October 17, 2025

Arizona Health Care Cost Containment System
801 E. Jefferson Street
Phoenix, AZ 85034

Re: AMPM 961 – Incident, Accident, and Death Reporting

Dear AHCCCS:

On behalf of the undersigned organizations representing Arizona's provider community, we thank AHCCCS for the opportunity to comment on the proposed revisions to AMPM Policy 961 - Incident, Accident, and Death Reporting.

We share AHCCCS's commitment to patient safety and effective oversight. However, the policy as currently drafted raises significant concerns regarding operational feasibility, clarity, and alignment with statewide efforts to streamline reporting. **We, the organizations that have signed onto this letter, respectfully request a meeting with AHCCCS leadership as soon as possible, and before the close of the comment period, to discuss these issues**. Our key concerns include the following.

Overbroad and ambiguous language. Clear and precise language in policy manuals is essential for effective program administration. When policies are articulated with specificity, it reduces ambiguity and ensures consistent interpretation among contractors and providers. This clarity fosters a uniform application of the rules, leading to predictable and positive outcomes for patients. By creating straightforward policies, we enhance compliance, minimize the risk of audit findings and legal challenges, and bolster provider trust within the system. For both providers and patients, well-defined policies can streamline processes, facilitate timely payments, reduce claim denials, and improve access to care. The following are issues we've identified as overbroad or ambiguous:

1. **Section III, Policy, Paragraph 2**. The new language "and the following reporting requirements below" is somewhat confusing. We recommend the following language:
    - *All providers are required to register for an account in the AHCCCS QM Portal within 30 days of becoming a registered provider with AHCCCS. Providers serving*

Fee-for-Service (FFS) members must enter all reportable IADs into the AHCCCS QM Portal, as well as follow the additional reporting requirements specified below. Furthermore, FFS Providers should refer to the Quality of Care and FFS Provider requirements in the Arizona Medical Provider Manual (AMPM) Policy 830.

2. **Section III, Policy, Paragraph 3**. Generally speaking, issues related to this paragraph are confusing, and it is unclear what problem AHCCCS is trying to solve.
3. **Section III, Policy, Paragraph** 3. The following new language is inconsistent with AHCCCS definitions "*All IADs shall be reported by the Rendering Service Provider or provider organization[10].*"
    - The revised policy defines Rendering Service Provider; however, there is no definition for *provider organization* provided, nor is there a definition for *provider organization* in AHCCCS's Contract and Policy and Dictionary. Additionally, footnote 10 states, "*Added to clarify reporting requirements **are the responsibility of the rendering provider** with the exception of emergency and crisis intervention providers.*"
        - The **OR** between the Rendering Service Provider and the provider organization creates confusion and is in direct conflict with the footnote language.
        - The sentence as written creates confusion for Rendering Service Providers and the organizations that employ them. In most cases, an organization (hospital, FQHC, behavioral health organization, etc.) has policies and procedures for reporting IADs. As written, organizations employing Rendering Service Providers will be required to re-educate their staff regarding who is the required reporter.
4. **Section III, Policy, Paragraph 3**. We have several concerns regarding the last sentence in this paragraph, which states: "*Reportable events that occur outside of the provision of care and result in an Emergency Department of Crisis engagement for members assigned to a Health Home, IADs shall be reported by the Health Home upon notification of the reportable event.*"
    - First, the only definition of Health Home can be found in AHCCCS's Contract and Policy Dictionary, which states: "*A provider that either provides or coordinates and monitors the provision of all primary, physical health, behavioral health and services and supports to treat the whole person. A Health Home can be an Outpatient Behavioral Health Clinic, a Federally Qualified Health Center (FQHC) or an Integrated Care Provider. Members may or may not be formally assigned to a health home*."

        - There are thousands of AHCCCS members assigned to health homes, but these members and the assigned provider are not aware of the assignment. Additionally, as specified in the definition, members may or may not be formally assigned to a health home. Given these two issues, we believe the newly proposed language will create situations where providers are held responsible for reports that they could not make because they (1) have a member who is not formally assigned to them as a health home or (2) the member is formally assigned, but neither the member nor the provider is aware of this assignment, (3) or both.
    - Second, if this language stands as written, we are concerned that there is no mechanism in place to notify health homes when a member has been involved in a reportable event that resulted in a crisis engagement or emergency department visit. We request that AHCCCS explain how this information will be transmitted to all health home providers without creating additional layers of cost and administrative burden.

Section A, Minimum Requirements for Incident, Accident, and Death Reporting

5. **Page 2, Paragraph 1**. Since AHCCCS opened this policy to make improvements we want to take the opportunity to seek clarity on the first sentence in paragraph one, which states: "*The Contractor shall develop a process to ensure that all high profile, media, and sentinel events can be reported to the Contractor by individual and organizational providers, members, or family members at any time of day including evenings, weekends, and holidays*."
    - The policy provides an outline of the elements of a **Sentinel IAD**, not a sentinel event. We recommend using consistent language.
    - The policy, nor the AHCCCS's Contract and Policy Dictionary, defines "high-profile" or "media" event. These terms are subjective, and we request that they be removed.
    - **Recommended rewrite**: The Contractor will establish a process to ensure that all Sentinel IADs can be reported by individual and organizational providers, as well as members or their family members, at any time of day, including evenings, weekends, and holidays.
6. **Page 4, subparagraph g.ix.** The addition of "inpatient provider site" to the list of entities that must report a medication error appears to target Health Care Institutions

licensed under Title 9, Chapter 10 of the Arizona Administrative Code (A.A.C.). However, it is unclear whether this definition is exclusive to licensed health care institutions or if it also includes other facilities.

- Assuming the policy is referring to licensed health care institutions, we question the necessity of adding them to this section. These organizations' medication errors are heavily monitored by internal pharmacy and therapeutic (P&T) committees, safety officers, and incident reporting systems. Additionally, there is oversight from ADHS and the AZ Board of Pharmacy, CMS, The Joint Commission, FDA, AHRQ, and PSOs
- **Recommendation**: We recommend that AHCCCS limit reporting for inpatient facilities under AMPM 961 to medication errors resulting in actual or potential harm, rather than all errors, to avoid duplicative reporting and preserve the integrity of hospital-based safety improvement systems.

7. **Page 4, subparagraph k**. We have several concerns regarding the revision of this subparagraph, which states: "*Any other incident that causes clinical concern. It is the responsibility of the provider to disclose in any circumstance where the obligation to disclose may not be otherwise clear*[15]." The footnote states that the new language is "*Added to clarify incidents for reporting.*"
   - We appreciate AHCCCS's efforts to clarify an ambiguous requirement; however, the proposed language is actually more confusing than the original wording. However, the new catch-all category for reportable IADs – "*any other incident that causes clinical concern*" – is overly broad and ambiguous. The standard is completely subjective in nature and arguably could apply to even the most minor of incidents. This lack of specificity may create confusion for providers about which incidents must be disclosed, potentially leading to inconsistent reporting practices and exposing providers to compliance risks. Providers may be placed on corrective action plans for not reporting incidents that they reasonably believe did not meet the ambiguously worded criteria.
   - **Recommendation**: We urge AHCCCS not to adopt this change and work with the provider community to draft language that reflects a standard that is clearly defined and reportable.
8. **Page 4, subparagraph g.** Inclusion of potentially unsubstantiated "allegations of abuse" in the list of Sentinel IADs lacks clarity and may lead to inconsistent interpretations. It would be administratively burdensome for providers and organizations to report and for AHCCCS to review allegations of abuse that healthcare providers investigate and find to be false.

- This new proposal raises the question of whether AHCCCS intends to take adverse action against a provider based on an unsubstantiated allegation.

Section B, Contractor Requirements

9. **Page 5, paragraph E.1:** We have concerns regarding the rewrite of this paragraph which states: "*For IADs that require correction: Within one business day of reviewing a submitted IAD, if the Contractor determines that the IAD is missing any needed information or otherwise requires correction, the Contractor is responsible for returning this to the provider along with an explanation of what needs to be corrected and/or added to the IAD, as well as a due date for submission of corrections. The provider is then responsible for acknowledging receipt of the need for correction within 1 business day. If the provider fails to acknowledge receipt within 1 business day, the Contractor is responsible for reaching out to the provider to confirm receipt and understanding. The provider is then responsible for submitting the corrections back to the Contractor within the timeline specified by the Contractor. The Contractor shall ensure appropriate resolution of each IAD returned to the provider, including steps to address non-responsive providers.*"
    - **This language creates conflicting and burdensome reporting timelines for providers**. Differing deadlines between ADHS and AHCCCS create confusion in crisis situations. For instance, the ADHS death reporting requirement for skilled nursing facilities is one working day, while the self-injurious reports allow for two working days.
    - **Conflicting standards increase compliance risk and divert staff attention during critical moments of resident care**.
    - **The proposed 24-hour correction window and one-day acknowledgement requirement are not operationally feasible for many providers**. For example, the 24-hour window is impractical for rural and safety-net providers that operate with extremely limited staff and resources. These facilities lack dedicated compliance staff available around the clock to meet 24-hour deadlines or manage multiple, overlapping reporting systems. The one-day acknowledgement period does not account for common issues with communication reliability. For example, it is not uncommon for correction requests to be sent to the wrong address or for providers to receive them several days after the initial email, making compliance with the deadline difficult.
    - **Duplication and fragmentation.** The proposed requirements layer additional responsibilities on MCOs and providers, duplicating obligations already in place

with ADHS, APS, and law enforcement. This will be burdensome from both a clinical and administrative perspective. If there are differing results from an investigation, it creates new complications regarding which entity is the final authority in determining the outcome.

- **Recommendation.** By creating a separate system for provider and MCO reporting, tracking, documentation, and investigation, this approach runs contrary to the statewide effort underway to streamline reporting and better serve public safety. Rather than advancing fragmentation, **we urge AHCCCS to collaborate with its sister agencies to streamline processes and provide clear instructions, thereby improving compliance and reducing administrative burden**.
- **Recommendation.** Engage managed care organizations (MCOs) and providers in a discussion about the current Quality of Care (QOC) request process. Currently, when providers receive a QOC from an MCO, it does not specify the facility or entity where the encounter took place. Often, the QOC pertains to an incident that occurred at the transferring facility, which means the receiving provider may be unaware of the issue. This lack of clarity makes it challenging, if not impossible, for our facilities to investigate or respond effectively if the inquiry does not involve our clinical team or facility.

General Feedback

To the extent possible, we recommend that updating policies align with the Arizona Bill Drafting Manual, which applies to all the statutes and laws of this state. Although the AMPM is not a statute, these policies regulate provider behavior and should be viewed as "law."

The revision of AMPM961 adds the phrase “but not limited to” following the word “including”. Using the term “includes or including” is inherently not a term of exclusion. According to the manual “[T]he words "include," "includes" and "including," when used by themselves to introduce a list of examples, are words of "inclusion," not of limitation or exclusion. It is therefore unnecessary, and occasionally confusing and erroneous, to use the phrase "includes, but is not limited to." Since "includes" is not exhaustive, the words "but is not limited to" are redundant, add nothing and invite misinterpretation. “

Conclusion

Given these concerns, we respectfully urge AHCCCS to convene a joint meeting with **the organizations that have signed onto this letter** as soon as possible. This discussion should allow for clarification of intent, alignment with statewide reporting initiatives, and the identification of feasible solutions that support provider compliance. **We request that this important meeting take place well in advance of the November 7th comment deadline.**

We share AHCCCS's commitment to patient safety, program integrity, and effective oversight. The undersigned organizations remain dedicated to working collaboratively with AHCCCS to ensure patient safety while creating a regulatory environment that is clear, consistent, and sustainable.

Sincerely,

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