone tell me what is wrong with it?







So the HCBS Unit Cost based upon this CES Date of 10/14/2021 was $5.62. The HCBS Unit Cost did not change to $5.71 until 01/01/2022, therefore this HCBS Unit Cost is incorrect and should have been reflected as $5.62. Also, the Institutional Gross Cost did not change to $6,979.80 until 01/01/2022, therefore this Institutional Gross Cost is incorrect and should have reflected $6,926.40.

Policy 1620-C

ANY QUESTIONS?

THANK YOU!!







Payor of Last Resort

Cheryl Begay, Tribal ALTCS CM Coordinator

AHCCCS
Arizona Health Care Cost Containment System

Payer of Last Resort

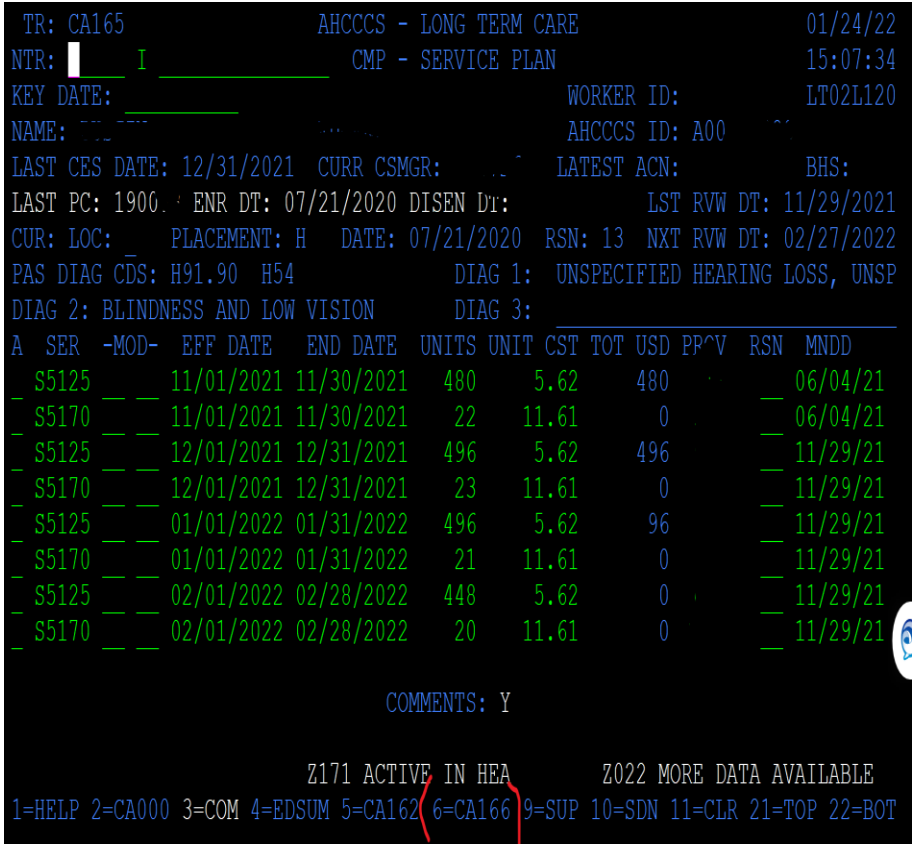
AHCCCS is considered the “Payer of Last Resort” (per A.A.C. R9-22-1003), unless specifically prohibited by federal or state law. AHCCCS shall be used as a source of payment for covered services only after all other sources of payment for covered services have been exhausted per A.R.S. 36-2946.

- NOTE: This means that AHCCCS has liability for payment of benefits after other first and third-party payer benefits have paid on the claim.

Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

IMPORTANT: The claims submitted to AHCCCS **must** exactly match the original claims submitted to the primary payer source.

PMMIS Medical Coverage



Go to CA166, and then press F9 to verify if the member has Medicare (Primary) or Third Party Coverage.

Payer of Last Resort

- **IMPORTANT:** If a member's record indicates the existence of first or third party coverage, but no insurance payment is indicated on the claim (EOB for example) **from that first or third-party coverage source**, **then the claim submitted to AHCCCS Medicaid will deny.**

- When a member has Medicare, first or third-party coverage, and EOB will be required by AHCCCS in order for AHCCCS to process the claim.
  - **This is required even IF the provider knows in advance that the service is not covered by the other payer source and that no payment will be made.** The provider must still submit to the other payer source first to obtain documentation of the valid denial (such as an EOB).

AHCCCS Tribal ALTCS Technical Assistance

- Daily rosters are sent out via email to each Tribal ALTCS program.
- Newly enrolled members will have a PAS Summary attached to the daily roster email.
- The PAS Summary will also include medical conditions with diagnosis codes AND Medical Coverage and Benefits Information from HEAplus.

It is the responsibility of the Tribal ALTCS program staff to know how to look up the medical coverage and benefits information in PMMIS.

Policy 1620-C

ANY QUESTIONS?

THANK YOU!!

Tribal ALTCS Prior Authorization Requests Report

Vanessa Torrez, Tribal ALTCS Nurse

AHCCCS
Arizona Health Care Cost Containment System

DME & HOME MOD
Prior Authorization Request

DME	TOTAL: 1392
DUPLICATE	158
MISSING INFORMATION	154
MULTIPLE MEMBERS	2
NO PA REQUIRED	6
PA APPROVED	1065
PENDED PA	7

HOMEMOD	163
DUPLICATE	11
MISSING INFORMATION	12
PA APPROVED/BID/AWARD LTR	140

ALF & SNF
Prior Authorization Request

ALF BH	495
DUPLICATE	113
MISSING INFORMATION	91
MULTIPLE MEMBERS	6
NO PA REQUIRED	1
PA APPROVED	282
PENDED PA	2

SNF	630
DUPLICATE	90
MISSING INFORMATION	47
NO PA REQUIRED	1
PA APPROVED	492

Policy 1620-C

ANY QUESTIONS?

THANK YOU!!

Tribal Plan Recognitions