



Reinsurance Policy Manual

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General Information

I. Introduction

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services incurred for a member beyond an annual deductible level. The Arizona Health Care Cost Containment System (AHCCCS) is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. This risk-sharing program is available when the provisions delineated in this manual, the AHCCCS Medical Policy Manual (AMPM) and the contract are met. Failure to comply with any of the provisions in the contract, this manual, or other program materials may result in denial of reinsurance reimbursement.

All due dates denote on or before 5:00 p.m. on the due date indicated. If the due date lands on a weekend or State recognized holiday then the due date is the next **business** day on or before 5:00 PM.

II. Purpose & Overview

The purpose of the manual is to provide general information regarding the AHCCCS reinsurance program, including the requirements for eligibility, determination of benefits, and deductible rate.

The primary objective of the manual is to establish consistency and uniformity in the processing of reinsurance. Throughout the manual a toolbox icon (see below) will be displayed which will indicate to the reader when to click on a hyperlink to take the reader to the AHCCCS website for more detailed information for a process. Not every process step can be included in this manual and because of that the Reinsurance Team has prepared several tools to assist in processing reinsurance.



Toolbox Icon

III. Definitions/Acronyms

ACC	A contracted Managed Care Organization (also known as a health plan) that, except in limited circumstances, is responsible for the provision of both physical and behavioral health services to eligible Title XIX/XXI persons enrolled by the administration.
ACC-RBHA	A contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible persons assigned by the administration and provision of comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration.
ACOM	AHCCCS Contractor Operations Manual

ADHS	Arizona Department of Health Services
AHCCCS	Arizona Health Care Cost Containment System
ALTCS	Arizona Long Term Care System
AMPM	AHCCCS Medical Policy Manual provides information regarding covered healthcare services and is available on the AHCCCS website.
BEHAVIORAL HEALTH	Behavioral Health Services means the assessment, diagnosis, or treatment of an individual's behavioral health issue and include services for both mental health and substance abuse conditions.
HIGH COST SPECIALTY DRUGS	A drug that is high dollar per unit cost and low utilization.
BIOLOGIC DRUGS	Biologics is the term used for biological or products produced by biotechnology. These drugs are also referred to as biologicals, biologic drugs, biological drugs, or biopharmaceuticals.
CASE	A record for a member that is comprised of one or more adjudicated encounter(s).
CASE TYPE	A description of the type of reinsurance being paid to the Contractor based on the member's medical condition and eligibility. PMMIS Screen RF776 lists case types.
DCS/CHP	Department of Child Safety Comprehensive Health Plan- A department within the Arizona Department of Child Safety that is responsible for managing the medical needs of foster children in Arizona under A.R.S.§ 8-512.
CLEAN CLAIM STATUS/ CLEAN ENCOUNTER	A claim/encounter that may be processed in PMMIS without obtaining additional information from the provider or Contractor of service or from a third party; and has passed all of the Encounter and Reinsurance edits within the 15-month timely filing deadline. This does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
COINSURANCE	The percentage rate at which AHCCCS will reimburse the Contractor for covered services above the deductible.
CONTRACTOR	An organization or entity that has a prepaid capitated contract with the AHCCCS administration to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statutes and Rules, and Federal law and regulations.
CONTRACT YEAR	The contract year for reinsurance is the twelve-month period beginning on October 1 st through and including September 30 th . The contract year may not correspond with the term of a contract as specified in Section A of an entity's contract with AHCCCS.

CRS	Children's Rehabilitative Services is a designation for Title XIX and Title XXI children in need of medical treatment, rehabilitation, and related support 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.
DBF	Division of Business and Finance
DEDUCTIBLE	The annual amount of reinsurance covered services that must be paid and encountered by a Contractor for each individual member before the Contractor receives reinsurance payments from AHCCCS.
DMC	Division of Managed Care
DOS	Date of Service
ENCOUNTER	A record of health care related service that is a mirror image of a claim and is rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
GAUCHER'S DISEASE	An inherited metabolic disorder in which harmful quantities of a fatty substance called glucocerebroside accumulates in the spleen, liver, bone marrow and, in rare cases, the brain.
GENERAL MENTAL HEALTH (GMH)	A classification of diagnoses that is not Seriously Mentally Ill; these diagnoses are not so severe that people cannot function without intense services and medication(s).
HEMOPHILIA	This is a group of hereditary genetic disorders that impair the body's ability to control blood clotting or coagulation. There are three types of hemophilia - A, B, and C. The severity of hemophilia is related to the amount of clotting factor in the blood.
IMD	Institution for Mental Disease
MM	AHCCCS Medical Management
PPC	Prior Period Coverage is the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor.
PROSPECTIVE	The period of time from when the Contractor receives notification the member has been assigned to their plan and they are prospectively capitated for the member.
PT	Provider Type
RAR	Reinsurance Action Request
RI	Reinsurance
RTC	Residential Treatment Center

**SUBSTANCE ABUSE
(SA)**

Substance Abuse:

As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that:

- a. Alters the individual's behavior or mental functioning;
- b. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
- c. Impairs, reduces, or destroys the individual's social or economic functioning.

SNF

Skilled Nursing Facility: nursing facility for those members who need nursing care 24 hours a day, but who do not require hospital care under the daily direction of a physician.

TITLE XIX MEMBER

Members include those members eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work. The funding source is different from a Title XXI member therefore the payments are accounted for separately by AHCCCS.

TITLE XXI MEMBER

Member eligible to receive services under Title XXI of the Social Security Act. The funding source is different from a Title XIX member therefore the payments are accounted for separately by AHCCCS.

TPL

Third Party Liability

Von WILLEBRAND'S

An inherited blood disorder characterized by prolonged bleeding time. It is the most common hereditary bleeding disorder in humans.

TOOLBOX LINK TO ALL FORMS & INSTRUCTIONS ON AHCCCS WEBSITE



@AHCCCS Website:

<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/>

Chapter One: ACC, ACC-RBHA (SMI Integrated) & DCS/CHP Contractors Regular Reinsurance

I. Eligibility

Regular Reinsurance (RAC case type) is available to partially reimburse the Contractors participating in the ACC, ACC-RBHA (SMI Integrated) Program for covered inpatient hospital services, with limitations, as described in contract, the AMPM, and this manual, when the cost of care for a member exceeds an annual deductible amount. Except as described below, members who are enrolled with an ACC, ACC-RBHA (SMI Integrated) Contractor on a capitated basis and meet the appropriate deductible amount may qualify for Reinsurance reimbursement. Members who are eligible under State Only Transplants do not qualify for RAC. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.



Form Types:

- ❖ Form Type **I or L**

II. Determination of Reinsurance Benefits

Services that are covered under Regular Reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen entitled "RI Covered Services."

When Skilled Nursing Facility services are provided within 30 days following an acute inpatient hospital stay, the per diem cost of a continuous nursing facility stay up to 90 days of service in any contract year shall be eligible for reinsurance coverage. A second admission to a Skilled Nursing Facility in the same contract year is not eligible for reinsurance unless there is an additional Inpatient stay directly preceding the second admission. The total number of nursing facility days eligible for reinsurance shall not exceed 90 days per contract year regardless of whether there is one or multiple post-hospitalization nursing facility admissions.



Services provided at mental health residential treatment centers and subacute facilities are not eligible for reinsurance reimbursement

Provider Types:

- ❖ Subacute: B1, B2, B3, B5, B6
- ❖ Mental Health Residential Treatment Center: 78

Effective with 10/1/18 dates of service, PPC inpatient expenses are covered under the Regular Reinsurance program. Encounters with PPC contract types are eligible for reinsurance. In order to determine whether a claim qualifies for reinsurance reimbursement, AHCCCS evaluates the adjudicated encounters for services that have been provided. The following is a summary (the RI 325 screen in PMMIS provides the details) of the services covered under Regular Reinsurance:

- Inpatient services

Acute Care Facility – PT 02

Inpatient Services provided in an acute care facility. Encounters in which the day of admission and the day of discharge are the same, (referred to as a “same day admit and discharge”) are valued on the outpatient hospital fee schedule and are not eligible for reinsurance coverage. Encounters in which the day of admission and the day of transfer are the same, (referred to as “same day admit and transfer”) are eligible for reinsurance coverage.

- Psychiatric Inpatient Services
Arizona Department of Health Services (ADHS) Facility - PT 71
Inpatient services provided in an accredited psychiatric hospital as licensed by ADHS
- Skilled Nursing Facility Services
Skilled Nursing Facility - PT 22
Skilled Nursing Facility Services provided within thirty (30) days post discharge of an acute care stay, limited to ninety (90) paid days per contract year. The Skilled Nursing Facility stay must be the first continuous Skilled Nursing Facility stay post inpatient discharge, e.g. Inpatient stay ends 1/1 and member is admitted to a Skilled Nursing Facility on 1/14 and discharged on 1/20; a second admission to the Skilled Nursing Facility is not eligible for reinsurance unless there is an additional Inpatient stay preceding the second admission. The Contractor shall submit their Nursing Facility Contracted Rates for Reinsurance at the beginning of every Contract Year. The DAP rates should be incorporated into the submitted rates.
- Specialty Per Diem Facilities – PT C4
Inpatient services provided in Specialty Per Diem Facilities, specifically Long Term Acute Care (LTAC) facilities.
- Care provided in a Medicare certified Institution for Mental Disease (IMD) for individuals under the age of 21 and over 64 years of age.
- Reinsurance covered services are listed in detail on the RI 325 screen in PMMIS.

There can only be one Regular Reinsurance case per AHCCCS enrolled recipient per contract year, per Contractor.

For services or pharmaceuticals, in the instances in which AHCCCS has Specialty Contracts, or legislation and/or policy limits the allowable reimbursement, the amount to be used in the **computation of reinsurance**, will be **the lesser of the AHCCCS contracted/mandated amount or the Contractor paid amount**. Adjudicated encounters for these covered services provided to enrolled members will be used to determine benefits.

I. Regular Reinsurance Deductibles-ACC/ACC-RBHA (SMI Integrated)

AHCCCS is self-insured for the regular reinsurance program which is characterized by an annual deductible level established for each member for the reinsurance contract year which is October 1st through September 30th. The deductible is the responsibility of the Contractor and is subject to change by AHCCCS. Any change in the annual deductible amount would have a corresponding impact on capitation rates.

When a member enrolled with an ACC/RBHA (SMI Integrated) Contractor changes Contractors within a contract year, for reinsurance purposes, all eligible inpatient costs, nursing facility costs and inpatient psychiatric costs incurred for that member do not follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level.

Annual deductible levels apply to all members except for State Only Transplant members.

<i>Reinsurance Case Type</i>	<i>Deductible</i>	<i>Coinsurance</i>
Regular Reinsurance-ACC/ACC-RBHA (SMI Integrated) Contractors	\$150,000	75%
Regular Reinsurance-DCS/CHP Contractor	\$150,000	75%

These deductible levels are subject to change by AHCCCS during the term of this contract. Any change in deductible levels will have a corresponding impact on capitation rates.

Chapter Two: ALTCS Contractors Regular EPD Reinsurance

I. Eligibility

- ❖ LMO = Long-term care Metro w/out Medicare
- ❖ LRO = Long-term care Rural w/out Medicare
- ❖ LMW = Long-term care Metro w/Medicare
- ❖ LRW = Long-term care Rural w/Medicare

Regular ALTCS Reinsurance (LMO, LRO, LMW and LRW case types) is offered to partially reimburse the Contractors participating in the ALTCS Elderly and Physically Disabled Program for covered services as described in contract, the AMPM and this manual, when the cost of care for a member exceeds an annual deductible amount. All members who are enrolled with a Contractor on a capitated basis and meet the appropriate deductible amount may qualify for reinsurance reimbursement. The deductible amounts and coinsurance percentages are detailed in contract. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible.



Form Types:

- ❖ Form Types **I**

LMW or LRW:

- ❖ Member must have Medicare **Part A or Part C**

II. Determination of Benefits

Services that are covered under reinsurance are specified in the AHCCCS Reinsurance System on the RI325 screen entitled "RI Covered Services." Not all AHCCCS covered services are covered by Reinsurance. Long term care services or services usually covered under a facility's room and board charges are excluded from ALTCS Reinsurance benefits.

Effective 10/1/18 AHCCCS will use eligible adjudicated encounters for PPC and prospective inpatient hospital services to determine reinsurance benefits for regular ALTCS reinsurance cases.

If a BIO (Biological/High Cost Specialty Drug) case type was established for the member at the beginning of the Contract Year then the ALTCS case is not automatically created. In these cases, it is necessary for the Contractor to submit a RAR form and the Reinsurance Case Creation form to establish the LMO, LRO, LMW, or LRW case type.

III. Deductibles

The deductible level is based on the Contractors' statewide ALTCS enrollment as of October 1st of each contract year.

When a member with an annual enrollment choice changes Contractors within a contract year, for reinsurance purposes, all eligible inpatient costs, nursing facility costs and inpatient psychiatric costs incurred for that member **do not** follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level.

<i>Statewide Plan Enrollment</i>	<i>Deductible with Medicare Part A</i>	<i>Deductible Without Medicare Part A</i>	<i>Coinsurance</i>
0-1,999	\$150,000	\$150,000	75%
2,000+	\$150,000	\$150,000	75%

These deductible levels are subject to change by AHCCCS during the term of this contract. Any change in deductible levels will have a corresponding impact on capitation rates.

Chapter Three: ALTCS Contractors DDD Regular Reinsurance

I. Eligibility

Regular reinsurance (DES case type) is available to partially reimburse the Contractor participating in the Division of Developmentally Disabled (DDD) Services Program for covered inpatient facility services as described in contract, the AMPM, and this manual, when the cost of care for a member exceeds an annual deductible amount. Except as described below, members who are enrolled with the DDD Contractor on a capitated basis and meet the appropriate deductible amount may qualify for Reinsurance reimbursement. The coinsurance percentage is the rate at which AHCCCS will reimburse the Contractor for covered inpatient facility services incurred above the deductible.



Form Types:

- ❖ Form Types **I**

II. Determination of Benefits

Services that are covered under Regular Reinsurance (DES) are specified in the AHCCCS Reinsurance System on the RI325 screen entitled "RI Covered Services."

III. Deductibles

The deductible level is a set amount of \$150,000.00 established as of October 1st of each contract year with 75% coinsurance.

Chapter Four: Catastrophic Reinsurance

I. Eligibility

Catastrophic reinsurance is available to partially reimburse the Contractor for the cost of care associated with certain medical conditions, specific drugs, and pregnancy terminations and High Cost Behavioral Health, as described below and in the AMPM.

II. Determination of Benefits

For members diagnosed with Hemophilia, von Willebrand's Disease, or Gaucher's Disease, or members receiving one of the covered biological and/ or High-Cost Specialty drugs, Catastrophic reinsurance is requested by submitting a request with medical documentation to the AHCCCS Medical Management (MM) department within 30 calendar days of the identification of the catastrophic case. Contractors' clinical staff must review the medical documentation to ensure the member's condition meets the criteria for catastrophic reinsurance. If criteria is met, the Contractor must submit the Request for Catastrophic Reinsurance to AHCCCS MM within thirty (30) calendar days of:

- (a) Initial diagnosis,
- (b) Enrollment with the Contractor,
- (c) When the Contractor becomes aware of the condition, and
- (d) Beginning of each contract year.

Catastrophic reinsurance will be retrospectively provided for a maximum of 30 calendar days from the date the request is received by AHCCCS MM except for Department of Child Safety (DCS/CHP) and Division of Developmentally Disabled Services (DDD) plans, which will be retrospectively provided a maximum of 45 calendar days from the date the request is received by AHCCCS MM. Catastrophic reinsurance cases for members with Medicare or other coverage can be requested but all claims must be submitted to the other payor(s) first as AHCCCS is the payor of last resort.

III. Catastrophic Reinsurance

<i>Case Type</i>	<i>Deductible</i>	<i>Coinsurance</i>
Hemophilia	\$0	85%
Von Willebrand's	\$0	85%
Gaucher's Disease	\$0	85%
State Only Terminations	\$0	100%
Behavioral Health	\$0	75%

Process for Requesting Reinsurance Case Creation

The Contractor must submit the Request for Catastrophic Reinsurance Form, located on the AHCCCS website, to AHCCCS MM in order to secure catastrophic reinsurance. (See link below)

For newly diagnosed or newly enrolled members to the Contractors, the Contractor must submit the Request for Catastrophic Reinsurance Form and supporting clinical documentation within 30 calendar days of the initial diagnosis or enrollment with the Contractor. An exception is made for Department of Child Safety (DCS/CHP) and Division of Developmentally Disabled Services (DDD) plans, which will have 45 calendar days to submit the Request for Catastrophic Reinsurance Form and supporting clinical documentation from the initial diagnosis or enrollment with the Contractor.

For continuation of previously approved catastrophic reinsurance, the Contractor must submit the request form within 30 calendar days of the start of the contract year. The Contractor must submit the Request for Catastrophic Reinsurance and the Non-Transplant Catastrophic Reinsurance Member list (see link below) to AHCCCS MM as specified in Contract. The Contractor will not need to submit supporting clinical documentation, as AHCCCS MM will use previously submitted documentation.



@AHCCCS Website- Click on Request for Catastrophic Reinsurance:

<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/ Reinsurance Information>

Note – **END DATE:** If the member's AHCCCS eligibility has an end date, then the catastrophic reinsurance will be approved only for the period of eligibility. **The Contractor is responsible for tracking the end date of the case and if the member's eligibility is extended, the Contractor must submit the Request for Catastrophic Reinsurance Form to extend reinsurance. Catastrophic reinsurance will be retrospectively provided for a maximum of 30 days from the**

date the request is received by AHCCCS MM and Department of Child Safety (DCS/CHP) and Division of Developmentally Disabled Services (DDD) plans will have a maximum of 45 days from the date the request is received by AHCCCS MM.

IV. HEMOPHILIA

For members diagnosed with hemophilia, all medically necessary covered services provided during the contract year shall be eligible for reinsurance reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of hemophilia will be used to determine reinsurance reimbursement.

Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia. AHCCCS holds a specialty contract for anti-hemophilic agents and related services for Hemophilia. The Contractor shall exclusively utilize the AHCCCS contract for Hemophilia Factor and Blood Disorders as the authorizing payor. As such, the Contractor will provide prior authorization, care coordination, and reimbursement for all components covered under the Contract for their members. The Contractor will comply with the terms and conditions of the AHCCCS Contract. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower.

V. Von WILLEBRAND'S DISEASE

For members diagnosed with Von Willebrand's Disease, all medically necessary covered services provided during the contract year shall be eligible for reinsurance reimbursement. Adjudicated encounters for services provided to enrolled members with a diagnosis of Von Willebrand's Disease will be used to determine reinsurance reimbursement. Von Willebrand's Disease reinsurance coverage is based on the following:

Von Willebrand's Disease reinsurance coverage is based on the following:

- Type 1 and Type 2A must not respond to desmopressin (DDAVP);
- Type 2B, Type 2M and Type 2N are eligible based on the diagnoses only;
- Type 3 is eligible based on the diagnosis only.

The Contractor must conduct a review of clinical records to determine the member's type of Von Willebrand's Disease and whether the member has responded to a DDAVP medication prior to requesting catastrophic reinsurance.

VI. GAUCHER'S DISEASE

All medically necessary covered services provided during the contract year shall be eligible for reinsurance reimbursement for all members with a diagnosis of Gaucher's Disease Type I. Timely adjudicated encounters for services provided to these enrolled members will be used to determine reinsurance reimbursement.



Members with Gaucher's Disease Type 2 and Type 3 are not eligible for catastrophic reinsurance reimbursement **due to** the limited effect of the enzyme replacement infusions.

VII. BIOLOGICAL/HIGH-COST SPECIALTY DRUGS

Catastrophic reinsurance is available to cover the cost of certain biological and/or High-Cost specialty drugs when determined to be medically necessary.

Catastrophic reinsurance for biological and/ or High-Cost Specialty drug coverage is only available for the actual acquisition costs of the following drugs. See Biologic and High-Cost Specialty Drug List on the Reinsurance page on the AHCCCS website, a link is provided below.

<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/>

A biosimilar is a biological drug approved by the FDA based on a showing that it is highly similar to an FDA-Approved biological drug, known as the brand name reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Many biosimilars for the reference product have been FDA approved as interchangeable with the reference product.

When a biosimilar is FDA approved for a brand name reference drug AHCCCS will determine if the biosimilar is more cost effective than the brand name reference product.

When AHCCCS determines that the biosimilar product is more cost effective than the brand name reference product, AHCCCS will reimburse 85% of biosimilar actual acquisition drug cost and the brand name reference products will be removed from the Reinsurance Biologic and High-Cost Specialty Drug List

If AHCCCS determines that the brand name reference product is more cost effective than the biosimilar product, AHCCCS will continue to reimburse 85% of the actual acquisition cost of the brand name reference product and the biosimilar will not be reimbursed under the reinsurance program.

When AHCCCS has specialty contracts, state plan language, legislation or policies that limit the allowable reimbursement for drugs under the reinsurance program, AHCCCS will reimburse the lesser of the AHCCCS contracted/mandated amount or the Contractor paid amount.

To be eligible for Reinsurance, all Biologic/High-Cost Specialty Drugs must be billed and adjudicated as a pharmacy claim transaction through the MCO's Pharmacy Benefit Manager's (PBM) point of sale system. The MCOs shall submit the adjudicated claims as a Form Type C Encounter to AHCCCS in order to be eligible for reimbursement under the Reinsurance Program.

To determine the actual acquisition cost for reinsurance drugs, the MCO may use the Wholesale Acquisition Cost of the drug or may request the provider submit the manufacturer's or wholesaler's invoice for the drugs listed on the reinsurance list. For some specific drugs, including but not limited to, cell and gene therapies, the Reinsurance Program requires verification of the payment made by the MCO to the provider which can be a screenshot of the Wholesale Acquisition Cost from the PBM's pharmacy claims system or the provider's invoice.

When a member with a High-Cost Specialty (BIO) case is eligible for, or enrolled in Medicare, all High-Cost Specialty drug claims, covered under Reinsurance, must first be submitted to and reimbursed by Medicare as AHCCCS is a secondary payor to Medicare Part B.

Under Medicare, drug claims may be covered under Medicare Part B or Medicare Part D. Many of the drugs covered under Reinsurance could be covered under Medicare Part B or D depending on how the drug is administered to the member.

When a drug is administered at home or self-administered, the drug is not covered under Medicare Part B and should be billed to the member's Medicare Part D plan. In some instances, the Medicare Part D plan may deny the requested drug, in which the member must appeal the decision through Medicare.

When a drug is physician-administered at the office or administered in an infusion center, then the drug, if listed under Medicare Part B, is billed to the Medicare Part B plan. The Medicare Part B plan reimburses the provider 80% of the cost of the drug and AHCCCS and its MCO Contractors

are responsible for up to 20% of the remaining cost. The primary payment from Medicare plus the secondary payment (up to) 20% may not be greater than if AHCCCS had been the primary payer for the entire claim.

Members transitioning to and from different biologics and/or High-Cost specialty drugs or receiving multiple biologics and/or High-Cost specialty drugs must request authorization from AHCCCS Medical Management for each separate drug to receive Reinsurance.

For multiple reinsurance drugs to treat the same medical condition, please refer to the AHCCCS Fee For Service prior authorization criteria to determine if the criterion supports the use of multiple medications given/administered at the same time to an individual.

When the prior authorization criterion is not supportive of the use of multiple drugs to treat the same condition, the reinsurance program will not reimburse multiple medications. For additional questions, please check with the Medical Management staff assigned to the MCO.

Requests for new biological drugs/High-Cost specialty drugs can be submitted to the AHCCCS Reinsurance Unit for consideration for Reinsurance purposes.

VIII. Terminations of Pregnancy Involving State Only Funds

AHCCCS covers pregnancy termination, involving state only funds, if the pregnancy termination is medically necessary according to an assessment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:

- a. Creating a serious physical or mental health problem for the pregnant member
- b. Seriously impairing a bodily function of the pregnant member
- c. Causing dysfunction of a bodily organ or part of the pregnant member
- d. Exacerbating a health problem of the pregnant member, or
- e. Preventing the pregnant member from obtaining treatment for a health problem.

The attending physician must attest that a pregnancy termination has been determined medically necessary by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (see - Attachment C of the AHCCCS Medical Policy Manual, Chapter 400, Policy 410 "Maternity Care Services").



AHCCCS Website

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>

All outpatient medically necessary covered services related to the pregnancy termination, for the date of service only on the day the pregnancy was terminated, will be considered for reinsurance reimbursement at 100% of the lesser of the Contractors paid amount or the AHCCCS Fee Schedule amount. Adjudicated encounters for these covered services provided to enrolled members will be used to determine reinsurance benefits.

IX. High-Cost Behavioral Health

Expenditures for members enrolled in the High Cost Behavioral Health (BEH) Program will also be considered for catastrophic reinsurance reimbursement. BEH reinsurance only applies to members enrolled in the ALTCS program prior to October 1, 2007. Effective October 1, 2007, the High Cost

Behavioral Health Program services were discontinued under catastrophic coverage unless the case was approved prior to October 1, 2007 and the member was active on September 30, 2007.

If the Contractor believes that a member who has been approved for BEH reinsurance continues to require a specialized treatment program and placement, the Contractor must submit a reauthorization request for continued reinsurance reimbursement. The reauthorization request and supporting documentation (described in AMPM 1620-I) must be submitted and received by AHCCCS Integrated System of Care no later than 10 business days prior to the expiration of the current approval. Failure to comply with the 10-business day timeframe or the documentation requirements will result in a denial of additional reinsurance reimbursement.

Authorizations are typically for twelve (12) months but may be authorized for a shorter time period based upon the individual case. The requests must include the supporting documentation as described in AMPM 1620-I.

For ALTCS behavioral health members, medically necessary covered services provided during the contract year may be eligible for reimbursement. Adjudicated encounters for covered services provided to enrolled members with significant behavioral management problems will be used to determine reimbursement. Reinsurance coverage will be based on documentation substantiating the member has been placed in the least restrictive treatment setting to safely manage the member's needs. The Contractor shall submit their Nursing Facility Contracted Rates for Reinsurance at the beginning of every Contract Year.

For additional information refer to AMPM policy 1620-I on the AHCCCS website.

Chapter 5: High Dollar Enhanced Reinsurance Coverage – Cases over \$1,000,000+

For all reinsurance case types **other than transplants**, Contractors will be reimbursed 100% for all medically necessary reinsurance covered expenses provided in a reinsurance contract year, after the reinsurance case total value meets or exceeds \$1 million. The \$1 million figure represents total health plan paid amount including the deductible. Once this level is met, the Contractor must submit a Reinsurance Action Request and CRN Transfer Request via the SFTP, and notify via email, the AHCCCS Reinsurance Supervisor and Reinsurance Analyst to create the following case type:

- Catastrophic Regular Acute (CRA) and/or Catastrophic Hemophilia (CHM), Catastrophic Biological/High-Cost Specialty Drug (CRB) **or**
- Catastrophic ALTCS (CLT) case and receive enhanced reinsurance reimbursement.

Notification must include:

- ☐ Request to create the CRA, CHM, CRB or CLT case **and**
- ☐ List of encounters (in numerical order) that are to be transferred on the Catastrophic Request for CRN Transfer Form to the CRA, CHM, CRB or CLT case.
- ☐ In the event that an individual encounter must be split in order to balance the regular case at \$1,000,000, designate a dollar amount to be transferred to the catastrophic case on the Reinsurance Action Request.

Failure to notify

[1] Failure to notify AHCCCS of a request for another case type **or** [2] Failure to notify the reinsurance unit of encounters that should be transferred **or** [3] Failure to adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters and the other catastrophic case for 100% reimbursement.

Chapter Six: Transplants

I. Overview and Eligibility

Transplant reinsurance coverage is available to partially reimburse Contractors for the cost of care for an enrolled member who meets transplant criteria specified in the AMPM, Chapter 300, Policy 310-DD. 310-DD can be found:



<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/310DD.pdf>

AHCCCS establishes transplant contracts for FFS members and makes the contracts available to its Contractors. Contractors may utilize the AHCCCS contracts but are not required to and may alternatively contract with a transplant facility of their choice. If a Contractor decides not to utilize the AHCCCS transplant contract, AHCCCS will not be involved with negotiated payment rates and contract terms between the provider and the Contractor. When the AHCCCS specialty contract is utilized, the Contractor is the authorizing payer. The Contractor is responsible for prior authorization, care coordination, and reimbursement for all components covered under the contract. A Contractor utilizing the contract must comply with the terms and conditions of the contract. For services that qualify for transplant reinsurance coverage, the Contractor will be reimbursed using the AHCCCS contracted rate for the transplant components. The contracts are not subject to quick pay discounts or interest.

To be eligible for transplant reinsurance reimbursement, the Contractor must notify AHCCCS MM within 30 calendar days of the first component of the transplant utilizing the 'Request for Transplant Reinsurance Form'. Reinsurance will be retroactively provided for a maximum of 30 calendar days from the date the letter was received by AHCCCS MM. Upon receipt of the request from the Contractor, AHCCCS MM will review and activate the transplant reinsurance case.

Note: Individuals who qualify for transplant services, but who are later determined ineligible, due to excess income, may qualify for extended eligibility (refer to State Only Transplants Option 1 and Option 2 in Section IV below).

In addition, Contractors must timely submit clean reinsurance claims (i.e., Transplant Invoice Cover Sheet, UB, HCFA 1500, proof of payment and all other supporting documentation as described in this chapter and or the AMPM) to AHCCCS no later than 15 months from the end date of service for each transplant component to receive reinsurance reimbursement. The submission date is the date of receipt by the AHCCCS Administration, DBF Reinsurance Department.

Failure to comply with either the notification to AHCCCS MM within 30 calendar days of the first component, filing requirement, or the clean claim submission requirement may result in the denial of reinsurance reimbursement.

For all transplant case types, it is critical that Contractors perform timely and complete evaluations to determine whether a particular transplant is medically necessary, is considered the standard of care, and is not considered experimental. If it is determined by AHCCCS that a transplant does not meet criteria for transplant reinsurance coverage, it will **not** be covered under regular reinsurance coverage (previously referred to as "inpatient" reinsurance coverage).

II. Contract Information

The contracted rates are comprised of components (stages) at a fixed price for each component. The Contractor may reference the transplant contract for further details. The contract is available on the AHCCCS website at the following link:



<https://www.azahcccs.gov/Resources/Downloads/Solicitations/Open/RFPs/YH13-0008/YH13-0008TransplantationServices.pdf>

In general, the components are defined as follows:

- Outpatient transplant evaluation
- Donor search and/or harvesting of the donor cells for stem cell transplants
- Preparation and transplant
- Post-transplant care (Days 1 – 30 and Days 31 – 60)

III. Covered Transplants

The AHCCCS Administration, as the single State agency, has the authority under Federal law to determine which transplants, if any, will be reimbursed as covered services for Title XIX adults. As with other AHCCCS-covered services, transplants must be medically necessary, cost effective, and Federally and State reimbursable. Arizona State regulations specifically address transplant services.

However, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program for individuals under age 21 covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions whether or not the transplant is covered by the AHCCCS State Plan.

AHCCCS covers medically necessary transplant services and related immunosuppressant medications in accordance with Federal and State law and regulations. Please refer to the AMPM, Chapter 300, Policy 310-DD and the Specialty Contract for Transplantation Services for a complete list of the AHCCCS covered transplants. The transplant contract rates are updated annually and posted on the AHCCCS web site at:



<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transplantrates.html>

IV. Process for Transplant Reinsurance Case Creation:

The Contractor is responsible for the timely submission of a written request for reinsurance approval of a covered organ or stem cell transplantation. AHCCCS MM will review the submission, consult with the AHCCCS Medical Director as necessary, and inform the Contractor's Medical Director in writing of the approval or denial for transplant reinsurance.

The following steps represent the flow for requesting reinsurance for a transplant case:

- a. The Contractor receives a request for a transplant. The Contractor determines if the transplant type is medically necessary and covered under the AHCCCS State Plan in accordance with the AMPM Chapter 300-Policy 310-DD.
- b. If the Contractor receives a request for transplant that is outside of the AMPM criteria, the Contractor may consult an independent review organization regarding

whether the requested transplant is considered the standard of care and is medically necessary. If the Contractor determines the transplant request should be authorized, the Contractor will inform AHCCCS MM of the pending decision. The Contractor then submits a request for transplant reinsurance approval to AHCCCS MM within thirty (30) days of the initiation of the first transplant component. (See Sample Letter for Request for Transplant Reinsurance located on the AHCCCS website.) The Contractor may initially authorize an evaluation or a search only and the transplant facility may subsequently approve or deny the transplant after completion of the evaluation. The Contractor is not required to send additional notification to AHCCCS MM via a second letter.

- c. If the Contractor denies the transplant based on medical necessity or coverage criteria, the Contractor shall follow the requirements of issuance of a Notices of Adverse Benefits Determinations as outlined in the AHCCCS Contractor Operations Manual (ACOM), Policy 414.
- d. AHCCCS MM will review the transplant request and issue an approval of reinsurance indicating that the case has been approved and activated in the PMMIS system.

Notwithstanding the denial of reinsurance by AHCCCS, the Contractor is responsible for payment of claims for all services approved by the Contractor.



@AHCCCS Website Click on – ‘Request for Transplant Reinsurance Form’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/RequestTransplantReinsurance.doc>

Please refer to the Reinsurance Transplant Case Key Entry Instructions Manual for specific details relating to PMMIS case management.



@AHCCCS Website – ‘Reinsurance Transplant Case Key Entry Instructions’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceTransplantKeyInstructions.pdf>

V. Transplant Claim Reimbursement:

Transplant encounters must be filed with a CN1 code of 09. If encounters are not submitted with a CN1 code of 09, then the encounter will not associate to the case. The Contractor is required to void and replace the encounter with the correct CN1 code if there is more than 45 days before the 15-month timely filing deadline.

If there is less than 45 days, a request may be made to the Reinsurance Analyst to manually associate the CRN's. The Contractor must submit a list of the CRNs by form type and in numerical order that must be transferred on a Reinsurance Action Request Form, prior to the 15-month timely filing deadline. This manual way of associating CRN's can be time consuming for the Analyst and is only to be used as a last resort and should not include all or nearly all of the CRN's for that stage.

Reinsurance payments will be linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounter submissions must agree (the billed charges and health plan paid amounts on the PMMIS RI115 screen must equal the billed charges and health plan paid amounts on the hard copy documents) with supporting transplant stage claims and/or invoices. Pro-rated calculations are to be applied only when tandem transplants occur or when a member changes Health Plans, (Health Plan Id # changes) in the middle of a transplant stage. The calculation is based on the number of days used during the stage.

Transplant Checklist:

- Invoice Coversheet available on the AHCCCS website, link furnished below, and a copy of the invoice from the facility. Each stage must be identified and include the documentation listed below
- Copy of Invoice from Facility
- Stages identified & included in documentation
- Hard copy of Hospital UB
- Copy of all appropriate HCFA 1500's (by DOS) **TOTALED** for reference
- Contractor's PAID AMOUNT clearly identified for each component
- Proof of payment to the Facility
- Payments equal to Facility Claims/Invoices:
 - Transplant Stages
 - Billed Amounts
 - Health Plan paid Amount
- Total Billed Charges (PMMIS RI 115) = Copy of Claims/Invoices
- Health Plan Paid Amounts (PMMIS RI 115) = Copy of Claims/Invoices
- List all by [1] Stage and [2] Form Type :
 - No Pay
 - Non-Allowed
 - Denied
- In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with the transplant facility's related claims and/or invoices. The total billed charges and health plan paid amounts from the PMMIS RI115 screen must agree to the totals on the hard copies of the claims/invoices submitted. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage.

Facility Claims or Invoices

Contractors shall post information to their AHCCCS Reinsurance SFTP folder and submit an email indicating the information has been posted.



@AHCCCS Website – 'Transplant Stage Invoice Cover Sheet'

[Transplant Stage Cover Invoice Sheet](#)

VI. Processing Rules for Transplants that Span Contract Years:

1. The stage rate that is paid to the facility is the rate based on the end date of the stage

2. It is not necessary to split the encounter between the two contract years, however, the stage must be split between the two contract years based on the actual dates within the two contract years.
3. The only exception to number 2 is when a 61+ component exists. If the encounters cross contract years, the stage must be split in order to pay.
4. A Reinsurance Action Request Form must be submitted identifying the encounter (s) with any dates of service that span contract years. AHCCCS staff will associate/transfer the encounter(s) to the case/stage based on the end date of the stage.



@AHCCCS Website Click on – ‘Reinsurance Action Request Form’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceActionRequestForm.doc>

VII. Outlier Threshold Coverage for Transplants:

A transplant case may qualify for outlier coverage when a specified contractual outlier threshold (listed on the transplant rate sheets) is met or exceeded. Only stages adjudicated for payment may be considered for Outlier payment. When submitting a request for outlier consideration the outlier worksheet must accompany the request. The outlier stage in PMMIS is created by Reinsurance Finance. The worksheet is available on the AHCCCS website furnished below. The outpatient evaluation component is not eligible for outlier reimbursement.

Outlier Checklist:

- ❑ Completed Transplant Outlier Worksheet.
- ❑ Copy of mock Outlier UB (should this be the process used) for case dates of service inclusive of the contract year of the transplant case stages currently in PMMIS.
- ❑ Identify the AHCCCS UB CRN.
- ❑ **Outlier claim will reflect a zero pay for the earlier contract year with the Outlier payment reflected on the latest contract year, as reimbursement is based on the end date of the stage.**
- ❑ Reinsurance Action Request identifies the mock UB(s) AHCCCS CRN.
- ❑ All Transplant Stages Invoice Coversheets of adjudicated stages that are part of the Outlier.
- ❑ Proof of payment to the facility.
- ❑ List of all no pay/non allowed and/or non-covered/denied charges totaled by stage and form type.



@AHCCCS Website – ‘Transplant Outlier Template Effective October 1, 2014’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantOutlierForm10-01-2016.xls>

VIII. Claim (Encounter) Documentation and Timeframes for Contracts

In order to be considered for reimbursement, Contractors must timely submit approved/adjudicated transplant claims for each stage of the solid organ transplantation or hematopoietic cellular therapy

with the documentation described below to the DBF Reinsurance Unit. Clean claims must be received and adjudicated no later than 15 months from the end date of service for each particular transplant stage. **In order to be considered a clean claim, the complete set of encounters for the particular stage must be adjudicated and determined payable on or before the 15-month timeframe.** Outlier claim components must be submitted no later than fifteen (15) months from the end date of the last completed stage. Approximately forty-five days are necessary for AHCCCS to complete the adjudication process. Therefore, Contractors are advised to submit the encounter file at least 45 days prior to the 15-month deadline to ensure that the adjudication meets the 15-month timeframe. If the Contractor submits the encounter file to AHCCCS less than 45 days before the 15-month timeframe and the adjudication has not been completed by the 15 month deadline, then the claim will be denied for not having achieved clean claim status within the required timeframe. The timeliness of the claim submission for each stage of the transplant will be based on the submission date for the complete set of encounters related to the stage. For example, if the first stage of a transplant ends on August 15, 2016, the claim for this stage must be received by AHCCCS on or before November 15, 2017. The complete set of encounters must be adjudicated on or before November 15, 2017, which means the encounter file should be submitted to AHCCCS no later than noon on October 9, 2017. **Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage.**

IX. 11/61+ Stay:

When the post-transplant inpatient care is continuous (from the date of the prep and transplant component) and exceeds 10 days for kidney transplants and 60 days for all other case types, the following processing rules apply:

- The claim/encounter for the continuous inpatient stay for day 11+ for kidney and day 61+ for all other case types for all members will be reimbursed at 75% of the transplant per diem rate less the deductible.
- The claim/encounter for the continuous inpatient stay for day 11+ for kidney transplants and day 61+ for all other case types will be eligible for outlier reimbursement (not to be confused with transplant outlier reimbursement) when the cost threshold is met or exceeded.
- All encounters representative of the continuous inpatient stay must be received by AHCCCS prior to adjudication of 11/61+
- Inpatient encounters submitted for an 11/61+ stage that span contract years need to be split.
- Inpatient encounters split due to spanning contract years which qualify for outlier should be priced at the CCR in effect at the end of the contract year for the beginning portion of the stay and the CCR in effect at the end date of the stay for the final portion of the stay.
- A worksheet and the instructions for completing the worksheet are available on the AHCCCS website at the following link:



@AHCCCS Website Click on - 'Day 11+ or 61+ Transplant Component Worksheet/Instructions Example'

https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantComponentWorksheet_InstructionsExample_Effective10-01-2014.xlsx

X. Transportation and Lodging:

Transportation, room, and board are reimbursable to the Contractor at the **AHCCCS allowable rates** for the transplant candidate/recipient, potential donor/donor and, if needed, one adult caregiver.

Transplant transportation reinsurance is only available for the candidate/recipient, potential donor, and if needed one adult caregiver to and from the transplant facility and during the evaluation, donor search, donor harvest, prep and transplant and during the post transplant components. Transportation returning to the transplant facility after the conclusion of the post transplant components is not eligible for reinsurance reimbursement.

The Contractor must submit a request to AHCCCS Reinsurance Finance on the Transplant Transportation Lodging form found at the link below.



@AHCCCS Website – ‘Transplant Transportation Lodging Form’

<https://www.azahcccs.gov/PlansProviders/Downloads/Reinsurance/TransplantTransportationLodgingForm.doc>

Exclusions and Considerations:

- Transplant reinsurance is not available for members who have an alternate payer, e.g., Medicare or TPL.
- Bone grafts and corneal transplants do not qualify for transplant reinsurance coverage.
- Kidney transplants are included within the Contractors capitation rate and do not qualify for transplant reinsurance.
- When the types of services listed in this section do not qualify for transplant reinsurance, they may qualify under the regular reinsurance program (as described in Chapters 2 and 3 of this manual).
- Donor Leukocyte Infusion (DLI) is paid as a second sequence for the harvest only. The only component paid is the donor harvest. If the DLI occurs outside days 1-30 or 31-60, a new case will need to be added for the donor harvest only. DLI using frozen cells are not paid under the Transplant Contract.
- Transplant reinsurance for Circulatory Assist Devices (CADs) including Ventricular Assist Devices (VADs) is only available as bridge to transplant. When the member qualifies for destination therapy, it is covered through the Contractors medical management process and will not be paid under the Transplant Contract. If the CAD or VAD is billed as inpatient as destination therapy, the stay may be eligible for Regular (RAC) Reinsurance if the deductible is met. If at the time of request the member is not a bridge to transplant candidate but it is anticipated the member may be in the future the MCO should notify AHCCCS MM within 30 calendardays of insertion. Reinsurance will be available 90 calendardays retroactively if member becomes a bridge to transplant candidate.
- Total Body Irradiation (TBI) is authorized by AHCCCS MM and billed as a separate case type.
- Effective 10/01/2024, CAR-T Drugs are reinsured under the High-Cost Specialty Drug (BIO) Case type. They must be billed on a Form C to qualify for reinsurance. See Chapter 4 - VII. Biological/High-Cost Specialty Drug for details.
- The billing for pre-transplant hospital stays follows section 31 in Arizona DRG Payment Policies Document found on the AHCCCS website.

<http://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html>

If it is determined by AHCCCS that a transplant, other than the situations listed above, does not meet AHCCCS criteria for the transplant, it will **not** be considered for reinsurance coverage, including regular reinsurance coverage.

XI. Transplants for Members with Medicare:



Don't forget about Medicare

Transplant Reinsurance is not available for members who have Medicare Part A or Medicare Part A and B. Exceptions:

A transplant may be covered under the below circumstances:

- If a member has Medicare Part A and has exhausted their Medicare Part A benefit (including lifetime reserve days) during a transplant stage, only that stage and subsequent stages may qualify for reinsurance. If the stage(s) qualify, any payments received from Medicare coverage will be deducted from the reinsurance reimbursement.
- If a member has Medicare Part B only, the case may qualify for Transplant Reinsurance and any payments received from Medicare coverage will be deducted from the reinsurance reimbursement.
- In instances where a member qualifies for partial transplant coverage, an EOB with Medicare payments is required and must balance with Medicare payments in PMMIS. In addition, if the member has exhausted Medicare Part A, the EOB must have a statement to that effect.
- If Medicare does not cover a transplant type based on the member's diagnoses and the transplant type is an AHCCCS covered benefit, the case will qualify for transplant reinsurance.

Important:

If the member chooses not to use their available lifetime reserve days, the stages **will not qualify for reinsurance reimbursement**.

XII. Multi-Organ Transplants that are not covered in the AHCCCS Specialty Contracts:

AHCCCS MM may authorize cases that overlap when a second transplant component is started for a separate transplant type within the timeframe of an established component. Therefore, if a member requires a multi-organ transplant the following billing rules apply:

AHCCCS reinsurance will cover the preparation and transplant components for each organ (when performed separately), and the post-transplant component that provides the Contractor with the highest reimbursement and covers the longest period of time.

If a second covered organ transplant is performed during the post-transplant periods of the first transplant, AHCCCS will prorate the first transplant component and provide reinsurance reimbursement for the surgical component of the second transplant. This component is followed by the initial day 1-30 post-transplant component and the day 31- 60 post-transplant component. For example: If, on day 15 post-transplant of the first transplant, the determination to conduct the prep and transplant of another organ is made, day 15 ends the component phase of days 1-30 of the first transplant, and 50% of the 1-30 post-transplant component is paid. Day 16 becomes day 1 of the prep and transplant for the second transplant. Remaining transplant components follow. All applicable notification and claims filing requirements apply.

XIII. Multi-sequence transplants:

When a transplant case occurs that requires an additional transplant for the same transplant type (e.g. bone marrow), AHCCCS MM may authorize cases that overlap when an additional transplant sequence is started within the timeframe of an established component. Therefore, if a member requires a second or third sequence transplant the following billing rules apply:

AHCCCS reinsurance will cover the initial transplant until the prep and transplant of the additional sequence occurs. If an additional sequence is performed during the post-transplant periods of the previous transplant, AHCCCS will prorate the transplant component that coincides with the prep and transplant of the following sequence.

For example: If on day 15 post-transplant of the initial sequence, the determination to conduct the prep and transplant of an additional sequence is made, day 15 ends the component phase of days 1-30 of the first initial sequence of the transplant, and 50% of the 1-30 post-transplant component is paid for the initial sequence. Day 16 becomes day 1 of the prep and transplant for the additional sequence of the transplant. All applicable notification and claims filing requirements apply.

Each sequence of a Transplant is subject to its own outlier. The Donor and Harvest stages, if included in the outlier per contract can only be included in the sequence 1 outlier.

XIV. Non-Contracted Facilities or Non-Contracted Transplant Types

To qualify for reinsurance, AHCCCS must review and approve all requests for services at non-contracted transplant facilities or non-contracted transplant types prior to the commencement of services. If a Contractor intends to use a non-contracted transplant facility for a covered transplant and AHCCCS already holds a contract for that transplant type, or a non-contracted transplant type at a contracted transplant facility, the Contractor must obtain prior approval from the AHCCCS Medical Director. **If prior approval is not obtained, and the Contractor incurs costs at a non-contracted facility or a non-contracted transplant type, those costs will not be eligible for either transplant or regular reinsurance. In addition, those costs will be excluded from any applicable reconciliation calculations.** An approved transplant performed at a non-contracted facility will be reimbursed at 85% of the lesser of 1) the AHCCCS transplant contracted rate for the same organ or tissue, if available, or 2) the health plan paid amount. Depending on the unique circumstances of each approved non-contracted transplant, AHCCCS Reinsurance unit may consider, on a case-by-case basis, reinsurance coverage at 85% of the Contractor's paid amount for comparable case/component rates.

XV. Split Stages when Contractor enrollment changes

When an AHCCCS transplant recipient changes contractors during a transplant stage the contracted facility must split the stage charges accordingly and pro-rate the transplant contracted stage amount to the two separate Contractors. This would also be the necessary process for the outlier should that provision be allowed by contract as the outlier stage is a total of all services during the transplant dates of service. The Contractors will be responsible for setting up the stages in PMMIS for the appropriate dates of service they are responsible for. See AMPM Policy 520 for Contractor responsibilities related to AHCCCS MM notification and care coordination.

Example

Heart
Billed Charges eligible for Outlier consideration
Total billed charges (TBC)

Contractor XYZ

HRT02 PREP AND TRANSPLANT TBC \$200,000.00

HRT10 OUTLIER Stage is 40% of eligible Outlier TBC

40 % of Outlier would be billed to Contractor XYZ

Contractor ZYX

HRT03 FOLLOW UP CARE 1-30 TBC \$100,000.00

HRT04 FOLLOW UP CARE 31-60 TBC \$200,000.00

TOTAL OF ALL BILLED CHARGES \$500,000.00

HRT10 OUTLIER Stage is 60% of eligible Outlier TBC

60% of Outlier would be billed to Contractor ZYX

Chapter Seven: Transplant Extended Eligibility, State Only Transplants

Transplant Extended Eligibility -Option 1 and Option 2: Individuals approved for transplant and **on the transplant waiting list** who subsequently lose eligibility may be eligible for one of two eligibility options. Extended eligibility is authorized only for members who have met all the following conditions:

- 1) The individual has been determined ineligible due to excess income,
- 2) The individual was on the transplant waitlist before AHCCCS eligibility expired, and
- 3) The individual entered a contractual arrangement with the transplant facility to pay the amount of income, which is in excess of the eligibility income standards (referred to as transplant share of cost).

Reinsurance coverage for State Only Option 1 and Option 2 members (as described in Section D, Paragraph 2, Eligibility Categories) for transplants received at an AHCCCS contracted facility is paid at the lesser of 1) 100% of the AHCCCS contract amount for the transplantation services rendered, less the transplant share of cost; or 2) 100% of the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplant services rendered less the transplant share of cost, or the Contractor paid amount, less the transplant share of cost. All Option 1 and Option 2 transplants are subject to the terms regarding out of State transplants set forth above and in the AHCCCS Reinsurance Policy Manual. The AHCCCS contracted transplant rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS-covered organ transplant under Option 1 or 2, the Contractor shall notify AHCCCS MM as specified in the AMPM Chapter 300, Policy 310 Attachments A.

Option 1: Extended eligibility is for one twelve-month continuous period of time. During that time, the member is eligible for all AHCCCS covered services as long as they continue to remain on the transplant waiting list. All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters. The member must be enrolled under Rate Code 3100 or 310Z for the Option 1 Case to be created. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.

Option 2: Extended eligibility covers transplant services only. At the time that the transplant is scheduled to be performed, the transplant candidate will reapply and will be re-enrolled with her/her previous Contractor to receive all covered transplant services. The Member must be enrolled under Rate Code 3200 or 320Z.

Refer to AMPM Policy 310-DD Attachment A for additional information.

Chapter Eight: Processing Encounters:

Encounter Submission

Contractors are reimbursed for reinsurance claims by submitting encounters that associate to a reinsurance case. All reinsurance associated encounters except as provided below for “Disputed Matters”, must reach an adjudicated/approved status within fifteen months from the end date of service, or date of eligibility posting, whichever is later. Encounters should never be manually replaced or voided during the Reinsurance Payment Cycle which runs from the evening of the first Wednesday of the month until the morning of the second Wednesday of the month. Contractors voiding or replacing encounters during the Reinsurance Payment Cycle may be subject to Administrative Action per ACOM 408.

I. Voids

When a void encounter is submitted for a previously paid associated Reinsurance encounter, the reinsurance payment related to the voided encounter will be recouped.

II. Replacements

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is less than the original health plan paid amount, the difference will be recouped.

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is greater than the original health plan paid amount, the additional amount will be paid **if** the replacement encounter was adjudicated **and** reached approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later.

❖ Replacement Encounter

- ☐ Timely submission
- ☐ Health Plan Paid amount is greater than on the original Health Plan Paid amount
- ☐ Replacement encounter was Adjudicated - **AND** -
- ☐ Replacement encounter reached Approved Status (CLM STAT 31)

Result→ Any additional reinsurance payment due will be paid.

When a replacement encounter is submitted timely for a previously paid associated Reinsurance encounter and the replaced health plan paid amount is greater than the original health plan paid amount, but the replacement encounter was not adjudicated **and** did not reach approved status (CLM STAT 31) within 15 months from end date of service, or date of eligibility posting, whichever is later within the same encounter cycle, then the original health plan paid amount will be recouped.

❖ Replacement Encounter

- ☐ Timely submission
- ☐ Health Plan Paid amount is greater than on the original Health Plan Paid amount
- ☐ Replacement encounter was not Adjudicated - **AND** -
- ☐ Replacement encounter did not reach Approved Status (CLM STAT 31)

☐ Within the SAME ENCOUNTER CYCLE

→
Result Original Health Plan Paid Amount will be recouped.

When a replacement encounter is **not** submitted timely, **and** does **not** adjudicate to encounter approved status (CLM STAT 31) within 15 months from the end date of service, or date of eligibility posting, whichever is later, within the same encounter cycle it was submitted, and any of the following scenarios occur:

- 1) the original encounter was never associated to a Reinsurance case;
- 2) the original encounter associated to a Reinsurance case but never reached pay status (PY);
- 3) the original encounter has a previous reinsurance paid amount of zero (\$0.00),

THEN the replacement encounter will be subject to the reinsurance timely filing limit edits H583 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER END DOS or H584 REINSURANCE CLAIM RECEIVED MORE THAN 15 MONTHS AFTER ELIG POSTING.

❖ Replacement Encounter

- ☐ Not submitted Timely
- ☐ Replacement encounter did not Adjudicate - **AND** -
- ☐ Replacement encounter did not reach Approved Status (CLM STAT 31)
- ☐ Within the SAME ENCOUNTER CYCLE
- ☐ Original encounter (encounter identified on the 837 & NCPDP)
Never associated to the case -**OR**-
- ☐ Original encounter (encounter identified on the 837 & NCPDP)
Never reached "PY" -**OR**-
- ☐ Original encounter (encounter identified on the 837 & NCPDP)
Reinsurance Paid Amount = \$0.

→
Result Replacement encounter will be subject to:
 [1] Timely Filing Edits
 Edit H583 -or- Edit H584

❖ Replacement Encounter

- ☐ Not submitted Timely
- ☐ Replacement encounter did not Adjudicate - **AND** -
- ☐ Replacement encounter did not reach Approved Status (CLM STAT 31)
- ☐ Within the SAME ENCOUNTER CYCLE
- ☐ Original encounter (encounter identified on the 837 & NCPDP)
Reinsurance Paid Amount > \$0.

Result → Original Health Plan Paid Amount will be recouped



When it comes to the topic of Replacement Encounters it is a TWO-STEP Process!

- First step
The Original Health Plan Paid Amount will be RECOUPED. -**THEN**-
- Second step
The Replacement Encounter transaction/process

III. New Day

When a new encounter (not a replacement encounter) is submitted for a previously voided encounter, the new encounter is considered a “new day” encounter and subject to the timely filing rules (stated above) when associated to a reinsurance case (i.e. the Reinsurance system will recoup all reinsurance payments made related to the voided encounter. The reinsurance system will then calculate the timely filing limits on the new day encounter of 15 months from end date of service or date of eligibility posting whichever is later, regardless of when the original encounter was adjudicated).

Chapter Nine: Coordination of Benefits and Third-Party Payments

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. 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 coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 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 party.

The two methods used in the 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.

Contractors are required to notify AHCCCS or its authorized representative, within ten (10) business days of the identification of a 1st or 3rd party liability case with known Reinsurance. Failure to comply with the notification requirements may result in those sanctions specified in contract. Should AHCCCS or its authorized representative identify third party recovery payments received by the Contractors that do not comply with the notification requirements in this section the following actions shall occur:

- A. For open cases, AHCCCS shall reimburse itself 100% percent of any duplicate payments by adjusting the Reinsurance case. An administrative fee of 15 percent of the duplicate payments may be added to the adjustment.
- B. For closed cases, AHCCCS or its authorized representative shall bill the Contractor directly for 100% percent of the duplicate payments. An administrative fee equal to the current TPL Contractor's contingency fee schedule shall be added to the billing.

All Medicare and Third-Party payers' should be billed and the encounter adjudicated through the Contractor's system prior to submission to AHCCCS. In addition, the Medicare Allowed, Medicare Paid, Third Party Payments and Value Code fields, as applicable, must be completed when the encounter is submitted for Reinsurance consideration.

Chapter Ten: Time Limits for Filing Reinsurance Claims

A claim for reinsurance may be filed for any encounter of an AHCCCS reinsurance covered service. In order to qualify for reinsurance consideration, the reinsurance claim must be filed and must reach clean claim status within the submission timeframes described below. An inpatient reinsurance claim consists of valid encounter(s) containing the information specified in this manual, policy, and contract.

Reinsurance claims for regular reinsurance cases are created automatically by PMMIS once the encounter reaches an adjudicated status through the Encounter System. For all other types of reinsurance claims, however, the Contractor must file a **written** request for reinsurance

consideration with the AHCCCS MM, or the DBF Reinsurance Unit within the required timeframes as described in this manual, policy and contract.

Claims for reinsurance must be submitted to AHCCCS and must attain a clean status no later than fifteen (15) months from the end date of service.

Exceptions:

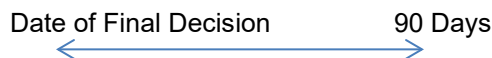
- **Retro Eligibility Encounters**
An exception for claims submission will be made for retro eligibility encounters; the claim for reinsurance must be submitted to the AHCCCS Administration and must attain a clean claim status no later than fifteen (15) months from the **date of eligibility posting**.



- **Transplant Encounters**
For transplant reinsurance claims, refer to Transplant reinsurance claims must be submitted in clean claim status no later than 15 months from the end date of the particular transplant stage.



- **Exception from 15-month timeframe**
For encounters which are the subject of a member appeal, provider claim dispute, grievance or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the greater of: 1) 90 days from the **date of the final decision in that proceeding/action** or 2) 15 months from the end date of service/date of eligibility posting to file the reinsurance claim **AND** for the reinsurance claim to **reach adjudicated/approved status**. Therefore, reinsurance encounters for disputed matters will be considered timely if **both the decision letter is received and the encounters reach adjudicated/approved status no later than 90 days from the date of the final decision in that proceeding/action even though the 15 month deadline has expired.**



Note that an adjudicated/approved claim/encounter is one that has passed all of the Encounter and Reinsurance edits and that can be processed without obtaining additional information from the provider of service, the Contractor, or from a third party. This **does not include** claims under investigation for fraud or abuse or claims under review for medical necessity. With respect to hospital/long term care encounters, "date of service" means the date of discharge.

Chapter Eleven: Reimbursement

AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages. Covered amounts in excess of the deductible level shall be reimbursed based upon costs paid by the Contractor, net of interest, penalties, discounts and coinsurance, unless the costs are paid under a sub-capitated arrangement.

In sub-capitated arrangements AHCCCS shall base reimbursement of Reinsurance encounters on the lower of the AHCCCS allowed amount or the reported Health Plan paid amount, net of interest, penalties, discounts and coinsurance. Reimbursement for Regular Reinsurance benefits will be made once each month, subject to the availability of funds.

AHCCCS Reinsurance must be notified of any Reinsurance over payments.



Any final claims which cross over contract years will not be eligible for regular reinsurance.

AHCCCS will not pay regular reinsurance on interim claims. The **final claim** submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the **hospital stay do not cross contract years**.

Effective 10/1/18, AHCCCS will pay reinsurance on claims containing any Prior Period Coverage (PPC) and Prospective Coverage for regular and catastrophic reinsurance types.

Transplant Days 11+/61+ paid at the per diem rate are not subject to the transplant outlier (prep and transplant through day 60) but are subject to outlier pursuant to the transplant Specialty Contract at an established cost threshold. See the Day 11+/61+ Outlier Worksheet and Instructions located on the AHCCCS website.



The fact that an encounter has been approved and adjudicated is separate to whether the encounter qualifies for payment under reinsurance. To qualify for reimbursement under the Reinsurance Program, the encounter must independently meet all criteria, including but not limited to, medical necessity of the service, cost effectiveness of the service, non-experimental nature of the service, dollar thresholds etc.

Contractors shall post Reinsurance Action Requests and other Reinsurance related documentation to their AHCCCS Reinsurance SFTP folder and submit an email indicating the information has been posted.

Let's Talk Medicare

❖ Medicare Calculations –

The Reinsurance system DOES NOT calculate the Medicare fields on the Encounter or 837. The data on the 837 is translated in the Encounter system. The Reinsurance data is populated and mapped from the fields in the Encounter system. **If**, there are issues regarding how the Contractor submits Medicare amounts on the 837 and its translation to the Encounter then the Contractor must address these issues with the AHCCCS Encounter Unit.

❖ PMMIS' view of Medicare –

The Encounter System categorizes Medicare as the type of Medicare appropriate for the stay.

Meaning, if the Encounter is Form type I then the Encounter System reads the Medicare Field as Medicare Pt A dollars. If the Encounter is Form type A then the Encounter System reads the Medicare Field as Medicare Pt B dollars.

Scenario Examples:

- If the member has only Medicare Pt B and the encounter is for an inpatient stay, then on the encounter the Medicare Pt B dollars should be placed under Other Coverage.

- If the member has only Medicare Pt B and the encounter is for a doctor visit, then on the encounter the Medicare Pt B dollars should be placed under Medicare Coverage

Form Type	Type of Medicare	Field on Encounter
I	Medicare Pt A	Medicare
	Medicare Pt B	Other Insurance
A	Medicare Pt A	Does Not Apply
	Medicare Pt B	Medicare
O	Medicare Pt A	Does Not Apply
	Medicare Pt B	Medicare

❖ Medicare Lesser of Logic –

- The Medicare copay, coinsurance or deductible, **or**
- The difference between the Contractor's contracted rate and the Medicare paid amount.



@AHCCCS Website:

<http://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/200/201.pdf>

❖ Edit A510 –
Medicare Deductible and Coinsurance Exceeds Allowed Amount

- Reinsurance Internal Pend –

Medicare Deductible Amount
+ Medicare Coinsurance
Amount > AHCCCS Allowed Amount

Approval/Denial of CRN is the decision of the Reinsurance Compliance Auditor.

Chapter Twelve: Reinsurance Review

On an annual basis, each MCO must provide documentation for Reinsurance Auditor review demonstrating compliance with acceptable policies and standards outlined in the Reinsurance Policy Manual, and as described in the Reinsurance Review template as posted on the AHCCCS website in the following location:

<https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/>

MCO's are required to complete the Reinsurance Review template for submission with the required documentation as outlined in the Contract Section F, Attachment F3, Contractor Chart of Deliverables.

ACC and CHP MCO reinsurance review will be due in January of the calendar year, ACC RBHA is due in June, and DDD and EPD MCOs will be due in September of the calendar year.

Chapter Thirteen: Claim Dispute/Hearing Director's Decisions

Encounters for reinsurance claims that have passed the fifteen month deadline and are being adjusted due to a grievance or appeal decision must be submitted and pass all encounter and reinsurance edits within 90 calendar days of the date of the final claim dispute decision or hearing decision, or Director's decision, or other legal action/proceeding whichever is applicable. Failure to submit the encounter and the decision documentation within this timeframe will result in the loss of any related reinsurance dollars. MCO's should make every attempt to settle claims disputes with providers in a timely manner. In circumstances where a claims dispute extends longer than a contract year, MCO's should report this information to the Reinsurance Supervisor along with the dollar amount in dispute.

Chapter Fourteen: Administrative Dispute Process

Contractors must follow the AHCCCS reinsurance submission processes described in contract, policy and this manual in order for encounters to be reviewed for potential reinsurance payment. If a Contractor has exhausted the reinsurance refiling/reconsideration processes and still disagrees with an action taken regarding a reinsurance claim, the Contractor may file an administrative dispute concerning the payment, denial, or recoupment of a reinsurance claim.

In order for the administrative dispute to be considered by the AHCCCS Administration, the administrative dispute must be **TIMELY** filed by the Contractor. To be timely filed, the administrative dispute must be **RECEIVED** by the AHCCCS Administration no later than 60 days from the remit associated with the Reinsurance Case Summary Report containing the original payment, denial, or recoupment of a timely submitted reinsurance claim. Detailed information regarding the individual reinsurance claims may be found in the monthly Reinsurance Case Summary Report which is received by Contractors in advance of the remit.

All administrative disputes must be in writing and must state the factual and legal basis explaining why the Contractor believes the payment, denial, or recoupment to be incorrect. All administrative disputes must be directed to:

AHCCCS Administration
AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P. O. Box 25520
Phoenix, AZ, 85002

In order for a service and the corresponding encounters to qualify for reinsurance coverage, the service must independently meet criteria for coverage of reinsurance based on consideration of **all** relevant information and documentation. A Hearing Decision which determines that a Contractor must reimburse a particular medical service does not, in and of itself, establish that the service qualifies for reinsurance coverage, under catastrophic, behavioral health, transplant or regular inpatient reinsurance. Hearing Decisions are based on evidence from the official hearing record which may be limited depending upon the evidence presented by the parties. In contrast, reinsurance coverage determinations are based on evaluation of **all** pertinent information and data, whether or not the information was presented at a hearing. Contractors are prohibited from

recouping monies paid to providers for services authorized by the Contractor but which have been subsequently denied reinsurance coverage by AHCCCS. Also, Contractors are prohibited from recouping monies paid to providers for services authorized by the Contractor but which have been subsequently denied reinsurance coverage by AHCCCS.

Quick Reference

CN1 Indicator Crosswalk to Sub Cap Codes			
CN1	DEFINITION	SUB CAP	DESCRIPTION
Blank		00	- No sub-capitated payment arrangement - Services: fee-for-service basis. (FFS) - Subscriber Exception code is 25 (PMMIS Screen Ri320), - Sub-Cap code is 05.
01	DRG	00	- Full sub-capitation arrangement - Services: Fully sub-capitated contractual arrangement. - Subscriber exception code is 25 (PMMIS Screen Ri320) - Sub-Cap code is 05.
02	Per Diem	00	- Full Sub-Capitation arrangement - Services: Fully Sub-Capitated contractual arrangement. - Subscriber exception code is 25 (PMMIS Screen Ri320) - Sub-Cap code is 05.
03	Variable Per Diem	00	- Full Sub-Capitation arrangement - Services: Fully Sub-Capitated contractual arrangement - Subscriber Exception code is 25 (PMMIS Screen Ri320), - Sub-Cap code is 05.
04	Flat	00	- Full Sub-Capitation arrangement - Services: Fully Sub-Capitated contractual arrangement. - Subscriber exception code is 25 (PMMIS Screen Ri320) - Sub-Cap code is 05.
05	Capitated	01	- Full Sub-Capitation arrangement - Services: Fully Sub-Capitated contractual arrangement. - Subscriber Exception code is 25 (PMMIS Screen Ri320), - Sub-Cap code is 05.
06	Percent	00	- Partial Sub-Capitation arrangement - Services: Sub-Capitated provider that's excluded from the Sub-Capitated payment arrangement. - Subscriber exception code is 25 (PMMIS Screen Ri320) - Sub-Cap code is 05.
09	Other	08	- Negotiated settlement - Services: Negotiated settlement, for example-grievance settlement - Subscriber exception code is not 25 (PMMIS Screen Ri320)
09	Other	04	- Contracted Transplant Service - Services paid via catastrophic reinsurance - Subscriber exception code is 25 (PMMIS Screen Ri320)
	Identified by Filename	06	Denied claim used to report valid AHCCCS services that are denied. For example, if a claim was denied for untimely submission.

Summary of Reinsurance Coverage

Case Type	Deductible	Co-ins
RAC-Acute Contractors	\$150,000	75%
RAC-DCS/CHP Contractor	\$150,000	75%
Catastrophic –Biologics/ High Cost Specialty Drug	n/a	85%
Transplant	n/a	85%
Other-High\$ Enhanced	n/a	100%
Hemophilia	n/a	85%
Von Willebrand's	n/a	85%
Gaucher's	n/a	85%
State Only Termination	n/a	100%
DES – DDD	\$150,000	75%
RAC-ALTCS – EPD MC PT.A 0-1,999	\$150,000	75%
RAC-ALTCS – EPD MC PT.A 2,000+	\$150,000	75%
RAC-ALTCS – EPD No PT.A 0-1,999	\$150,000	75%
RAC-ALTCS – EPD No PT.A 2,000+	\$150,000	75%

Reinsurance Contract Year	Contract Year Ending
CY38	10/01/19 – 9/30/20
CY39	10/01/20 – 9/30/21
CY40	10/01/21 – 9/30/22
CY41	10/01/2022 -09/30/23
CY42	10/01/2023 - 09/30/24
CY43	10/01/2024 – 09/30/2025
CY44	10/01/2025 - 09/30/2026

Reinsurance Reports

The following reports (available in comma delimited format or report text format) are available via the AHCCCS FTP Server for Contractors' use and reference:

RI91L205 - Reinsurance Pend Report

This report is a summary of case information for all active cases that have pending reinsurance encounters during that reporting period. It lists the edit codes, edit descriptions, and edit counts.

RI81L310 - Reinsurance Remittance Advice Report

This report is generated after the monthly reinsurance payment cycle, and is summary of all financial activity applied to only those cases that were included in the payment cycle. Financial activity and reinsurance encounters detailed on the Reinsurance Remittance Advice includes payments, replacements, voids, recoupments and denials.

RI91L105 - Reinsurance Case Summary Report

This report is a summary of case information for all active cases during the monthly reinsurance cycle and lists the status of all reinsurance encounters associated to each reinsurance case. Also included are the case level totals for the allowed amount, liability, deductible, premium tax paid and total paid.

RI91L100 - Reinsurance Case Initiation Report

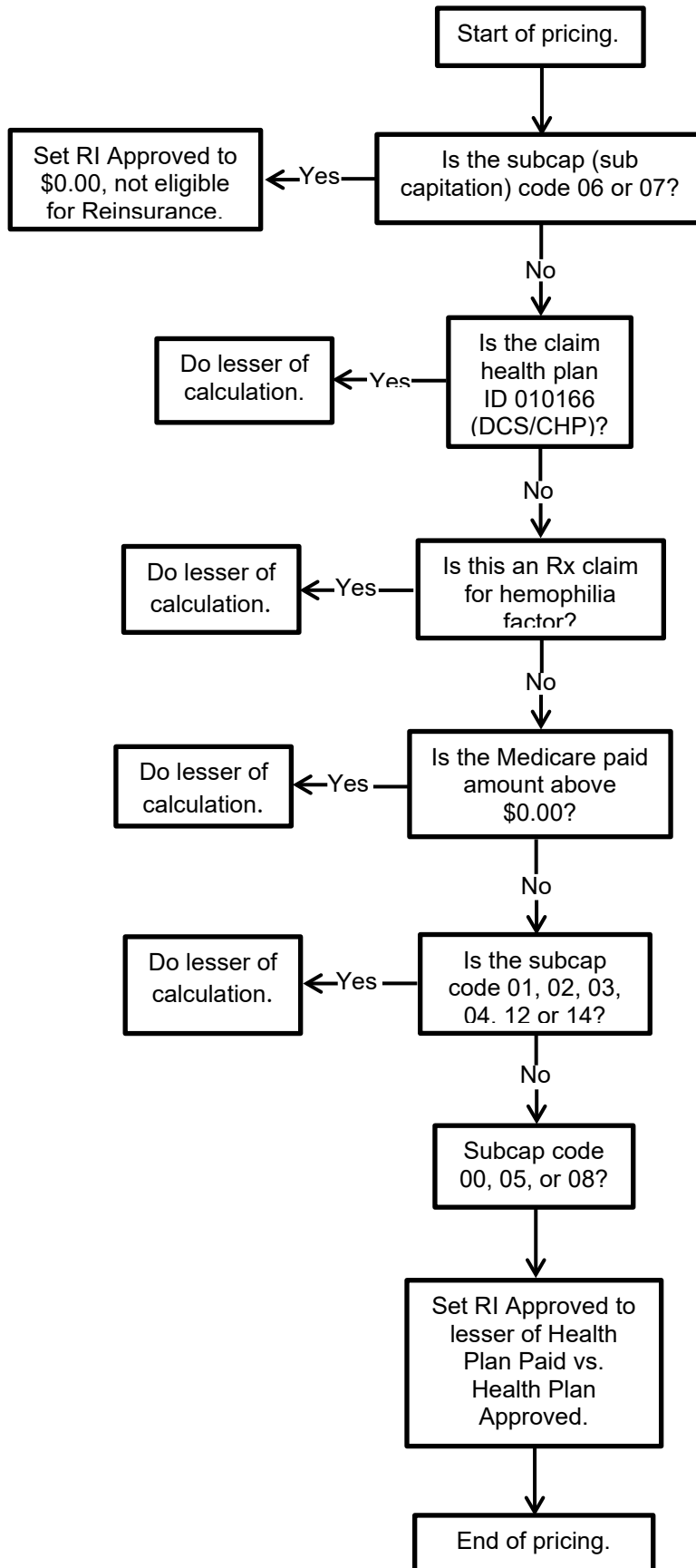
This report is a summary of case information created during the previous month's encounters associated to the cases created in the reporting period.

RI91L315 - Reinsurance Case Reconciliation Report

This report is a summary of case information with a detailed listing of encounters that potentially apply to an active reinsurance case but have not been associated to the case due to pend errors. Also included are those encounters in the edit/audit process to enable reconciliation of the encounter records with the reinsurance records.

❖ Pricing & Lesser of Logic Flowchart

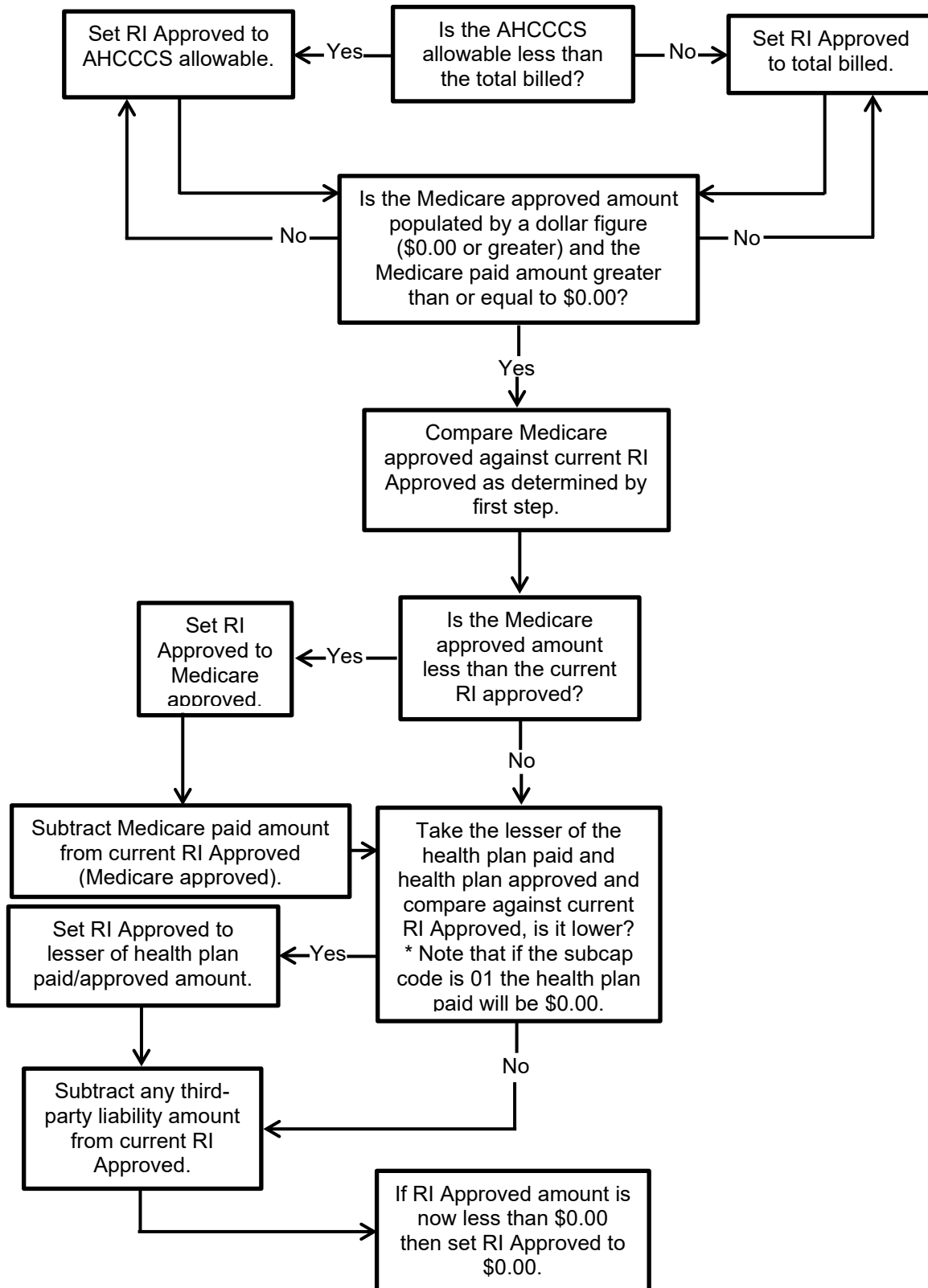
-Determining the Reinsurance Approved Amount (Pricing)



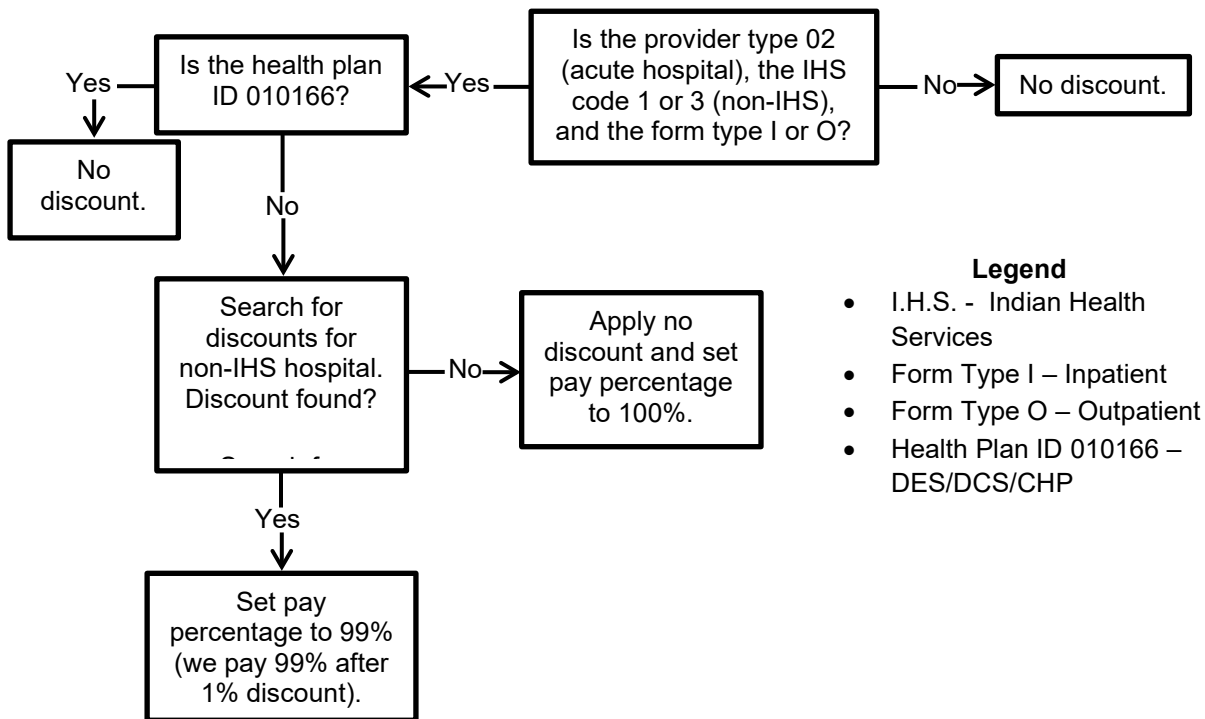
Legend (in order of appearance)

- Subcap – Subcapitated
- Subcap 06 – Denied Claim
- Subcap 07 – Utilization Encounters
- DCS/CHP – DCS/CHP
- Rx Claim – Prescription Claim
- Hemophilia Factor – Medication used to treat blood-clotting disorders.
- Subcap 01 – Subcapitated
- Subcap 02 – Partially Subcapitated
- Subcap 03 – DES DD State Owned Facility
- Subcap 04 – Contracted Transplant Service
- Subcap 12 - Subcapitated PCP Rate Parity
- Subcap 14 – Transplant Service PCP Rate Parity
- Subcap 00 – Fee for Service
- Subcap 05 – Medical Services for Non-Contracted Service
- Subcap 08 – Negotiated Settlement PCP Rate Parity

❖ Lesser of Calculation Flowchart



❖ **Discount Determination Flowchart**



❖ **Health Plan Paid/Health Plan Approved Interest Payment Flowchart**

