330 - ACCESS TO PROFESSIONAL SERVICES INITIATIVE

EFFECTIVE DATE: 10/01/19, 10/01/20[1]

APPROVAL DATE: 01/16/20, 08/05/20, 09/03/20[2]

I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/CMDP (CMDP)[3], DES/DDD (DDD), and RBHA Contractors. The Contractor is responsible for adhering to all requirements as specified in Contract, Policy, 42 CFR Part 457 and 42 CFR Part 438. This Policy establishes requirements for Contractors regarding the Access to Professional Services Initiative (APSI).

II. DEFINITIONS

ACCESS TO PROFESSIONAL SERVICES INITIATIVE (APSI) ELIGIBLE ENCOUNTERS	Fully adjudicated and approved Prospective and Prior Period Coverage (PPC) professional and dental expenses incurred by the Contractor that are subject to the rate increase to designated hospitals for services performed by Qualified Practitioners. APSI Eligible Encounters excludes the following: 1. Subcapitated/block purchase expenses, 2. Encounters where AHCCCS is not the primary payer, and 3. Encounters billed for Long-Acting Reversible Contraceptives (LARC) billed on a 1500 by the hospital using these CPT codes: J7296 - J7298, J7300, J7301, and J7307. 3.4. Encounters for payments made by the Contractor to Federally Qualified Health Centers (FQHCs).[4]

[1] Date changes are effective
[2] Date presented at APC Meeting or without APC review, the date Policy is approved by Assistant Director(s)/Designee
[3] Policy will be applicable to CMDP
[4] Added to clarify the definition of an eligible encounter

AFFILIATION AGREEMENT

1. The practitioner is employed by an organization owned by the designated hospital.
2. The practitioner is employed by an organization that is owned by an organization that also owns the designated hospital and the practitioner is practicing at one of the designated hospitals.
3. There is a contract between a practitioner (or the practitioner's employer) and
   a) The designated hospital,
   b) An organization owned by the designated hospital, or
   c) An organization that is owned by an organization that also owns the designated hospital, that requires the practitioner to provide services exclusively to the designated hospital or the organization that the practitioner (or practitioner's employer) has contract with and the practitioner is practicing at one of the designated hospitals, or
4. There is a contract between the practitioner (or the practitioner's employer) and a hospital whose employed physicians and physicians contracted exclusively at a designated hospital makes up less than 25% of its credentialed medical staff.

DESIGNATED HOSPITALS

1. A hospital facility with an Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching program and which is operated pursuant to the authority in A.R.S. Title 48, Chapter 31; or,
2. A hospital facility with:
   a. An ACGME-accredited teaching program with a state university, and
   b. AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2014; or
3. A freestanding children's hospital or a pediatric unit of a general acute care hospital with greater than 100 licensed pediatric beds, excluding nursery beds.

PREMIUM TAX

The tax imposed pursuant to A.R.S. §36-2905 and §36-2944.01 for all payments made to Contractors for the Contract year.

QUALIFIED PRACTITIONERS

Providers who have a contract with the Contractor, are employed by or have an Affiliation Agreement with one of the Designated Hospitals, and who bill for services under the Tax Identification Numbers (TINs) of the Designated Hospital or an organization that is party to an Affiliation Agreement with Designated Hospitals identified in Section III of this Policy, and include the following practitioners:

1. Physicians, including doctors of medicine and doctors of osteopathic medicine (Provider Types 08 and 31),
2. Certified Registered Nurse Anesthetists (Provider Type 12),
3. Certified Registered Nurse Practitioners (Provider Type 19),
4. Physician Assistants (Provider Type 18),
5. Certified Nurse Midwives (Provider Type 09),
6. Clinical Social Workers (Provider Type 85),
7. Clinical Psychologists (Provider Type 11),
8. Dentists (Provider Type 07),
9. Optometrists (Provider Type 69), and
10. Other Providers that bill under Form Type A (Form 1500) and D (Dental).

III. POLICY

AHCCCS seeks to provide enhanced support to certain Qualified Practitioners who deliver essential services to AHCCCS members and to support Qualified Practitioners who are critical to professional training and education efforts.

APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Contractor's rates for professional services provided by Qualified Practitioners affiliated with Designated Hospitals.

A. GENERAL

1. Designated Hospitals participating in APSI include the following:
   a. Banner University Medical Center Phoenix,
   b. Banner University Medical Center Tucson,
   c. Banner University Medical Center South,
   d. Cardon Children's Medical Center at Banner Desert Medical Center,
   e. Maricopa Medical Center/Valleywise Health Integrated Health System,
   f. Phoenix Children's Hospital,
   g. Dignity Health St. Joseph's Hospital and Medical Center, and
   h. Tucson Medical Center.

   The amount due from or due to the Contractors as a result of this payment methodology is determined on an annual basis and is based on a rate increase of an

annually designated percentage over the contracted rates that will not result in provider payments that will exceed the Average Commercial Rate (ACR).

B. CONTRACTOR RESPONSIBILITIES

1. AHCCCS is removing APSI from capitation rates and Contractors will no longer directly reimburse the APSI increase on a per claim basis. Instead, AHCCCS will make quarterly lump sum directed payments to Contractors as specified in the Section on AHCCCS Responsibilities.

2. Contractors will be responsible for making payments to Designated Hospitals as directed by AHCCCS once funds are received by AHCCCS from public entities in support of the APSI.

3. Contractors will have 15 business days from receipt of funds to pay the Designated Hospitals, less Premium Tax, as directed by AHCCCS.

4. Submitted APSI Eligible Encounters shall indicate if the encounter is eligible to have APSI applied. Technical guidance has and will continue to be provided on how to transmit this information. Contractors will no longer directly reimburse the APSI increase on a per claim basis, but by making payments as directed by AHCCCS.

5. It is the responsibility of the Contractor to have any identified encounter data issues from Designated Hospitals corrected and adjudicated no later than nine months from the end of the Contract year.

6. If the Contractor performs recoupments/refunds/recoveries on any APSI claims, the related encounters shall be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. If the Contractor does not submit the revised encounters within the required timeframe, AHCCCS may recoup the estimated impact on the final payment and reserves the right to impost administrative actions on the Contractor. AHCCCS reserves the right to adjust any previously issued APSI final payment results for the impact of the revised encounters and recoup any amounts due to AHCCCS.

C. AHCCCS RESPONSIBILITIES

1. AHCCCS will communicate the Tax Identification Numbers (TIN)s to Contractors prior to the beginning of the Contract Year End (CYE).

2. AHCCCS will estimate the total dollar amount to be paid to Designated Hospitals by TIN prior to the beginning of the Contract year, based on adjudicated and approved encounters from a prior period.

3. The final payment will be calculated with APSI Eligible Encounters for the Contract year being reconciled, less the estimated payments that were made during the Contract year. Data for the final payment will be extracted no sooner than nine months following the end of the Contract year (e.g. for CYE 20, AHCCCS will extract APSI Eligible Encounters no sooner than the second encounter cycle in June 2021, calculate the percentage increase, and subtract the estimated payments that were previously made). Refer to Attachment A for an example of the final payment calculation.

4. The final payment will be made to Contractors no sooner than eleven months following the end of the Contract year. This will allow for completion of the claims lag and encounter reporting. AHCCCS will provide to the Contractor the data used for the final payment and provide a set time period for review and comment by the Contractor.

   Upon completion of the review period, AHCCCS will evaluate Contractor comments and make any adjustments to the data or final payment as warranted.

5. When making payments to Contractors, AHCCCS will provide a list by TIN reflecting how payments should be made to Designated Hospitals.

6. AHCCCS will make payments to Contractors once all funds are received via Intergovernmental Transfers (IGTs).

7. All payments made to Contractors will include Premium Tax.