



**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF BUSINESS AND FINANCE**

SECTION A: CONTRACT AMENDMENT

1. AMENDMENT #: <p align="center">58</p>	2. CONTRACT #: <p align="center">AHCCCS # YH6-0014 DES # E 2005004</p>	3. EFFECTIVE DATE OF AMENDMENT: <p align="center">October 1, 2016</p>	4. PROGRAM: <p align="center">DHCM – DES/DDD</p>
5. CONTRACTOR NAME AND ADDRESS: <p align="center">Arizona Department of Economic Security Division of Developmental Disabilities DES/DDD, Site Code 2HA1 1789 W. Jefferson Street Phoenix, AZ 85007</p>			
6. PURPOSE: To amend the Contract for the period October 1, 2016 through June 30, 2017 and to amend Section B, Capitation Rates and Contractor Specific Requirements, Section C, Definitions, Section D, Program Requirements, and Section F, Attachments.			
<p>➤ THE ABOVE REFERENCED CONTRACT IS HEREBY AMENDED AS FOLLOWS:</p> <ul style="list-style-type: none"> ➤ Section B, Capitation Rates and Contractor Specific Requirements ➤ Section C, Definitions ➤ Section D, Program Requirements ➤ Section F, Attachments <p>Therefore, this Contract is hereby REMOVED IN ITS ENTIRETY, including but not limited to all terms, conditions, requirements, and pricing and is amended, restated and REPLACED with the documents attached hereto as of the Effective Date of this Amendment.</p> <p>Refer to the individual Contract sections for specific changes.</p>			
<p>7. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT.</p> <p>IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.</p>			
8. SIGNATURE OF AUTHORIZED REPRESENTATIVE: <p align="center">DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</p>	9. SIGNATURE OF AHCCCS CONTRACTING OFFICER: <p align="center">DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</p>		
TYPED NAME:	TYPED NAME:		
TITLE:	TITLE:		
DATE:	DATE:		

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SECTION B. CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS

DES/DDD shall provide services as described in this contract. In consideration for the provision of services, DES/DDD will be paid as shown below for the period October 1, 2016 through June 30, 2017 unless otherwise modified by contract amendment.

**ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)
DES/DDD**

DDD Capitation Rates

	CYE 17 10-01-16 – 12-31-16
DDD	\$3546.90
Targeted Case Management	\$151.59

DDD Capitation Rates

	CYE 17 01-01-17 – 06-30-17
DDD	\$3556.07
Targeted Case Management	\$151.59

Stated rates are payable to the Contractor until such time new rates are established as described in Section D, Paragraph 56, Compensation and Paragraph 57 Annual Submission of Budget.

Contractor Specific Requirements:

Geographic Service Areas: The DES/DDD Contractor serves eligible members statewide in the following Geographic Service Areas (GSAs) and counties:

GSA	County
02	Yuma, La Paz
04	Apache, Coconino, Mohave, Navajo
06	Yavapai
08	Gila, Pinal
10	Pima, Santa Cruz
12	Maricopa
14	Cochise, Graham, Greenlee

High Need/High Cost Program: The Contractor shall collaborate with the Regional Behavioral Health Authority (RBHA) to select members for the High Need/High Cost Program and implement interventions for care coordination in order to promote appropriate utilization of services and improve member outcomes. The Contractor is required to include the number of members indicated below, by RBHA, and as further outlined in Section D, Paragraph 24, Medical Management of the contract:

**SECTION B.
CAPITATION RATES & CONTRACTOR SPECIFIC REQS**

Contract/RFP No. YH6-0014

	# of High Need/High Cost Members		
DDD Geographic Service Area	Health Choice Integrated Care (HCIC)	Cenpatico Integrated Care (C- IC)	Mercy Maricopa Integrated Care (MMIC)
Statewide	5	5	10

Zip Code Alignment: Zip codes 85542, 85192, and 85550 were moved from the GSA which includes Gila County and assigned to the GSA which includes Graham County. As part of the Greater AZ Integrated RBHA implementation effective October 1, 2015, this move occurred to align tribal members from a single tribe into a single RBHA. This change was implemented for this contract as well in order to keep zip code assignment consistent between AHCCCS lines of business.

[END OF SECTION B]

The definitions specified in Part 1 below refer to terms found in all AHCCCS contracts. The definitions specified in Part 2 below refer to terms that exist in one or more contracts but do not appear in all contracts.

638 TRIBAL FACILITY	A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facility, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.
ACUTE CARE CONTRACTOR	A contracted managed care organization (also known as a health plan) that provides acute care physical health services to AHCCCS members in the acute care program who are Title XIX or Title XXI eligible. The Acute Care Contractor is also responsible for providing behavioral health services for its enrolled members who are treated by a Primary Care Provider (PCP) for anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD). Acute Care Contractors are also responsible for providing behavioral health services for dual eligible adult members with General Mental Health and/or Substance Abuse (GMH/SA) needs.
ACUTE CARE SERVICES	Medically necessary services that are covered for AHCCCS members and which are provided through contractual agreements with managed Care Contractors or on a Fee-For-Service (FFS) basis through AHCCCS.
ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.
ADMINISTRATIVE SERVICES SUBCONTRACTS	<p>An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:</p> <ul style="list-style-type: none">a. Claims processing, including pharmacy claims,b. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization),c. Management Service Agreements;d. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,e. DDD acute care subcontractors. <p>Providers are not Administrative Services Subcontractors.</p>
ADULT	A person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS MEMBER	See "MEMBER."
AHCCCS RULES	See "ARIZONA ADMINISTRATIVE CODE."
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.
AMERICAN INDIAN HEALTH PROGRAM (AIHP)	An acute care Fee-For-Service program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider. AIHP was formerly known as AHCCCS IHS.
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as "Rules." AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The state agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona's Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program and described in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
AUTHORIZED REPRESENTATIVE	Authorized representative means a person who is authorized to apply for medical assistance or act on behalf of another person (A.A.C. R9-22-101).

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

BALANCED BUDGET ACT (BBA)	See “MEDICAID MANAGED CARE REGULATIONS.”
BEHAVIORAL HEALTH (BH)	A mental health and substance use/abuse collectively.
BEHAVIORAL HEALTH DISORDER	Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders (DSM) excluding those diagnoses such as mental retardation, learning disorders and dementia, which are not typically responsive to mental health or substance abuse treatment.
BEHAVIORAL HEALTH PROFESSIONAL	As specified in A.A.C. R9-10-101, an individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to: <ol style="list-style-type: none">Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251; orExcept for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101.;A psychiatrist as defined in A.R.S. §36-501;A psychologist as defined in A.R.S. §32-2061;A physician;A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; orA behavior analyst as defined in A.R.S. §32-2091; orA registered nurse
BEHAVIORAL HEALTH RESIDENTIAL FACILITY	A health care institution that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to: <ol style="list-style-type: none">Have a limited or reduced ability to meet the individual's basic physical needs;Suffer harm that significantly impairs the individual’s judgment, reason, behavior, or capacity to recognize reality;Be a danger to self;Be a danger to others;Be persistently or acutely disabled as defined in A.R.S. § 36-501; orBe gravely disabled.
BEHAVIORAL HEALTH SERVICES	Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual’s behavioral health issue. See also “COVERED SERVICES.”
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.

BORDER COMMUNITIES	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and §36-2907.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children’s Health Insurance Program.
CHILD	A person under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.
CHILD AND FAMILY TEAM (CFT)	A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)	Children under age 19 who are blind, children with disabilities, and related populations (eligible for SSI under Title XVI). Children eligible under section 1902(e)(3) of the Social Security Act (Katie Beckett); in foster care or other out-of-home placement; receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS).
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

CLIENT INFORMATION SYSTEM (CIS)	The centralized processing system for files from each TRBHA/RBHA to AHCCCS as well as an informational repository for a variety of BH related reporting. The CIS system includes Member Enrollment and Eligibility, Encounter processing data, Demographics and SMI determination processes.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.
CONTRACT SERVICES	See “COVERED SERVICES.”
CONTRACTOR	An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, §36-2940, or §36-2944 to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements, AHCCCS Statute and Rules, and Federal law and regulations.
CONVICTED	A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	A monetary amount that the member pays directly to a provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 7.
CORRECTIVE ACTION PLAN (CAP)	A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/ tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.
COVERED SERVICES	The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements.
CREDENTIALING	The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.
DAY	A day means a calendar day unless otherwise specified.
DAY – BUSINESS/WORKING	A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)	The state agency that formerly had the duties set forth by the legislature to provide BH services within Arizona.
DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with a developmental/intellectual disability.
DISENROLLMENT	The discontinuance of a member's eligibility to receive covered services through a Contractor.
DIVISION OF HEALTH CARE MANAGEMENT (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home.
EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)	A comprehensive child health program of prevention, treatment, correction, and improvement of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].
ENCOUNTER	A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.10(a)].
ENROLLMENT	The process by which an eligible person becomes a member of a Contractor's plan.
EQUITY PARTNERS	The sponsoring organizations or parent companies of the managed care organization that share in the returns generated by the organization, both profits and liabilities.
EVIDENCE-BASED PRACTICE	An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the person receiving services.
EXHIBITS	All items attached as part of the solicitation.
FEDERAL FINANCIAL PARTICIPATION (FFP)	FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FEE-FOR-SERVICE (FFS)	A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.
FEE-FOR-SERVICE MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.
GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMH/SA)	A classification of adult persons age 18 and older who have general behavioral health issues, have not been determined to have a serious mental illness, but are eligible to receive covered behavioral health services.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

GRIEVANCE AND APPEAL SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.
HEALTH PLAN	See "CONTRACTOR."
INCURRED BUT NOT REPORTED LIABILITY (IBNR)	Incurred but not reported liability for services rendered for which claims have not been received.
INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)	See "SERVICE PLAN"
INDIAN HEALTH SERVICES (IHS)	The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as outlined in 25 U.S.C. 1661.
INFORMATION SYSTEMS	The component of the Offeror's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
INTERGOVERNMENTAL AGREEMENT (IGA)	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).
LIABLE PARTY	An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in A.A.C. R9-22-1001.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

LIEN	A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MAJOR UPGRADE	Any systems upgrade or changes that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.
MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency [42 CFR 455.101].
MATERIAL CHANGE TO BUSINESS OPERATIONS	Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency [42 CFR 455.101].
MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
MEDICAID MANAGED CARE REGULATIONS	The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.

**SECTION C.
DEFINITIONS**

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MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICAL RECORDS	A chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the provider's physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
MEDICALLY NECESSARY	As defined in 9 A.A.C. 22 Article 101. Medically necessary means a covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or prolong life.
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981.
MEMBER INFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.
OFFEROR	An organization or other entity that submits a proposal to AHCCCS in response to a Request For Proposal as defined in 9 A.A.C. 22, Article 1.
PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

**SECTION C.
DEFINITIONS**

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PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
PERFORMANCE STANDARDS	A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors.
POSTSTABILIZATION CARE SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438.114(a)].
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 and §36-2944.01 for all payments made to Contractors for the contract year.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.
PRIMARY CARE PROVIDER (PCP)	An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.
PRIMARY PREVENTION	The focus on methods to reduce, control, eliminate and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.
PRIOR AUTHORIZATION	Prior authorization is a process used to determine in advance of provision whether or not a prescribed procedure, service, or medication will be covered. The process is intended to act as a safety and cost savings measure.
PRIOR PERIOD	See "PRIOR PERIOD COVERAGE."

**PRIOR PERIOD
COVERAGE (PPC)**

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 (usually the first day of the month of application) until the date the member is enrolled with the Contractor. Refer to A.A.C. R9-22-701. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis.

**PRIOR QUARTER
COVERAGE**

The period of time prior to an individual's month of application for AHCCCS coverage, during which a member may be eligible for covered services. Prior Quarter Coverage is limited to the three month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant:

1. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month; and
2. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made. Refer to A.A.C. R9-22-303

AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.

**PROGRAM
CONTRACTOR**

See "CONTRACTOR"

PROVIDER

Any person or entity that contracts with AHCCCS or a Contractor for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

PROVIDER GROUP

Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

**PRUDENT LAYPERSON
(for purposes of
determining whether an
emergency medical
condition exists)**

A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.

**QUALIFIED MEDICARE
BENEFICIARY DUAL
ELIGIBLE (QMB DUAL)**

A person determined eligible under A.A.C. R9-29-101 et seq. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.

REFERRAL

A verbal, written, telephonic, electronic or in-person request for health services.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	A Managed Care Organization that has a contract with the administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the managed care organization. Additionally the Managed Care Organization shall coordinate the delivery of comprehensive physical health services to all eligible persons with a serious mental illness enrolled by the administration to the managed care organization.
REINSURANCE	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
REQUEST FOR PROPOSAL (RFP)	A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a proposal under 9 A.A.C. 22 Article 6.
ROOM AND BOARD (OR ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.
SCOPE OF SERVICES	See "COVERED SERVICES."
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract.
SERVICE PLAN	A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
SPECIAL HEALTH CARE NEEDS	Serious or chronic physical, developmental and/or behavioral health conditions. Members with special health care needs require medically necessary services of a type or amount beyond that generally required by members.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
STATE	The State of Arizona.
STATEWIDE	Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE PLAN	The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children’s Health Insurance Program.
SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22 Article 1.
SUBCONTRACTOR	<ol style="list-style-type: none">1. A provider of health care who agrees to furnish covered services to members.2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUBSIDIARY	An entity owned or controlled by the Contractor.
SUBSTANCE USE DISORDERS	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY (TPL)	See “LIABLE PARTY.”

- TITLE XIX** Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which include those populations 42 U.S.C. 1396 a(a)(10)(A).
- TITLE XIX MEMBER** Title XIX members include those 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, Adult Group at or below 106% Federal Poverty Level (Adults \leq 106%), Adult Group above 106% Federal Poverty Level (Adults $>$ 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.
- TREATMENT** A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue. Refer to A.A.C. R9-10-101.
- TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)** A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401, §36-3407.
- YEAR** See "CONTRACT YEAR."

[END OF PART 1 DEFINITIONS]

PART 2. DEFINITIONS PERTAINING TO ONE OR MORE AHCCCS CONTRACTS

1931 (also referred to as TANF related)	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL). See also “TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF).”
ABUSE (OF MEMBER)	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. §46-451 and A.R.S. §13-3623.
ABUSE (BY PROVIDER)	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
ACUTE CARE ONLY (ACO)	ACO refers to the enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who either 1) refuses HCBS offered by the case manager; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Care Services cannot be provided; or 4) has equity value in a home that exceeds \$552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive LTC institutional, alternative residential or HCBS.
ADMINISTRATIVE OFFICE OF THE COURTS (AOC)	The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.
ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)	Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).
ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS <= 106%)	Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AID FOR FAMILIES WITH DEPENDENT CHILDREN (AFDC)	See “TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF).”

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners physician assistants and other health care providers.
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a person to change Contractors every 12 months.
ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)	The department established pursuant to A.R.S. §8-451 to protect children and to perform the following: <ol style="list-style-type: none">1. Investigate reports of abuse and neglect.2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.
ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.
BED HOLD	A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and therapeutic leave. Refer to the Arizona Medicaid State Plan, 42 C.F.R. §§447.40 and 483.12, and 9 A.A.C. 28 for more information on the bed hold service and AMPM Chapter 100.
BEHAVIORAL HEALTH PARAPROFESSIONAL	As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that: <ol style="list-style-type: none">a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; andb. Are provided under supervision by a behavioral health professional.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

**BEHAVIORAL HEALTH
RESIDENTIAL FACILITY**

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

- a. Have a limited or reduced ability to meet the individual's basic physical needs;
- b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
- c. Be a danger to self;
- d. Be a danger to others;
- e. Be persistently or acutely disabled as defined in A.R.S. § 36-501; or
- f. Be gravely disabled.

**BEHAVIORAL HEALTH
TECHNICIAN**

As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

- a. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
- b. Are provided with clinical oversight by a behavioral health professional.

**BREAST AND CERVICAL
CANCER TREATMENT
PROGRAM (BCCTP)**

Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.

**CARE MANAGEMENT
PROGRAM (CMP)**

Activities to identify the top tier of high need/high cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care management is an administrative function performed by the health plan. Distinct from case management, Care Managers should not perform the day-to-day duties of service delivery.

CARE MANAGEMENT

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

CASE MANAGEMENT

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

**CASH MANAGEMENT
IMPROVEMENT ACT
(CMIA)**

Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

CHILDREN'S REHABILITATIVE SERVICES (CRS)	A program that provides medical treatment, rehabilitation, and related support services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS-related services as specified in 9 A.A.C. 22.
CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors.
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.
COMPETITIVE BID PROCESS	A state procurement system used to select Contractors to provide covered services on a geographic basis.
COUNTY OF FISCAL RESPONSIBILITY	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
CRS-ELIGIBLE	An individual AHCCCS member who has completed the CRS application process, as delineated in the CRS Policy and Procedure Manual, and has met all applicable criteria to be eligible to receive CRS-related services as specified in 9 A.A.C. 22.
CRS RECIPIENT	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS related covered Services.
DEVELOPMENTAL DISABILITY (DD)	As defined in A.R.S. §36-551, a strongly demonstrated potential that a child under six years of age has a developmental disability or will become a child with a developmental disability, as determined by a test performed pursuant to section 36-694 or by other appropriate tests, or a severe, chronic disability that: a. Is attributable to cognitive disability, cerebral palsy, epilepsy or autism. b. Is manifested before age eighteen. c. Is likely to continue indefinitely. d. Results in substantial functional limitations in three or more of the following areas of major life activity: (i) Self-care. (ii) Receptive and expressive language. (iii) Learning. (iv) Mobility. (v) Self-direction. (vi) Capacity for independent living. (vii) Economic self-sufficiency. e. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

EPISODE OF CARE	The period between the beginning of treatment and the ending of covered services for an individual. The beginning and end of an episode of care is marked with a demographic file submission. Over time, an individual may have multiple episodes of care.
FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member.
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may also include siblings, grandparents, aunts and uncles.
FEDERAL EMERGENCY SERVICES (FES)	A program delineated in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of “health center” under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.
FIELD CLINIC	A “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.
FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as defined in A.A.C. R9-28-101.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. §36-2931 and §36-2939.
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.
INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF)	A placement setting for persons with intellectual disabilities.
JUVENILE PROBATION OFFICE (JPO)	An officer within the Arizona Department of Juvenile Corrections assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juveniles who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program. (A.R.S. §8-353)
KIDSCARE	Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The Kids Care program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).
MEDICAL PRACTITIONER	A physician, physician assistant or registered nurse practitioner.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
PERSON WITH A DEVELOPMENTAL/ INTELLECTUAL DISABILITY	An individual who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). Services for AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.
RATE CODE	Eligibility classification for capitation payment purposes.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

RURAL HEALTH CLINIC (RHC)	A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.
SERIOUS MENTAL ILLNESS (SMI)	A condition as defined in A.R.S. §36-550 and determined in a person 18 years of age or older.
SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA)	Eligible pregnant women under Section 9401 of the Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 U.S.C. 1396(a)(10)(A)(ii)(IX), November 5, 1990, with individually budgeted incomes at or below 150% of the FPL, and children in families with individually budgeted incomes ranging from below 100% to 140% of the FPL, depending on the age of the child.
SMI ELIGIBILITY DETERMINATION	The process, after assessment and submission of required documentation to determine, whether a member meets the criteria for Serious Mental Illness.
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.
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.
TELEMEDICINE	The practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation. Refer to A.R.S. §36-3601.
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).
TITLE XXI	Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.

**SECTION C.
DEFINITIONS**

Contract/RFP No. YH6-0014

TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the “Children’s Health Insurance Program” (CHIP). The Arizona version of CHIP is referred to as “KidsCare.”
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member’s developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.
VIRTUAL CLINICS	Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

[END OF PART 2 DEFINITIONS]

[END OF SECTION C]

SECTION D. PROGRAM REQUIREMENTS**1. PURPOSE AND APPLICABILITY**

The purpose of the contract between AHCCCS and DES/DDD (hereinafter 'the Contractor) is to implement and operate the provisions of the Arizona Long Term Care System (ALTCS) program approved under A.R.S. §36-2932 et seq. relating to the furnishing of covered services and items to each enrolled member. The terms of this contract apply to the Contractor, any provider participating in the Contractor's provider network, and any provider that furnishes items and services to an enrolled member upon the request or authorization of the Contractor.

In the event that a provision of Federal or State law, regulation, or policy is repealed or modified during the term of this contract, effective on the date the repeal or modification by its own terms takes effect:

1. The provisions of this contract shall be deemed to have been amended to incorporate the repeal or modification; and
2. The Contractor shall comply with the requirements of the contract as amended, unless AHCCCS and the Contractor otherwise stipulate in writing.

2. INTRODUCTION**AHCCCS' Mission and Vision**

The AHCCCS mission and vision is to reach across Arizona to provide comprehensive quality healthcare to those in need while shaping tomorrow's managed health care from today's experience, quality and innovation. The AHCCCS' ALTCS goal is to continuously improve ALTCS' efficiency and effectiveness and support member choice in the delivery of the highest quality long term care to our customers.

AHCCCS supports a program that promotes the values of:

- ◆ Choice
- ◆ Dignity
- ◆ Independence
- ◆ Individuality
- ◆ Privacy
- ◆ Self-determination

ALTCS Guiding Principles

- ◆ *Member-centered case management*
The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining their goal(s) for achieving or maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.
- ◆ *Consistency of services*
Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and the Contractor.
- ◆ *Accessibility of network*
Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed by the Contractor to meet member's needs which are not limited to normal business hours.

- ◆ *Most integrated setting*
Members are to be maintained in the most integrated setting that is medically necessary and appropriate. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- ◆ *Collaboration with stakeholders*
The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

3. ENROLLMENT AND DISENROLLMENT

AHCCCS does not use passive enrollment procedures [42 CFR 438.6(d)(2)]. AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions.¹ AHCCCS is solely responsible for enrolling and disenrolling ALTCS members and for providing notification of same to the Contractor. At the time of approval for ALTCS, active DD clients shall be enrolled with the Contractor. An ALTCS applicant screened as a potential DD client at the time of application for ALTCS shall be referred to the Contractor for a DD eligibility determination. DES will be allowed 30 days in which to determine DD eligibility and to notify the ALTCS local office. If a response is not received by ALTCS by the 30th day and the applicant is otherwise eligible for ALTCS, the ALTCS member will be considered an active DD client and shall be enrolled with the Contractor.

Prior Quarter Coverage: Pursuant to Federal Regulation 42 CFR 435.915, AHCCCS is required to implement Prior Quarter Coverage eligibility which expands the time period during which AHCCCS pays for covered services for eligible individuals to include services provided during any of the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during that month. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter. Upon verification or notification of Prior Quarter Coverage eligibility, providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period.

The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, nor because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. If an applicant or member is or would meet the Contractor criteria but does not cooperate with the Contractor, the applicant or member cannot be assessed for ALTCS eligibility as an EPD applicant.

The Contractor will provide AHCCCS with access to FOCUS in order for the AHCCCS to determine the developmental disability status of an ALTCS member/recipient.

The effective date of enrollment with the Contractor shall be retroactive to the effective date of ALTCS DD eligibility except when a member is enrolled with an acute health plan at the time of the ALTCS decision of approval. When this occurs, enrollment with the Contractor will become effective the date the ALTCS enrollment action is processed by PMMIS (referred to as the "PMMIS update"). The disenrollment from the acute health plan will be effective the day before the Contractor's effective enrollment date. Disenrollment from the Contractor takes effect per Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance.

The Contractor must continue to provide services until disenrollment from the Contractor becomes effective. This includes reinstatement of ALTCS eligibility and Contractor enrollment pending a decision on the member's eligibility appeal with AHCCCS. Services must be continued whether or not the Contractor has determined that the member no longer meets Contractor eligibility requirements.

4. **RESERVED**
5. **RESERVED**
6. **RESERVED**
7. **AHCCCS IDENTIFICATION CARDS**

The Contractor is responsible for the production, distribution and costs of AHCCCS member identification cards and the AHCCCS Notice of Privacy Practices in accordance with ACOM Policy 433. See also Attachment F3, Contractor Chart of Deliverables.

8. **TRANSITION ACTIVITIES**

Member Transition: The Contractor shall comply with the AMPM and the ACOM standards for member transitions between Contractors, to or from an AHCCCS Contractor, upon eligibility termination and upon termination or expiration of a contract. Also, see Paragraph 3, Enrollment and Disenrollment. The Contractor shall develop and implement policies and procedures, which comply with AHCCCS policy to address transition of all ALTCS members. The Enrollment Transition Information form must be completed for all ALTCS members and transmitted to the receiving Contractor. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.

Special consideration should be given to, but not limited to, the following:

1. Home-based members with significant conditions or treatments such as pain control, hypertension enteral feedings, oxygen, wound care, and ventilators;
2. Members who are receiving ongoing services such as daily in home care, behavioral health, dialysis, home health, pharmacy, medical supplies, transportation, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;
3. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;
4. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth;
5. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;
6. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. The individual appointed to this position must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all transition issues, responsibilities, and activities. This staff person shall interact closely with the transition staff of the receiving Contractor to ensure a safe, timely, and orderly transition. See ACOM Policy 402 for more information regarding the role and responsibilities of the Transition Coordinator.

When relinquishing members, the Contractor is responsible for timely notification of the receiving Contractor regarding pertinent information related to any special needs of transitioning members. The Contractor, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with the Contractor and service information, emergency numbers and instructions of how to obtain services. See ACOM Policy 402 and AMPM Chapter 500.

Members who transition from a Contractor to DES/DDD are considered newly enrolled. Initial contact and on-site visit timeframes as specified in AMPM Chapter 1600 shall apply unless specifically modified by AHCCCS.

Other Transition Activities: When an ALTCS member resides in an AHCCCS registered setting with no contract at the time of enrollment, The Contractor must give at least seven days advance written notice advising the member that he or she must move to a facility contracting with The Contractor. The reasons for the transfer must be included in the notice to the member and/or the member's representative. Medical Assistance to members who do not move to a contracting facility is limited to acute care services only. If a member's condition does not permit transfer to another facility, the Contractor should compensate the registered non-contracting provider's service rates or another reasonable alternative payment method until the member can be transferred.

9. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals, including but not limited to, ACOM, AMPM, Reporting Guides, and Manuals are hereby incorporated by reference into this contract. Guidelines, policies and manuals are available on the AHCCCS website. The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to the AHCCCS guidelines, policies, and manuals. The Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS Rules, Statutes and other resources are available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available on the AHCCCS website

10. SCOPE OF SERVICES

The Contractor shall, be responsible for providing the following acute, long term, and case management services in accordance with the AHCCCS Medical Policy Manual (AMPM), ACOM, and as approved by the AHCCCS Director [42 CFR 438.210(a)(1)][42 CFR 438.210(a)(4) and 438.224]. The Contractor shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished [42 CFR 438.210(a)(3)(i)(iii)]. The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the member [42 CFR 438.210(a)(3)(ii)]. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can be reasonably expected to achieve their purpose [42 CFR 438.210(a)(3); 42 CFR 438.210(a)(4)].

The Contractor shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is his or her patient, for [42 CFR 438.102]:

- a. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.100(b)(2)];
- b. Any information the member needs in order to decide among all relevant treatment options;
- c. The risks, benefits, and consequences of treatment or non-treatment; and,
- d. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(b)(2)(iv)].

The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. Notification must be submitted prior to entering into a contract with AHCCCS or prior to adopting the policy during the term of the contract [42 CFR 438.102(a)(2)]. Members must be notified on how to access the services. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to members during their initial appointment, and must be provided to members at least 30 days prior to the effective date of the policy.

The Contractor must ensure the coordination of services it provides with services the member receives from other entities. The Contractor must ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR 160 and 164, subparts A and E to the extent that they are applicable [42 CFR 438.208(b)(2) and (b)(4)][42 CFR 438.224].

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997. (1903(i) final sentence and 1903(i)(16) of the Social Security Act.ⁱⁱ

Authorization of Services: The Contractor shall have in place and follow written policies and procedures for the processing of requests for initial and continuing authorizations of services. The Contractor must have mechanisms in place to ensure consistent application of review criteria for authorization decisions. Any decision to deny a service, authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. [42 CFR 438.210(b)]

Notice of Action: The Contractor shall notify the requesting provider, and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested [42 CFR 438.400(b)]. The notice must meet the requirements of 42 CFR 438.404, AHCCCS Rules and ACOM Policy 414. The notice to the provider must also be in writing as specified in Attachment F1. [42 CFR 438.210(c)] The Contractor must comply with all decision timelines outlined in ACOM Policy 414.

ACUTE CARE SERVICES

Ambulatory Surgery: The Contractor shall provide surgical services for either emergency or scheduled surgeries when provided in an ambulatory or outpatient setting such as a free-standing surgical center or a hospital based outpatient surgical setting.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia, and von Willebrand's disease. See Paragraph 58, Reinsurance, *Catastrophic Reinsurance*.

Audiology: The Contractor shall provide medically necessary audiology services to evaluate hearing loss for all members, on both an inpatient and outpatient basis. Hearing aids are covered only for members under the age of 21 receiving EPSDT services.

American Indians: American Indian members, title XIX and XXI, on- or off-reservation, eligible to receive services, may choose to receive services at any time from an American Indian Health Facility (I/T/U) - Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, Urban Indian Health Program) [ARRA Section 5006(d), and SMD letter 10-001].ⁱⁱⁱ The Contractor shall not impose enrollment fees, premiums, or similar charges on American Indians served by an American Indian Health Facility (I/T/U) - Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, Urban Indian Health Program) (ARRA Section 5006(d), SMD letter 10-001).^{iv}

American Indian Health Program (AIHP): AHCCCS will reimburse claims on a FFS basis for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided to Title XIX members enrolled with the Contractor in an IHS or 638 tribal facility. Encounters for Title XIX services in IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

Behavioral Health: The Contractor shall provide behavioral health services to all members, including Acute Care Only members, as described in Section D, Paragraph 12, Behavioral Health Services.

Children's Rehabilitative Services (CRS): See Section D, Paragraph 13, Children's Rehabilitative Services.

Chiropractic Services: The Contractor shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. For Qualified Medicare Beneficiaries, regardless of age, Medicare approved chiropractic services shall also be covered subject to limitations specified in 42 CFR 410.21.

Dialysis: The Contractor shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified hospitals or Medicare-certified end stage renal disease (ESRD) providers. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illnesses discovered by the screenings for members under age 21. The Contractor shall ensure that these members receive required health screenings, including developmental and behavioral health screenings, in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule (Exhibit 430-1 and 430-1A in the AMPM), including appropriate oral health screening intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant or nurse practitioner.

Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention: The Contractor shall provide health care services through screening, diagnosis and medically necessary treatment for members 21 years of age and older. These services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, breast cancer, cervical cancer, and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in A.A.C. R9-22-205.

Emergency services: The Contractor shall provide emergency services per the following:

1. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule 9 A.A.C. 22, Article 1. Emergency medical services are covered without prior authorization. The Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies. The Contractor shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
2. All medical services necessary to rule out an emergency condition; and
3. Emergency transportation.

Per the Medicaid Managed Care regulations, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency services:

The Contractor must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the Contractor.

The Contractor may not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition 42 CFR 438.114.
2. A representative of the Contractor (an employee or subcontracting provider) instructs the member to seek emergency medical services.

Additionally, the Contractor may not:

1. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
2. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claim submissions by the hospital within 10 calendar days of the member's presentation for emergency services, constitutes notice to the Contractor. This notification stipulation is only related to the provision of emergency services.
3. Require notification of Emergency Department treat and release visits as a condition of payment unless the Contractor has prior approval of AHCCCS.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and such determination is binding on the Contractor responsible for coverage and payment. The Contractor shall comply with Medicaid Managed Care guidelines regarding the coordination of poststabilization care.

For additional information and requirements regarding emergency services, refer to A.A.C. R9-28-202 et seq. and 42 CFR 438.114.

Family Planning: The Contractor shall provide family planning services in accordance with the AMPM, and consistent with the terms of the demonstration, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, are also included. If the Contractor does not provide family planning services due to moral and religious objections, it must contract for these services through another health care delivery system or have an approved alternative in place.

Foot and Ankle Services:

Children: The Contractor shall provide foot care services for members under the age of 21 to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a nonprofessional person.

Adults: The Contractor shall provide foot and ankle services to include wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional person as described in the AMPM.

Pursuant to A.R.S. §36-2907, podiatry services performed by a podiatrist licensed pursuant to A.R.S. Title 32, Chapter 7 are covered for members when ordered by a primary care physician or primary care practitioner.

Hospital: Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, and obstetrics and newborn nurseries. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. Outpatient services include any of the above services, which may be appropriately provided on an outpatient or ambulatory basis (i.e. laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. Observation services include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability. Refer to the AMPM for limitations on hospital stays.

Immunizations: The Contractor shall provide medically necessary immunizations for adults 21 years of age and older. Refer to the AMPM for current immunization requirements. The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 23, Quality Management and Performance Improvement.

Incontinence Briefs: In general, incontinence briefs (diapers) are not covered for members unless medically necessary to treat a medical condition. However, for AHCCCS members over three years of age and under 21 years of age incontinence briefs, including pull-ups and incontinence pads, are also covered to prevent skin breakdown and to enable participation in social community, therapeutic, and educational activities under limited circumstances. In addition, effective December 15, 2014 for members in the ALTCS Program who are 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads are also covered in order to prevent skin breakdown as outlined in AMPM Policy 310-P. See A.A.C. R9-22-212 and AMPM Chapters 300 and 400.

Laboratory: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a free standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory with Clinical Laboratory Improvement Act (CLIA) licensure or a Certificate of Waiver.

Upon written request, the Contractor may obtain laboratory test data on members from a laboratory or hospital based laboratory subject to the requirements specified in A.R.S. §36-2903 (Q) and (R). The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by the Administration.

Maternity: The Contractor shall provide pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners or certified midwives or licensed midwives. Members may select or be assigned to a PCP specializing in obstetrics while they are pregnant. Members anticipated to have a low-risk delivery may elect to receive labor and delivery services in their home from their maternity provider, if this setting is included in allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by a certified nurse midwife or a licensed midwife, if they are in the Contractor's provider network. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical

services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

The Contractor shall allow women and their newborns to receive 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96-hour stay. However, for payment purposes, inpatient limits will apply to the extent consistent with EPSDT.

The Contractor shall inform all ALTCS DES/DDD enrolled pregnant women of voluntary HIV/AIDS testing and the availability of counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the member newsletter to encourage pregnant women to be tested and instructions on where to be tested. The Contractor shall report to AHCCCS, Division of Health Care Management (DHCM) the number of pregnant women who have been identified as HIV/AIDS positive for each quarter during the contract year. This report is due semi-annually as specified in Attachment F3, Contractor Chart of Deliverables.

Medical Foods: Medical foods are covered within the limitations defined in the AMPM for members diagnosed with a metabolic condition included under the ADHS Newborn Screening Program and as specified in the AMPM. The medical foods, including metabolic formula and modified low protein foods, must be prescribed or ordered under the supervision of a physician.

Medical Supplies, Durable Medical Equipment (DME), Orthotic and Prosthetic Devices: These services are covered when prescribed by the member's PCP, attending physician or practitioner, or by a dentist as described in the AMPM. Prosthetic devices must be medically necessary and meet criteria as described in the AMPM. For persons age 21 and older, AHCCCS will not pay for microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs. Medical equipment may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

Nutrition: Nutritional assessments may be conducted as a part of the EPSDT screenings for members under age 21, and to assist ALTCS members 21 years of age and older whose health status may improve with over- and under- nutritional intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. ALTCS covers nutritional therapy on an enteral, parenteral or oral basis, when determined medically necessary, according to the criteria specified in the AMPM, to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Oral Health: Members under the age of 21: The Contractor shall provide all members under the age of 21 with all medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services, and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor must develop processes to assign members to a dental home by one year of age and communicate that assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care as outlined in AMPM Chapter 400. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 20, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified in writing when dental screenings are due, if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice must be sent.

Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

Members 21 years of age and older: Pursuant to A.R.S. §36-2939, dental services, including dentures, are covered for persons 21 years of age or older in an amount of \$1,000.00 per member for each 12 month period beginning October 1 through September 30. The Contractor shall provide dental services to members according to the AMPM and shall develop systems to monitor utilization to assure appropriate Medicaid payments.

Orthotics: Orthotics are covered for AHCCCS members under the age of 21 as outlined in AMPM Policy 430. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:

1. The use of the orthotic is medically necessary as the preferred treatment option and consistent with Medicare guidelines;
2. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition; and
3. The orthotic is ordered by a physician or primary care practitioner.

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit. The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

Physician: The Contractor shall provide physician services to include medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians.

Poststabilization Care Services: Pursuant to AHCCCS rule A.A.C.R9-22-210 and 42 CFR 438.114, 422.113(c) and 422.133, the following conditions apply with respect to coverage and payment of emergency and poststabilization care services, except where otherwise noted in contract:

The Contractor must cover and pay for post-stabilization care services without authorization, regardless of whether the provider that furnishes the service has a contract with the Contractor, for the following situations:

1. Poststabilization care services that were pre-approved by the Contractor ;
2. Poststabilization care services were not pre-approved by the Contractor because the Contractor did not respond to the treating provider's request for pre-approval within one hour after being requested to approve such care or could not be contacted for pre-approval.
3. The Contractor representative and the treating physician cannot reach agreement concerning the member's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

Pursuant to 42 CFR 422.113(c)(3), Contractor financial responsibility for poststabilization care services that have not been pre-approved ends when:

1. A Contractor physician with privileges at the treating hospital assumes responsibility for the member's care;
2. A Contractor physician assumes responsibility for the member's care through transfer;
3. A Contractor representative and the treating physician reach an agreement concerning the member's care; or
4. The member is discharged.

Pregnancy Termination: AHCCCS covers pregnancy termination if the pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated; or the pregnancy is a result of rape or incest.

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This form must be submitted to the Contractor's Medical Director, and meet the requirements specified in the AMPM. The Certificate must certify that, in the physician's professional judgment, the criteria have been met.

Prescription Medications: Medications ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, Contractor formularies and prior authorization requirements. An appropriate over the counter (OTC) medication may be prescribed as defined in the AMPM when it is determined to be a lower cost alternative to a prescription medication. The Contractor shall comply with AMPM Policy 310-V.

Pharmaceutical Rebates: The Contractor, including the Contractor's Pharmacy Benefit Manager (PBM), is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section.

If the Contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements. For pharmacy related encounter data information Section D, Paragraph 74, Encounter Data Reporting.

Medicare Part D: The Medicare Modernization Act of 2003 (MMA) created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. AHCCCS does not cover prescription drugs that are covered under Part D for dual eligible members. AHCCCS will not cover prescription drugs for this population whether or not they are enrolled in Medicare Part D. AHCCCS covers federally reimbursable drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed by or under the direction of a licensed pharmacist, in accordance with Arizona State Board of Pharmacy Rules and Regulations, subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and are not covered by AHCCCS. This applies to members who are enrolled in Medicare Part D or are eligible for Medicare Part D. (See AMPM Chapter 300, Section 310-V)

340B Drug Pricing Program: All federally reimbursable drugs identified in the 340B Drug Pricing Program are required to be billed at the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price. The Contractor shall ensure that these drugs be reimbursed at the lesser of the two amounts above plus a professional (dispensing) fee. See Laws 2016, Second Regular Session, Chapter 122, A.R.S. §36-2930.03, and A.A.C. R9-22-710 (C) for further details. The 340B drug pricing program includes:

Eligible Organizations and Covered Entities	Effective Date
Drugs dispensed by FQHC/RHC and FQHC Look-Alike 340B pharmacies	Already implemented
Drugs dispensed by other 340B covered entities	Effective the later of January 1, 2017 or upon CMS approval

Drugs administered by 340B entity providers (including drugs administered by physicians)	To Be Determined during CYE 17
Drugs dispensed by licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital	Excluded from 340B reimbursement mandate at this time
Drugs administered by providers in licensed hospital and outpatient facilities that are owned or operated by a licensed hospital.	Excluded from 340B reimbursement mandate at this time

The Contractor is required to comply with any changes to reimbursement methodology for 340B entities.

Primary Care Provider: Primary Care Provider (PCP) services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services and behavioral health [42 CFR 438.208(b)]. The PCP is responsible for maintaining the member's primary medical record which contains documentation of all health risk assessments and health care services of which they are aware, whether or not they were provided by the PCP.

Radiology and Medical Imaging: These services are covered when ordered by the member's PCP, attending physician or dentist and are provided for diagnosis, prevention, treatment or assessment of a medical condition.

Rehabilitation Therapy: The Contractor shall provide medically necessary occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation. Outpatient Physical Therapy for members 21 years of age or older are subject to visit limits per contract year as described in the AMPM.

Respiratory Therapy: Respiratory therapy is covered when prescribed by the member's PCP or attending physician and is necessary to restore, maintain or improve respiratory functioning.

Support Services (State Only): Support services including, but not limited to, prevention education, ongoing support to maintain employment, and supported housing, are provided by the Regional Behavioral Health Authorities (RBHAs) as outlined in the Covered Behavioral Health Services Guide, to facilitate the delivery of or enhance the benefit received from other behavioral health services. The Contractor shall assist members with how to access support services and shall coordinate care for the member as appropriate.

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM, for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation; donor search; organ/tissue harvesting or procurement; preparation and transplantation services; and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided within limitations after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 58, Reinsurance.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-

emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

Treat and Refer: Interaction with an individual who has accessed 911 or a similar public emergency dispatch number, but whose illness or injury does not require ambulance transport to an emergency department based on the clinical information available at that time. The interaction must include: (1) documentation of an appropriate clinical and/or social evaluation, (2) a treatment/referral plan for accessing social, behavioral, and/or healthcare services that address the patient's immediate needs, and (3) evidence of efforts to follow-up with the patient to ascertain adherence with the treatment plan, and (4) documentation of efforts to assess customer satisfaction with the treat and refer visit. Treat and Refer standing orders shall be consistent with medical necessity and consider patient preference when the clinical condition allows.

Triage/Screening and Evaluation: These are covered services when provided by an acute care hospital, IHS or 638 tribal facility and after-hours settings to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine services necessary to alleviate or stabilize the emergent condition. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

Vision Services/Ophthalmology/Optomety: The Contractor shall provide all medically necessary emergency eye care, vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21. For members who are 21 years of age and older, the Contractor shall provide emergency care for eye conditions which meet the definition of an emergency medical condition, cataract removal, and/or Medically necessary vision examinations and prescriptive lenses and frames are covered if required following cataract removal. Refer to AMPM Chapter 300.

Members shall have full freedom to choose, within the Contractor's network, a Practitioner in the field of eye care, acting within their scope of practice, to provide the examination, care or treatment for which the member is eligible. A "Practitioner in the field of eye care" is defined to be either an ophthalmologist or an optometrist.

Well Exams: Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program.

LONG TERM CARE SERVICES

A more detailed description of services can be found in 9 A.A.C. 28, Article 2 and Chapter 1200 of the AMPM.

Attendant Care: A direct care service provided by a trained attendant (see ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care training requirements) for members who reside in their own homes and is a combination of services which may include homemaker services, personal care, coordination of services, general supervision and assistance, socialization and skills development. Attendant care services are not considered duplicative of hospice services.

Spouses as Paid Caregivers: A service option within Attendant Care. See AMPM Chapters 1200 and 1600 for requirements pertaining to Spouses as Paid Caregivers.

Agency with Choice: A service option for the delivery of Attendant Care. As of January 1, 2013 member's selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service

option, the member or individual representative will recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Community Transitional Services: A service to assist ALTCS institutionalized members to reintegrate into the community by providing financial assistance to move from an ALTCS institutional setting to their own home or apartment. Members moving from an ALTCS institutional setting to an alternative residential setting such as assisted living facilities or group homes are not eligible for this service. This service is limited to a one-time benefit per five years per member.

Direct Care Services: The services provided by Direct Care Workers are collectively known as Direct Care Services. There are three types of services within ALTCS that are provided by Direct Care Workers; these include Attendant Care, Personal Care, and Homemaker services.

Emergency Alert System: A service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone.

Habilitation: A service encompassing the provision of training in independent living skills or special developmental skills; sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services. This includes habilitation services such as Day Treatment and Training (also known as day care for persons with disabilities) and Supportive Employment.

Agency with Choice: A service option for the delivery of in-home/day habilitation. As of January 1, 2013 member's selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service option, the member or individual representative will recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Home Health Services: This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless AHCCCS Provider Registration verifies compliance with the surety bond requirements specified in Sections 1861(o)(7) and 1903(i)(18) of the Social Security Act.^v

Homemaker: A direct care service in which assistance is provided for the performance of routine household activities such as shopping, cooking, running errands, etc. (see ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care training requirements)

Agency with Choice: A service option for the delivery of Homemaker Services. As of January 1, 2013 member's selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service option, the member or individual representative will recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Home Modifications: A service that provides physical modification to the home setting that enables the member to function with greater independence and that has a specific adaptive purpose.

Hospice: A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with the Contractor.

The Contractor is required to pay nursing facilities 100% of the class specific contracted rate when a member elects the hospice benefit. The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. ALTCS services which are duplicative of the services included in the hospice benefit should not be provided. If, however, the hospice agency is unable to provide or cover medically necessary services the Contractor must provide the services. Attendant care services are not considered duplicative.

Personal Care: A direct care service that provides intermittent assistance with personal physical needs such as washing hair, bathing and dressing. (See ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care training requirements)

Agency with Choice: A service option for the delivery of personal care services. As of January 1, 2013 member's selecting Agency with Choice may enter into a partnership with a provider agency in which the agency/provider maintains the role of legal employer including the authority to hire and fire paid caregivers, conduct regular supervision visitations and provide standardized training to the caregiver. Under this service option, the member or individual representative will recruit, select and dismiss, paid caregivers, and may also elect to specify training for, manage and supervise caregivers on a day-to-day basis.

Private Duty Nursing: Nursing services for ALTCS members who require more individual and continuous care than is available from a nurse providing intermittent care. These services are available to all ALTCS members and are provided by a registered nurse or licensed practical nurse under the direction of the ALTCS member's primary care provider or physician of record. Contractors who contract with independent nurses to provide private duty nursing must develop oversight activities to monitor service delivery and quality of care.

Respite Care: A service that provides an interval of rest and/or relief to a family member or other person(s) caring for the ALTCS member. It is available for up to 24-hours per day and is limited to 600 hours per benefit year. Refer to AMPM Policy 1250-D.

LONG TERM CARE - INSTITUTIONAL SETTINGS

Institution for Mental Disease (IMD): A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Office of Behavioral Health Licensure licensed behavioral health inpatient facilities with more than 16 beds are considered IMDs.

Behavioral Health Inpatient Facility: A health care institution, as defined in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

- a. Have a limited or reduced ability to meet the individual's basic physical needs;
- b. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality;
- c. Be a danger to self;
- d. Be a danger to others;
- e. Be a person with persistent or acute disability as defined in A.R.S. §36-501; or
- f. Be a person with a grave disability as defined in A.R.S. §36-501.

Intermediate Care Facility for Persons with Intellectual Disability (ICF): A facility whose primary purpose is to provide health, habilitative and rehabilitative services to individuals with intellectual disabilities.

Nursing Facility, including Religious Nonmedical Health Care Institutions: The Contractor shall provide nursing facility services for members. The nursing facility must be licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not

require hospital care or direct daily care from a physician (Religious Nonmedical Health Care Institutions are exempt from state licensing requirements).

LONG TERM CARE - HCBS ALTERNATIVE RESIDENTIAL SETTINGS

Under the Home and Community-Based Services program, members may receive certain services while they are living in their own home. (See Section C for a definition of “home”.) In addition, there are other alternative HCBS settings as defined in 9 A.A.C. 28 Article 1 available to members. Members residing in these settings are responsible for the room and board payment. Every effort to advance a person-centered approach by promoting non-institutional, home-like settings that allows members to age in-place should be encouraged. Medicaid funds cannot be expended for room and board.

Alternative residential settings include the following:

Adult Developmental Home: An alternative residential setting for adults with developmental disabilities (18 or older) which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents. Refer to A.R.S. §36.551.

Assisted Living Facility: An Assisted Living Facilities (ALFs) is a residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All ALTCS approved residential settings in this category are required to meet ADHS licensing criteria as defined in 9 A.A.C. 10, Article 8. Of these facilities, ALTCS has approved three as covered settings.

Adult Foster Care Home: An ALTCS approved alternative residential setting that provides room and board, supervision and coordination of necessary adult foster care services within a family type environment for at least one and no more than four adult residents who are ALTCS members.

Assisted Living Home: An ALTCS approved alternative residential setting that provides supervision and coordination of necessary services to 10 or fewer residents.

Assisted Living Centers: An ALTCS approved alternative residential setting, as defined in A.R.S. §36-401, that provides supervision and coordination of necessary services to more than 11 or more residents. Under A.R.S. §36-2939 members residing in Assisted Living Centers must be offered the choice of single occupancy.

Behavioral Health Residential Facility: A behavioral health service agency licensed by ADHS, as defined in 9.A.A.C.10, that provides treatment to an individual experiencing a behavioral health issue that:

- a. Limits the individual’s ability to be independent, or
- b. Causes the individual to require treatment to maintain or enhance independence (A.A.C. R9-10-101).

Child Developmental Foster Home: An alternative residential setting for children (under age 18) with developmental disabilities which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents.

Group Home for Persons with Developmental Disabilities: A community residential facility for up to six residents that provides room, board, personal care, supervision and habilitation. The DD Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs for ALTCS members who cannot physically or functionally live independently in the community. Refer to A.A.C. Title 9, Chapter 33, Article 1 and A.R.S. §36-551.

Home Care Training to Home Care Client: These services are provided by behavioral health therapeutic home providers and are designed to maximize a member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services indicated by the member's service plan.

Adult: Home Care Training to Home Care Client services can only be provided for no more than three adults in an Behavioral Health Therapeutic Home (A.A.C. R9-10-101) licensed by ADHS/DLS or a home licensed by federally recognized tribes that attest to CMS via AHCCCS that they meet equivalent requirements.

Child: Home Care Training to Home Care Client services can only be provided for no more than three children in a Professional Foster Home (A.A.C. R6-5-5850) licensed by DES or a home licensed by federally recognized tribes that attest to CMS via AHCCCS that they meet equivalent requirements. A Professional Foster Care Home may be larger to accommodate sibling groups.

Substance Abuse Transitional Facility: An agency that provides behavioral health services to an individual who is intoxicated or may have a substance abuse problem (A.A.C. R9-10-101).

Traumatic Brain Injury Treatment Facility: An ALTCS HCBS approved alternative residential setting which is licensed by the ADHS as an Unclassified Health Care Facility and whose purpose is to provide services for the treatment of people with traumatic brain injuries.

Other services and settings, if approved by CMS and/or the Director of AHCCCS, may be added as appropriate. Exclusions and limitations of ALTCS covered services are discussed in AHCCCS and ALTCS Rules and the AMPM.

11. THERAPEUTIC LEAVE AND BED HOLD

Therapeutic leave and bed hold days are covered. Refer to the AMPM Chapter 100.

12. BEHAVIORAL HEALTH SERVICES

AHCCCS members receive behavioral health services through a Regional Behavioral Health Authority (RBHA) or for American Indians, through a Tribal Regional Behavioral Health Authority (TRBHA) or IHS or 638 tribal facility. Behavioral health services include but are not limited to screening, treatment and assistance in coordinating care among providers.

CRS Eligibility: DDD enrolled members receiving CRS services receive all behavioral health and CRS-related services through the CRS Contractor. Members continue to receive acute care and long term care services from the primary program of enrollment (DDD).

SMI Eligibility: DDD members who are diagnosed with Serious Mental Illness and who are not enrolled with the CRS Contractor will continue to receive acute care and long term care services from DDD. Behavioral health services for DDD members diagnosed with SMI are received through the RBHA. American Indian members determined to meet SMI criteria can choose to receive behavioral health services through a RBHA or TRBHA, IHS or 638 tribal facility.

Member Education: The Contractor shall be responsible for educating members in the Member Handbook and other materials to inform members how to access covered behavioral health services. Materials shall include information about behavioral health conditions that may be treated by a primary care provider (PCP) which includes anxiety, depression and ADHD. Refer to the AMPM Chapter 300 for covered behavioral health services.

Monitoring, Training and Education: The Contractor is responsible for training case managers and providers to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services and referrals, how to access services, including the petitioning process, how to involve the member and their family in decision-making and service planning, and information regarding initial and quarterly behavioral health consultation requirements. The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Training for case managers and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. The Contractor shall maintain documentation of the behavioral health trainings in accordance with AMPM Policy 310.

Referrals: A direct referral for a behavioral health evaluation may be made by any health care professional. A member, his/her family and/or guardian, may also self-refer to the T/RBHA for screening, evaluation or treatment or be referred by schools, State agencies, providers, or other parties. The Contractor shall develop, monitor and continually evaluate its processes for timely referral for behavioral health services.

EPSDT: As specified in Paragraph 10, Covered Services, EPSDT, the Contractor must provide developmental/behavioral health screenings for members up to 21 years of age in compliance with the AHCCCS periodicity schedule. The Contractor shall ensure the initiation and coordination of behavioral health referrals when determined necessary through the screening process.

Access to Behavioral Health Services: The Contractor is responsible for collaborating with T/RBHAs regarding referrals and follow-up activities, as necessary, for members identified by the Contractor as needing behavioral health evaluation and treatment. The Contractor is responsible for providing transportation to a member's first behavioral health evaluation appointment if a member is unable to provide their own transportation.

Coordination of Care: There shall be procedures in place for ensuring that members' behavioral health services are appropriately provided, are documented in the member's record and are tracked by the case manager. The Contractor shall also have procedures in place for ensuring communication occurs between the case manager, the PCP and behavioral health providers and that care is coordinated with other agencies and involved parties.

Medical Records: The Contractor is responsible for ensuring that a medical record is established by the PCP when behavioral health information is received from the T/RBHA or the behavioral health provider about a member assigned to a PCP even if the PCP has not yet seen the assigned member. In lieu of establishing a medical record, the information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

Sharing of Records: The Contractor shall, within 10 business days of receiving the request, require the PCP to coordinate care and respond to T/RBHA and/or behavioral health provider information requests pertaining to members receiving services through the behavioral health system. The response should include but is not limited to, current diagnoses, medications, laboratory results, most recent PCP visit, and information about recent hospital and emergency room visits. For guidance in addressing the needs of members with multi system involvement and complex behavioral health and co-occurring conditions, refer to AMPM Policy 570, Community Collaborative Care Teams.

The Contractor shall require the PCP to document or initial signifying review of member behavioral health information received from a behavioral health provider who is also treating the member. The Contractor shall have a policy and process in place to timely involve a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). For further guidance in addressing the needs of members with multi system involvement and complex behavior health and co-occurring conditions, refer to AMPM Policy, 570, Community Collaborative Care Teams. When attempting to place a member in a NF or HCBS

setting, the Contractor shall also disclose all information that pertains to the member's behaviors. To address members residing in a non-behavioral health unit who present with behaviors that may be a danger to self or danger to others, in order to promote early intervention and prevent an unnecessary change of placement. See AMPM Chapter 1600 and Appendix H.

Quality management processes for behavioral health services must be included in the Contractor's Quality Management Plan and shall meet the quality management requirements of AHCCCS as specified in the AMPM Chapter 900. The Contractor shall ensure that its quality management program incorporates monitoring of the PCP's referral to, coordination of care with, and transfer of care to behavioral health providers as required under this contract.

Sharing of Data: On a recurring basis (no less than quarterly based on adjudication date), AHCCCS shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services, during the member's enrollment period, from another contractor or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

Arizona State Hospital Discharges: For enrolled members who are inpatient at the Arizona State Hospital (AzSH), the Contractor is required to follow ACOM Policy 432 and AMPM Policy 1020 regarding medical care coordination for these members.

Medication Management Services: The Contractor shall allow PCPs to treat members diagnosed with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. The Contractor shall make available, on the Contractor's formulary, medications for the treatment of these disorders. The Contractor is responsible for these services both in the prospective and prior period coverage timeframes.

Tool Kits: Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AMPM. Refer to AMPM Appendix E, Childhood and Adolescent Behavioral Health Tool Kits and Appendix F Behavioral Health Tool Kits. These tool kits are a resource only and may not apply to all patients and all clinical situations. The tool kits are not intended to replace clinical judgment. The Contractor shall ensure that PCPs who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized, clinical tools/evidence-based guidelines. The Contractor shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

Step Therapy: The Contractor may implement step therapy for behavioral health medications used for treating anxiety, depression and ADHD disorders. The Contractor shall provide education and training for providers regarding the concept of step therapy. If the T/RBHA/behavioral health provider provides documentation to the Contractor that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the Contractor shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression or ADHD. The Contractor shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

Emergency Services: When members present in an emergency room setting, the Contractor is responsible for payment of all emergency room services and transportation for all members regardless of the principal diagnosis on the emergency room and/or transportation claim. In addition to those emergency services listed above, the Contractor is responsible for payment of the associated professional services when the principal diagnosis on the claim is physical health, as delineated in ACOM Policy 432.

Transfer of Care: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be transferred to a T/RBHA/ behavioral health provider for evaluation and/or continued medication management services, the Contractor shall require and ensure that the PCP coordinates the transfer of care. All affected subcontracts shall include this provision.

For members assigned to a T/RBHA, the Contractor shall establish policies and procedures for the transition of members to the T/RBHA for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members.

The policies and procedures must address, at a minimum, the following:

1. Guidelines for when a transition of the member to the T/RBHA for ongoing treatment is indicated;
2. Protocols for notifying the T/RBHA of the member's transfer, including reason for transfer, diagnostic information, and medication history;
3. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to T/RBHA requests for additional medical record information;
4. Protocols for transition of prescription services, including but not limited to notification to the T/RBHA of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination must ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with a T/RBHA prescriber and that all relevant member medical information including the reason for transfer is forwarded to the receiving T/RBHA prescriber prior to the member's first scheduled appointment with the T/RBHA prescriber; and
5. Contractor monitoring activities to ensure that members are appropriately transitioned to the T/RBHA for care.

13. CHILDREN'S REHABILITATIVE SERVICES

Children's Rehabilitative Services (CRS) is a program for children with special health care needs. The CRS program is administered by AHCCCS utilizing a CRS Contractor for children with special health care needs who meet CRS eligibility criteria. The CRS Contractor provides various combinations of acute, behavioral health and specialty CRS services for these children. The Contractor shall refer children to AHCCCS Division of Member Services (DMS) who are potentially eligible for services related to CRS covered conditions, as specified in A.A.C. R9-22, Article 13 and A.R.S. Title 36. The Contractor shall notify the member when a referral to CRS has been made. The Contractor is responsible for all care of members until those members are determined eligible for CRS by AHCCCS, Division of Member Services. See ACOM Policy 426 for the processes used to accept and process referrals to the CRS Program. In addition, the Contractor is responsible for CRS covered services for CRS-eligible members unless and until the Contractor has received confirmation from AHCCCS that the member has been determined eligible for CRS covered services, with the CRS Contractor. The Contractor shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Contractor. For detailed information regarding eligibility criteria, referral practices and Contractor CRS coordination issues, refer to the AMPM and the ACOM located on the AHCCCS website.

The Contractor shall respond to requests for services potentially covered by the CRS Contractor in accordance with the related ACOM and AMPM Policies. The Contractor is responsible for addressing prior authorization requests for CRS covered services if the CRS Contractor fails to comply with the timeframes specified in the related ACOM and AMPM Policies. The Contractor is responsible for payment of emergency department facility and professional claims (in or out of network), regardless of whether or not the service is related to the CRS condition. In addition, the Contractor remains ultimately responsible for the provision of all AHCCCS covered services denied by the CRS Contractor for the reason that it is not a service related to the CRS condition.

Referral to the CRS Contractor does not relieve the Contractor of the responsibility for providing timely medically necessary AHCCCS covered services not covered by the CRS Contractor. In the event that the CRS Contractor denies a medically necessary AHCCCS covered service for the reason that it is not related to a CRS covered condition, the Contractor must promptly respond to the service authorization request and authorize the provision of medically necessary covered services. The CRS Contractor cannot contest the Contractor's prior authorization determination if the CRS Contractor fails to timely respond to a service authorization request. The Contractor, through its Medical Directors, may request review from the CRS Contractor Medical Director when it denies a service for the reason that it is not covered by the CRS Program. In the event that the Contractor disagrees with a coverage decision by the CRS Contractor, the Contractor must cover the care or service while submitting an appeal to AHCCCS as specified in AMPM. The Contractor may also request a hearing with AHCCCS if it is dissatisfied with the CRS Contractor determination. If the AHCCCS review determines that the service should have been provided by the CRS Contractor, the CRS Contractor shall be financially responsible for the costs incurred by the Contractor in providing the service.

14. OUT-OF-SERVICE AREA AND OUT-OF-STATE PLACEMENT

ALTCS members who are temporarily out of the Contractor's service area may be provided long term care services while out of the service area, including HCBS. The Contractor is not expected to set up special contractual arrangements to provide long term care services out of the service area but, should consider authorization when member-specific providers, such as family Attendant Care, are available during the temporary absence. ALTCS members temporarily absent from Arizona without authorization from the Contractor are eligible for acute emergency services only. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Contractor shall report all absences of more than 30 days from the state to the ALTCS eligibility office for a determination of continued eligibility as specified in Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance.

The Contractor shall submit a written request to AHCCCS Division of Health Care Management as specified in AMPM Chapter 1600, before placing a member in a setting outside the state to facilitate a coordinated review with the Division of Member Services for any potential eligibility impact.

15. ALTCS TRANSITIONAL PROGRAM

The ALTCS Transitional Program is available for members (both institutional and HCBS) who, at the time of medical reassessment, have improved either medically, functionally or both to the extent that they no longer need institutional care, but who still need significant long term care services. For those members who are living in a medical institution when determined eligible for the ALTCS Transitional program, the Contractor shall arrange for home and community based placement as soon as possible, but not later than 90 days after the effective date of eligibility for the ALTCS Transitional Program.

ALTCS Transitional members are entitled to all ALTCS covered services except for institutional custodial care (services provided at an institutional level in a nursing facility or intermediate care facility). When institutional care is determined medically necessary, the period of institutionalization may not exceed 90 consecutive days. If institutional care is expected to exceed 90 consecutive days, the Contractor shall request a medical eligibility reassessment (PAS) within 45 days of institutional admission. ALTCS Transitional members determined by the PAS to be at risk of institutionalization will be transferred from the ALTCS Transitional Program to the regular ALTCS program effective the PAS reassessment disposition date.

Contractor compliance will be monitored through the AHCCCS Division of Health Care Management.

16. CASE MANAGEMENT

Case management is the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible

for ALTCS services. The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.

A case manager is a person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years' experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case managers shall not provide direct care services to members enrolled with the Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

The case manager will make every effort to foster a member-centered approach and respect maximum member/family self-determination while promoting the values of dignity, independence, individuality, privacy and choice. Case management begins with a respect for the member and member's family's preferences, interests, needs, culture, language and belief system.

The involvement of the member and the member's family in strengths and needs identification and in decision making is a basic tenet of case management practice. Care plan development is a shared responsibility with the member/family/significant others input seen as key to the success of the plan. The member/family/significant others are partners with the case managers in the development of the plan with the case manager in a facilitating mode.

Case managers are expected to use a holistic approach regarding the member assessment and needs taking into account not only ALTCS covered services but also other needed community resources as applicable. Case managers are expected to:

- a. Respect the member's rights;
- b. Support the member to have a meaningful role in planning and directing their own care to maximum extent possible;
- c. Provide adequate information and training to assist the member/family in making informed decisions and choices. This information must be reviewed until such time as the member/representative indicates s/he understands it;
- d. Be available to answer questions and address service issues raised by the member or representative, including between regularly scheduled review visits.
- e. Provide a continuum of service options that support the expectations and agreements established through the care plan process;
- f. Educate the member/family on how to timely report unavailability or other problems with service delivery to the Contractor or AHCCCS in order that unmet needs can be addressed as quickly as possible.
- g. Facilitate access to non-ALTCS services available throughout the community;
- h. Advocate for the member and/or family/significant others as the need occurs;
- i. Allow the member/family to identify their role in interacting with the service system including the extent to which the family/informal support system will provide uncompensated care ;
- j. Provide members with flexible and creative service delivery options;
- k. Educate members about member directed options for delivery of designated services. Review these options, at least annually, with members living in their own homes;
- l. Educate members on their option to choose their spouse as their paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs
- m. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services;
- n. Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member;
- o. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment; and

- p. Refer member cases, via electronic Member Change Report (MCR), to the AHCCCS Division of Member Services for a medical eligibility reassessment if a member is assessed to no longer require an institutional level of care. See the ALTCS Member Change Request User Guide for MCR instructions.

The Contractor must conduct case management orientation for new staff and on-going training programs for all case management staff that includes case management standards (as outlined in AMPM Chapter 1600), the ALTCS guiding principles and subjects relevant to the population served (e.g. disability issues, behavioral health, member rights, case manager's quality management role, etc.)

Case managers shall follow all applicable standards outlined in AMPM Chapter 1600 while conducting case management activities for and with ALTCS members/families/significant others.

The case manager shall make initial contact and periodic placement/service reviews on-site with the member/family/significant others within appropriate timeframes established by AHCCCS policy. The purpose of these visits shall be to assess the continued suitability and cost effectiveness of the services and placement in meeting the member's needs as well as the quality of the care delivered by the member's service providers. Additionally, at these reviews the member/family/significant other shall be asked to sign a service plan that indicates whether the member/representative agrees or disagrees with the services to be authorized. If the member disagrees, the case manager shall follow appropriate procedures for providing the member written notice of the action and the member's right to appeal the decision.

The case manager shall be responsible for assessing the member's overall functional and medical status at each review. This information must be incorporated into the service plan development and, for HCBS members as outlined in policy, the contingency plan process in order to ensure the member's needs are met. The case manager shall maintain a cost-effective individualized service plan, while assisting to resolve problems in the delivery of needed services.

The case manager shall assist members who receive Attendant Care, Personal Care, Homemaker and/or In-home Respite Care to develop the contingency/back-up plan which includes information about actions that the member/representative should take to report any gaps in those services. This plan must also include the "Member Service Preference Level" which identifies how quickly and by whom (informal vs. paid caregiver) the member/representative chooses to have a service gap filled if the scheduled caregiver of that service is not available. This contingency plan must be reviewed with the member/representative at each service review visit (at least every 90 days) and documented in the case file.

When screened as potentially having a developmental disability, an ALTCS applicant will be referred to the Contractor for an eligibility determination. If a determination is not made within 30 days of the referral, a PreAdmission Screening (PAS) tool will be completed for medical eligibility. If the applicant meets the ALTCS eligibility criteria, the individual will be enrolled with the Contractor. The Contractor will then be responsible for assessing and providing for the member's needs in a timely manner until such time as the member is determined to not meet Contractor eligibility and is disenrolled. The Contractor must provide notification of this determination to the local ALTCS office.

The Contractor must notify AHCCCS when members are determined no longer eligible under DD criteria. AHCCCS staff will then perform an EPD PAS to see if the member meets EPD medical eligibility criteria. If so, the member will be disenrolled from the Contractor and enrolled with an ALTCS EPD Contractor. In such situations, the Contractor must continue to provide services until the date of disenrollment from the Contractor and ensure a smooth transition of the member's care to the EPD Contractor.

Client Assessment and Tracking System: The Contractor shall ensure complete, correct and timely entry of data related to placement history and cost effectiveness studies into the Client Assessment and Tracking System (CATS). "Timely" shall mean within 14 days of the event which gave rise to the transaction (e.g., service approval by the case manager, placement change). Unless the Contractor is currently transmitting data to CATS

electronically, all data entry shall be entered on-line. If the Contractor is not currently on-line, it must have a systems interface in place so it can update the case management information no less than twice per month with an error rate of 5% or less. The Contractor is not required to enter service authorizations into the CATS. The Contractor is, however, expected to maintain a uniform tracking system in each member chart documenting the begin and end date of services inclusive of renewal of services and the number of units authorized for services as required by the AMPM Chapter 1600. See ACOM Policy 411 for a tutorial on access to and data entry into CATS.

The Contractor shall provide AHCCCS, within the timeline specified in Attachment F3, Contractor Chart of Deliverables, with an annual Case Management Plan. This plan shall outline how all case management and administrative standards in AMPM Chapter 1600 will be implemented and monitored by the Contractor. The administrative standards shall include but not be limited to a description of the Contractor's systematic method of monitoring its case management program as discussed in the following subparagraphs. The plan shall also include an evaluation of the Contractor's Case Management Plan from the prior year, to include lessons learned and strategies for improvement.

The Contractor shall implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of member assessments/service authorizations (inter-rater reliability). The Contractor shall compile reports of these monitoring activities to include analysis of the data and a description of the continuous improvement strategies the Contractor has taken to resolve identified issues. This information shall be made available upon request by AHCCCS.

The Contractor shall ensure adequate staffing to meet case management requirements. The Contractor's case management plan shall also describe their methodology for assigning and monitoring case management caseloads.

Caseload Ratios: A 1:35 caseload ratio will be in effect for any membership above the number of enrolled members as of June 30, 2006 (17,910). AHCCCS will annually determine an average weighted caseload based on 1:40 and 1:35 case manager ratios, the membership as of June 30, 2006 and the number of members above the June 30, 2006 baseline.

If caseloads exceed the annually determined average of 1:39, the Contractor shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must also be sufficient to cover case manager absenteeism, turnover and out-of-state members.

17. MEMBER INFORMATION

The Contractor shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by the Contractor, shall be approved by AHCCCS prior to distribution to members. The reading level and name of the evaluation methodology used shall be included. The Contractor should refer to ACOM Policy 404 for further information and requirements. See also Attachment F3, Contractor Chart of Deliverables.

All materials shall be translated when the Contractor is aware that a language is spoken by 3,000 or 10%, whichever is less, of the Contractor's members, who also have Limited English proficiency (LEP).

All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5%, whichever is less, of the Contractor's members, who also have LEP [42 CFR 438.10(c)(3)]. Vital materials must include, but are not limited to the following:

1. Member Handbooks
2. Consent Forms

3. Member notices
4. Grievance, appeal, and request for State fair hearing information
5. Written notices informing members of their right to interpretation and translation services

In addition, the following Vital Materials must include a tagline in all languages spoken by 1,000 or 5%, whichever is less, of the Contractor's members, who also have LEP. The Vital Materials must be made available in the LEP language spoken by 1,000 or 5% of the population upon request by the member.

1. Notices of Actions
2. Notices of Appeal Resolution
3. Communications requiring a response from the member

Oral interpretation services must be available and at no cost to all members regardless of the prevalence of the language. The Contractor must notify all members of their right to access oral interpretation services and how to access them. Refer to ACOM Policy 404. [42 CFR 438.10(c)(4) and (5)]

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in ACOM Policy 404 [42 CFR. 438.10(b)(1)]. Regardless of the format chosen by the Contractor, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. [42 CFR 438.10(b)(1) and (b)(3)] The Contractor must notify its members that alternative formats are available and how to access them [42 CFR 438.10(d)]. The Contractor shall adhere to the requirements for Social Networking Activities as described in ACOM Policy 425.

When there are program changes, notification shall be provided to members at least 30 days before implementation.

Website Requirements

The Contractor shall develop and maintain a website that is focused, informational, user-friendly, functional, and provides the information as required in ACOM Policy 416 and ACOM Policy 404.

Member Handbook and Provider Directory

The Contractor shall provide the following printed information to each member/representative or household within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]:

1. A **Member Handbook** which, at a minimum, shall include the items listed in ACOM Policy 404.

The Contractor shall review and update the Member Handbook at least once a year. The Handbook must be submitted to AHCCCS, Division of Health Care Management for approval as specified in Attachment F3, Contractor Chart of Deliverables.

Upon the initial case management assessment, and annually thereafter, the case manager will review the contents of the Member Handbook with the member or authorized representative.

2. A **Provider Directory**, which at a minimum, includes those items listed in ACOM Policy 404.

The Contractor has the option of providing the Provider Directory in hard copy format or providing written notification of how the Provider Directory information is available on the Contractor's website, via electronic mail, or via postal mailing as described in ACOM Policy 404. The written notification shall be sent to members within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)].

The Contractor must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is

seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. The Contractor shall have information available for potential enrollees as described in ACOM Policy 404 [42 CFR 438.10(f)(4)].

Member Newsletter

The Contractor must develop and distribute, at a minimum, two member newsletters during the contract year. The following types of information are to be contained in the newsletter at least annually:

1. Educational information on chronic illnesses and ways to self-manage care
2. Reminders of flu shots and other prevention measures at appropriate times
3. Medicare Part D issues
4. Cultural Competency, other than translation services
5. Contractor specific issues (in each newsletter)
6. Tobacco cessation information
7. HIV/AIDS testing for pregnant women
8. Other information as required by AHCCCS

Member Rights

The Contractor will, on an annual basis, inform all members of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)]. This information may be sent in a separate written communication or included with other written information such as in a member newsletter.

1. An updated Member Handbook at no cost to the member
2. The Provider Directory as described in ACOM Policy 404

The Contractor shall ensure compliance with any applicable Federal and State laws that pertain to member rights and ensure that its staff and subcontractors take those rights into account when furnishing services to members.

The Contractor shall ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member and to request that the record be amended or corrected, as specified in 45 CFR Part 164.

The Contractor shall ensure that each member is free to exercise their rights and that the exercise of those rights does not adversely affect the way the Contractor or its subcontractors treat the member. [42 CFR 438.100(c)]

18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS electronic Member Change Report provides the Contractor with a method for complying with notification to the ALTCS eligibility offices and AHCCCS of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, living arrangements, share of cost, income or resources; a change in medical condition which could affect eligibility; no long term care services provided; demographic changes or the member's death. See the ALTCS Member Change Report User Guide for MCR instructions.

19. PRE-ADMISSION SCREENING AND RESIDENT REVIEW

The Contractor shall ensure members have the Preadmission Screening and Resident Review (PASRR) Level I and, if needed, Level II screenings prior to admission to a nursing facility. Level I is the identification of members who are suspected of having mental illness or intellectual disability. Level II determines whether nursing facility or specialized services are needed. Failure to have the proper PASRR screening prior to placement of members in a nursing facility may result in Federal Financial Participation (FFP) being withheld from AHCCCS. Should withholding of FFP occur, AHCCCS will recoup the withheld amount from the

Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the nursing facility which admitted the member without the proper PASRR.

20. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

The Contractor shall provide quality medical care to members, regardless of payer source or eligibility category. The Contractor shall promote improvement in the quality of care provided to enrolled members through established Quality Management and Performance Improvement (QM/PI) processes. The Contractor shall execute processes to monitor, assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities, as specified in the AMPM Chapters 400 and 900 [42 CFR 438.240(a)(1) and (e)(2) and CFR 42 447.26]. See also Attachment F3, Contractor Chart of Deliverables.

The Contractor must ensure that the Quality Management/Quality Improvement Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Case Management. The Contractor is expected to integrate quality management processes, such as tracking and trending of issues through all areas of the organization, with ultimate responsibility for quality management/quality improvement residing within the Quality Management.

Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AMPM and this Paragraph.

Federal regulation prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) and that meet the following criteria:^{vi}

- a. Is identified in the State plan
- b. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines
- c. Has a negative consequence for the beneficiary
- d. Is auditable
- e. Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient [42 CFR 438.6(f)(2)(i), 42 CFR 434.6(a)(12)(i), 42 CFR 447.26(b)].

If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation as outlined in AMPM Chapter 900 and Attachment F3, Contractor Chart of Deliverables [42 CFR 438.6(f)(2)(ii) and 42 CFR 434.6(a)(12)(ii)].^{vii}

Quality Management Program

The Contractor shall have an ongoing quality management program for the services it furnishes to members. The quality management program shall include but is not limited to:

1. A written Quality Assessment and Performance improvement (QA/PI) plan and an evaluation of the previous year's QA/PI program.
2. Quality management quarterly reports that address strategies for QM/PI activities.
3. QM/PI program monitoring and evaluation activities which include Peer Review and Quality Management Committees which are chaired by the Contractor's local Chief Medical Officer.
4. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
5. Member rights and responsibilities [42 CFR 238.100(b)(2)(iv)].
6. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational assessment verification [42 CFR 438.206(b)(6)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's local

- Medical Director [42 CFR 438.214]. The Contractor should refer to the AMPM Chapter 900 and Attachment F3, Contractor Chart of Deliverables, for reporting requirements. The process:
- a. Shall follow a documented process for provisional credentialing, initial credentialing, recredentialing and organizational credentialing verification of providers who have signed contracts or participation agreements with the Contractor;
 - b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
 - c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
7. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, abuse, neglect, exploitation, and unexpected deaths. The resolution process must include:
 - a. Acknowledgement letter to the originator of the concern;
 - b. Documentation of all steps utilized during the investigation and resolution process;
 - c. Follow-up with the member to assist in ensuring immediate health care needs are met;
 - d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns;
 - e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern; and
 - f. Analysis of the effectiveness of the interventions taken.
 8. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
 9. Requirement for any ADHS licensed or certified provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. The Contractor shall monitor contracted providers for compliance with quality management measures including supervisory visits conducted by a Registered Nurse when a home health aide is providing services.
 10. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
 11. Performance Improvement Programs including performance measures and performance improvement projects.

Credential Verification Organization Contract: The Arizona Association of Health Plans (AzAHP) has established a contract with a Credential Verification Organization (CVO) that is responsible for receiving completed applications, attestations and primary source verification documents. The CVO is also responsible for conducting annual entity site visits to ensure compliance with AHCCCS requirements. The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and recredentialing process regardless of membership in the AzAHP. This requirement eases the administrative burden for providers that contract with AHCCCS Contractors which often results in duplicative submission of information used for credentialing purposes. The Contractor shall follow the AHCCCS recredentialing timelines for providers that submit their credentialing data and forms to the AzAHP CVO. The Contractor is responsible for completing the credentialing process. The Contractor shall continue to include utilization, performance, complaint, and quality of care information, as specified in the AMPM, to complete the credentialing or recredentialing files that are brought to the Credentialing Committee for a decision. In addition, the Contractor must also meet the AMPM requirements for provisional/temporary credentialing.

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall calculate and report to AHCCCS as outlined in AMPM Policy 950. The Contractor must report the credentialing information with regard to all credentialing applications as specified in Attachment F3, Contractor Chart of Deliverables.

The Contractor must have a process in place to conduct monitoring and oversight of care and services provided in the home and community based setting. Monitoring of HCBS sites may include a collaborative process involving quality management and case management staff (support coordinators), including the utilization of the case manager onsite visits with members. The Contractor must develop a process that, at a minimum, meets the requirements specified in the AMPM Chapter 900.

Performance Improvement: The Contractor's quality management program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and non-clinical care which are expected to have a favorable effect on health outcomes and member satisfaction [42 CFR 438.240(b)(2) and (c)]:

The Contractor must:

1. Measure and report to the State its performance, using standard measures required by AHCCCS, or as required by CMS;
2. Submit specified data to the State that enables the State to measure Contractor performance; or
3. Perform a combination of the above activities.

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

1. Measurement of performance using objective quality indicators
2. Implementation of system interventions to achieve improvement in quality
3. Evaluation of the effectiveness of the interventions
4. Planning and initiation of activities for increasing or sustaining improvement

Performance Measures:

The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures and links to the CMS and the measure host sites can be found on the AHCCCS website. The EPSDT Participation performance measure description utilizes the methodology established in CMS "Form 416" which can be found on the AHCCCS website.

The Contractor must comply with Federal performance measures and levels that may be identified and developed by CMS or those that are developed in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid and CHIP programs. As the Core Measure sets are implemented, performance measures required by AHCCCS may be updated to include these measures.

AHCCCS may utilize a hybrid or other methodologies for collecting and reporting performance measure rates, as allowed by the National Committee of Quality Assurance NCQA, for selected Healthcare Effectiveness Data and Information Set (HEDIS) measures or as allowed by other entities for nationally recognized measure sets. The Contractor shall collect data from medical records, electronic records or through approved processes such as those utilizing a health information exchange and provide these data with supporting documentation, as instructed by AHCCCS, for each hybrid measure. The number of records that each Contractor collects will be based on HEDIS, External Quality Review Organization (EQRO), or other sampling guidelines and may be affected by the Contractor's previous performance rate for the measure being collected.

The Contractor must have a process in place for monitoring performance measure rates. The Contractor shall utilize a standard methodology established or adopted by AHCCCS for measurement of each required performance measure. The Contractor's QM/PI Program will report its measured performance on an ongoing

basis to its Administration. The Contractor performance measure monitoring results shall also be reported to AHCCCS in conjunction with its EPSDT Improvement and Adult Quarterly Monitoring Report.

The Contractor must meet AHCCCS stated Minimum Performance Standards (MPS) for each population for which AHCCCS reports results. AHCCCS-reported rates are the official rates utilized for determination of Contractor compliance with performance requirements. It is equally important that in addition to meeting the contractual MPS, the Contractor continually improve performance measure outcomes from year to year. Contractor calculated and/or reported rates will be used strictly for monitoring Contractor actions and not be used for official reporting or for consideration in corrective action purposes.

Minimum Performance Standard: MPS is the minimal expected level of performance by the Contractor. If the Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to a sanction for each deficient measure.

The Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on the Contractor if it does not show statistically significant improvement in a measure rate as calculated by AHCCCS. Sanctions may also be imposed for statistically significant declines of rates even if they meet or exceed the MPS, for any rate that does not meet the AHCCCS MPS, or a rate that has a significant impact to the aggregate rate for the State. AHCCCS may require that the Contractor demonstrate that it is allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan for measures that are below the MPS or that show a statistically significant decrease in its rate even if it meets or exceeds the MPS.

An evidence-based corrective action plan that outlines the problem, planned actions for improvement, responsible staff and associated timelines as well as a place holder for evaluation of activities must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up desktop or on-site review to verify compliance with a corrective action plan.

All Performance Measures apply to all member populations [42 CFR 438.240(a)(2), (b)(2) and (c)]. AHCCCS may analyze and report results by placement, by Geographical Service Area (GSA) or County, as well as, applicable demographic factors.

Performance Measures

All Performance Measures described below may apply to all member populations [42 CFR 438.240(a)(2);(b)(2) and (c)]. AHCCCS may analyze and report results by placement (HCBS vs. nursing facility), GSA or County and/or other applicable demographic factors.

AHCCCS has established standards for the measures listed below.

The following table identifies the MPS for each measure:

DDD Performance Measures	
Measure	Minimum Performance Standard
Inpatient Utilization	51 Per 1000 Member Months
ED Utilization	43 Per 1000 Member Months

Hospital Readmissions	11%
Adults' Access to Preventive/Ambulatory Health Services	75%
Breast Cancer Screening (BCS)	50%
Cervical Cancer Screening (CCS)	64%
Chlamydia Screening in Women (CHL)	63%
DDD Performance Measures	
Measure	MPS
<i>Comprehensive Diabetes Management</i>	
CDC - HbA1c Testing	77%
CDC - HbA1c Poor Control (>9.0%)	41%
CDC - Eye Exam	49%
<i>Flu Shots for Adults, Ages 18 and Older (FVA)</i>	75%
Use of Opioids From Multiple Providers at High Dosage in Persons Without Cancer	Baseline Measurement Year
Children's Access to PCPs, by age: 12-24 mo.	93%
Children's Access to PCPs, by age: 25 mo.-6 yrs.	84%
DDD Performance Measures	DDD Performance Measures
MPS	MPS
Children's Access to PCPs, by age: 7-11 yrs.	83%
Children's Access to PCPs, by age: 12-19 yrs.	82%
Well-Child Visits: 3-6 yrs.	66%
Adolescent Well-Care Visit: 12-21 yrs.	41%
Children's Dental Visits: (ages 2-21)	60%
Percentage of Eligibles Who Received Preventive Dental Services ⁽¹⁾	46%
SEAL: Dental Sealants for Children Ages 6-9 at Elevated Caries Risk	Baseline Measurement Year; CMS will be establishing MPS
<i>Childhood Immunization Status</i>	
DTaP	85%
IPV ⁽²⁾	91%

MMR ⁽²⁾	91%
Hib ⁽²⁾	90%
HBV ⁽²⁾	90%
VZV ⁽²⁾	88%
PCV ⁽²⁾	82%
Hepatitis A (HAV)	85%
Rotavirus	60%
Influenza Combination 3 (4:3:1:3:3:1:4)	45% 68%

DDD Performance Measures	
Measure	MPS
<i>Adolescents Immunizations</i>	
Adolescent Meningococcal	75%
Adolescent Tdap/Td	75%
Combination 1	75%
Human Papillomavirus Vaccine for Female Adolescents	50%

Note:

⁽¹⁾ EPSDT Dental Participation Standards (Preventive Dental) are based on the CMS-established goal that States improve their rates of children ages one through 20 enrolled in Medicaid and who received any preventive dental service by 10 percentage points over a five-year period.

⁽²⁾ AHCCCS will continue to measure and report results of these individual antigens; however, a Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.

*Performance Measures with Reserve Status**

Measure	Minimum Performance Standard
Diabetes Admissions, Short-Term Complications (PQI-01)	67 Per 100,000 Member Months
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	282 Per 100,000 Member Months

Heart Failure Admission Rate (PQI-08)	75 Per 100,000 Member Months
Asthma in Younger Adults Admissions (PQI-15)	75 Per 100,000 Member Months
Annual Monitoring for Patients on Persistent Medications: Combo Rate	75%
Weight Assessment and counseling - Body Mass Index (BMI) Assessment for Children/Adolescents	50%
EPSDT Participation ⁽¹⁾	68%
Developmental Screening in the First Three Years of Life	55%

Note:

* Performance measures remain important to AHCCCS and as such will continue to be monitored by AHCCCS. Should Contractor performance results for Performance Measures in Reserve Status decline, the Contractor may be subject to corrective action. AHCCCS may require individual Contractors to implement improvement actions for Performance Measures with Reserve Status in order to ensure quality of care to AHCCCS members. Measures deemed in Reserve Status will be reported out when appropriate.

⁽¹⁾ The EPSDT Participation rate is the percent of all children and adolescents younger than 21 years who were due for at least one EPSDT visit, depending on their age and the state's EPSDT Periodicity Schedule, and had a visit during the contract year.

Contractor Performance is evaluated annually using the AHCCCS-reported rate for each measure. AHCCCS rates are considered the official measurement for each Performance Measure. AHCCCS calculated rates by Contractor for each measure will be compared with the MPS specified in the contract in effective during the measurement period. For instance, Performance Standards in the Contract Year Ending (CYE) 2015 contract apply to results calculated by AHCCCS for the CYE 2015 measurement period. AHCCCS will utilize methodologies that are reflective of the requirements for the measurement period. For instance, CYE 2014 performance measure data will be based on the published 2014 CMS Core Sets and 2014 HEDIS technical specifications. Contractors are responsible for monitoring and reporting to AHCCCS CQM the status of, and any discrepancies identified in encounters received by AHCCCS including paid, denied and pended for purposes of Performance Measure monitoring prior to the AHCCCS Performance Measure rate calculations being conducted.

The Contractor shall participate in immunization audits, at intervals specified by AHCCCS, based on random sampling to verify the immunization status of members at 24 months of age and by 13 years of age. If records are missing for more than five percent (5%) of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS. An EQRO may conduct a study to validate the Contractor's reported rates.

AHCCCS will measure and report the Contractor's EPSDT Participation rate and Dental Participation (Preventive Dental) rate, utilizing the CMS 416 methodology. The EPSDT Participation rate is the number of children younger than 21 years that receive medical screens in compliance with the State's Periodicity Schedule, compared to the number of children expected to receive medical screens per the State's Periodicity Schedule. The Preventive Dental Participation rate is the number of children aged one through 20 who have a

preventive dental visit, compared to the number of children who has at least 90-days continuous enrollment during the Contract Year (measurement period).

The Contractor is responsible for applying the correct CMS-416 methodology as developed and maintained by CMS for its internal monitoring of performance measure results.

AHCCCS uses the national CMS 416 methodology to generate the EPSDT Participation and Dental Participation rates through a CMS-validated process. The rates are generated one time a year and reported to CMS within specified timeframes. Aggregate rates as well as Contractor-specific rates are included in this process.

The Contractor must participate in the delivery and/or results review of member surveys as requested by AHCCCS. Surveys may include Home and Community Based (HCBS) Member Experience surveys, HEDIS Experience of Care (Consumer Assessment of Healthcare Providers and Systems – CAHPS) surveys, and/or any other tool that AHCCCS determines will benefit quality improvement efforts. While not included as an official performance measure, survey findings or performance rates for survey questions may result in the Contractor being required to develop a Corrective Action Plan (CAP) and/or participate in technical assistance or AHCCCS-led workgroups to improve any areas of concern noted by AHCCCS. Failure to effectively develop or implement AHCCCS-approved CAPs and drive improvement may result in additional regulatory action.

The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. The Contractor must implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence.

Performance Improvement Program: The Contractor shall have an ongoing program of Performance Improvement Projects (PIPs) that focus on clinical and non-clinical areas, as specified in the AMPM, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions;
4. Planning and initiation of activities for increasing or sustaining improvement.

PIPs are mandated by AHCCCS, the Contractor should also self-select additional projects based on opportunities for improvement identified by internal data and information. The Contractor shall report the status and results of each project to AHCCCS as requested using the AHCCCS PIP Reporting Template included in the AMPM. Each PIP must be completed in a reasonable time period to allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. [42 CFR 438.240(d)(2)]

Data Collection Procedures: When requested by AHCCCS, the Contractor must submit data for standardized Performance Measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting data. The Contractor is responsible for collecting valid and reliable data, including data collected by subcontracted acute care health plans, and for using qualified staff and personnel to collect the data. The Contractor must ensure that data collected by multiple parties/people for Performance Measures and/or PIP reporting is comparable and that an inter-rater reliability process was used to ensure consistent data collection. Data collected for Performance Measures and/or PIPs must be returned by the Contractor in a format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

21. MEDICAL MANAGEMENT

The Contractor shall implement processes to assess, plan, implement, evaluate, and as mandated, report Medical Management (MM) monitoring activities, as specified in the AMPM Chapter 1000. This shall include the Quarterly Inpatient Hospital Showings report, HIV Specialty Provider List, Transplant Log and Prior Authorization Requirements report as specified in the AMPM and Attachment F3, Contractor Chart of Deliverables. The Contractor shall evaluate MM activities, as specified in the AMPM Chapter 1000, including:

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer.
2. Prior authorization and Referral Management; for the processing of requests for initial and continuing authorizations of services the Contractor shall:
 - a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
 - b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
 - c. Monitor and ensure that all enrollees with special health care needs have direct access to care;
 - d. Review all prior authorization requirements for services, items or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements; A summary of the prior authorization requirement changes and the rationale for those changes must be included in the annual MM Evaluation submission; and
 - e. Comply with all decision timelines as outlined in the ACOM and the AMPM.
3. Development and/or Adoption of Practice Guidelines [42 CFR 438.235(b)], that:
 - a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
 - b. Consider the needs of the Contractor's members;
 - c. Are adopted in consultation with contracting health care professionals;
 - d. Are reviewed and updated periodically as appropriate, but at least annually;
 - e. Are disseminated by the Contractor to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
 - f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)].
4. Concurrent review:
 - a. Consistent application of review criteria; provide a basis for consistent decisions for utilization management, coverage of services and other areas to which the guidelines apply [42 CFR 438.236(d)];
 - b. Contractors must have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into an acute care facility or skilled nursing facility. The intent of the discharge planning policy and procedure is to increase the utilization management of inpatient admissions and decrease readmissions within 30 days of discharge; and
 - c. In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider -Preventable Condition (OPPC) (refer to AMPM Chapter 1000). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.
5. Continuity and coordination of care:
 - a. Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
 - b. Establish a process for timely and confidential communication of clinical information among providers;

- c. Must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who contact governmental entities for assistance, including AHCCCS;
- d. Must proactively provide care coordination for members who have both behavioral health and physical health needs. The Contractor must meet regularly with the CRS Contractor and the T/RBHAs to improve and address coordination of care issues. Meetings shall occur every other month or more frequently if needed to develop processes, implement interventions, and discuss outcomes. Care coordination meetings and staffings shall occur at least monthly or more often as necessary to affect change; and
- e. The Contractor must implement procedures to deliver primary care to and coordinate health care service for members. These procedures must ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee. [42 CFR 438.208(b)(1)].

The Contractor shall implement and report the following:

- Identify high need/high cost members for each Regional Behavioral Health Authority (RBHA) as specified in Section B, Capitation Rates and Contractor Specific Requirements in accordance with the standardized criteria developed by the AHCCCS/Contractor workgroup;
 - Plan interventions for addressing appropriate and timely care for these identified members; and
 - Report outcome summaries to AHCCCS utilizing the standardized template developed by the AHCCCS/Contractor workgroup as specified in Attachment F3, Contractor Chart of Deliverables.
6. Monitor and evaluate over and/or under-utilization of services [42 CFR 438.240(b)(3)].
 7. Evaluate new medical technologies and new uses of existing technologies; and
 8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee.

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438240(b)(4)].

On a recurring basis (no less than quarterly based on adjudication date), AHCCCS shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services, during the member's enrollment period, from another contractor or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

The Contractor shall develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members. In addition, the Contractor shall develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement must be reported in the annual MM Plan, Evaluation and Work Plan submitted to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables.

The Contractor will assess, monitor and report quarterly through the MM Committee, medical decisions to assure compliance with timeliness, language, Notice of Action intent, and that the decisions comply with all Contractor coverage criteria. This includes quarterly evaluation of all Notice of Action decisions that are made by a subcontracted entity.

The Contractor shall maintain a written MM Plan and a Work Plan that addresses monitoring MM activities (AMPM Chapter 1000). The Plan and Work Plan must be submitted for review within timelines specified in Attachment F3, Contractor Chart of Deliverables.

Criminal Justice System Reach-in Care Coordination: To facilitate the transition of members transitioning out of jails and prisons into communities, AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in criminal justice system "reach-in" care coordination efforts.

Effective October 1, 2016, the Contractor shall implement reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release. When behavioral health needs are identified, the Contractor shall also collaborate with the member's behavioral health Contractor (if the member's care is not integrated).

For CYE17, the Contractor is required to submit a Reach-In Plan, due October 31, 2016. The Plan, at a minimum, must include the following:

Administrative Requirements:

- Designation of a Justice System Liaison who will be responsible for the reach-in initiative and who:
 - Resides in Arizona,
 - Is the single point of contact to communicate with justice systems and the RBHAs, if appropriate, and
 - Is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC) and Probation Departments
- Identification of the name(s) and contact information for all criminal justice system partner(s)
- Identification of the name(s) and contact information for RBHA partner(s) for purposes of coordinating care for both physical and behavioral health needs
- Description of the process for coordination with Maricopa County jail, if appropriate, for identification of those members in probation status
- Designation of parameters for identification of members requiring reach-in care coordination (e.g. definition of chronic and/or complex care needs) through agreement with reach-in partners
- Description of the process and timeframes for communicating with reach-in partners
- Description of the process and timeframes for initiating communication with reach-in members
- Description of methodology for assessment of anticipated cost savings to include analysis of medical expense for these identified members prior to incarceration and subsequent to reach in activities and release.

Care Coordination Requirements:

- Develop process for identification of members meeting the established parameters for reach-in care coordination (chronic and/or complex care needs). The Contractor must utilize the 834 file data provided to the Contractor by AHCCCS to assist with identification of members. The Contractor may also use additional data if available for this purpose.
- Strategies for providing member education regarding care, services, resources, appointment information and health plan case management contact information

- Requirements for scheduling of initial appointments with appropriate provider(s) based on member needs; appointment to occur within 7 days of member release
- Strategies regarding ongoing follow up with the member after release from incarceration to assist with accessing and scheduling necessary services as identified in the member's care plan
- Should re-incarceration occur, strategies to reengage member and maintain care coordination
- Strategies to improve appropriate utilization of services
- Strategies to reduce recidivism within the member population
- Strategies to address social determinants of health

Beginning CYE18, the Contractor shall report the Reach-In Plan to AHCCCS in the annual Medical Management Plan and report outcome summaries in the Medical Management Evaluation, as specified in Attachment F3, Contractor Chart of Deliverables. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

The Contractor must notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Section D, Paragraph 55, Capitation Adjustment.

Engaging Members through Technology: AHCCCS is exploring options for engaging its membership through web based applications. AHCCCS is requesting the Contractor identify populations who can benefit from web based applications used to assist members with self-management of health care needs such as, chronic conditions, pregnancy, or other health related topics the Contractor considers to be most beneficial to members and submit a summary of findings. The Contractor shall submit an executive summary to AHCCCS, DHCM, Medical Management Unit by December 1, 2016 to include an explanation of how web based applications may serve to encourage member engagement.

Monitoring Controlled and Non-Controlled Medication Utilization: The Contractor must engage in activities to monitor controlled and non-controlled medication use as outlined in AMPM Policy 310-FF to ensure members receive clinically appropriate prescriptions. The Contractor is required to report to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, a Pharmacy and/or Prescriber - Member Assignment report which includes the number of members which on the date of the report are restricted to using a specific Pharmacy or Prescriber/Providers due to excessive use of prescriptive medications (narcotics and non-narcotics).

Inappropriate Emergency Department Utilization: The Contractor must identify and track members who utilize Emergency Department (ED) services inappropriately four or more times within a six month period. Interventions must be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service. The Contractor shall submit a semi-annual report as specified in AMPM Policy 1020 and Attachment F3, Contractor Chart of Deliverables.

Transplant Services and Immunosuppressant Medications: AHCCCS covers medically necessary transplantation services and related immunosuppressant medications in accordance with Federal and State law and regulations. The Contractor shall not make payments for organ transplants not provided for in the State Plan except as otherwise required pursuant to 42 USC 1396 (d)(r)(5) for persons receiving services under EPSDT. The Contractor must follow the written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to enrollees per Sections (1903(i) and 1903(i)(1)) of the Social Security Act. Refer to the AMPM, Chapter 300, Exhibit 310-DD and the AHCCCS Reinsurance Policy Manual.^{viii}

22. GRIEVANCE AND APPEAL SYSTEM

The Contractor shall have in place a written Grievance and Appeal System process for subcontractors, enrollees and non-contracted providers, which defines their rights regarding disputed matters with the Contractor. The Contractor Grievance and Appeal System for enrollees includes a grievance process (the procedures for addressing enrollee grievances), an appeals process and access to the state's fair hearing process as outlined in Attachment F1 Enrollee Grievance and Appeal System Standards. The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Attachment F2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Attachments F1, Enrollee Grievance and Appeal System Standards, F2, Provider Claim Dispute Standards, and 42 CFR Part 438 Subpart F.

Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 17, Member Handbook and Member Communication and Paragraph 69, Cultural Competency.

The Contractor shall provide the appropriate professional, paraprofessional and clerical personnel for the representation of the Contractor in all issues relating to the Grievance and Appeal System and any other matters arising under this contract which rise to the level of administrative hearing or a judicial proceeding. Unless there is an agreement with the State in advance, the Contractor shall be responsible for all attorney fees and costs awarded to the claimant in a judicial proceeding.

The Contractor may delegate the Grievance and Appeal System process to subcontractors, however, the Contractor must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the Grievance and Appeal System requirements. This information must include a description of: the right to a state fair hearing, the method for obtaining a state fair hearing, the Rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or a state fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent.

The Contractor must provide reports on the Grievance and Appeal System as required in the AHCCCS Grievance and Appeal System Reporting Guide available on the AHCCCS website. See also Attachment F3, Contractor Chart of Deliverables.

23. MATERNITY CARE PROVIDER STANDARDS

The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. Members becoming eligible or transitioning to another Contractor during their third trimester shall be allowed to complete maternity care and delivery with an AHCCCS registered provider from whom they have been receiving maternity services. The Contractor may include in its provider network the following maternity care providers:

- a. Arizona licensed allopathic and/or osteopathic physicians who are Obstetricians or general practice/family practice providers who provide maternity care services
- b. Physician Assistants
- c. Nurse Practitioners
- d. Certified Nurse Midwives
- e. Licensed Midwives

Pregnant members may choose, or be assigned, a PCP who provides obstetrical care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide primary care services that he or she is willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries shall have hospital privileges for obstetrical services. Practitioners performing deliveries in alternate settings shall have a documented hospital coverage agreement. Licensed midwives perform deliveries only in the member's home. Labor and delivery services may also be provided in the member's home by physicians, nurse practitioners and certified nurse midwives who include such services within their practice.

24. RESERVED

25. STAFF REQUIREMENTS AND SUPPORT SERVICES

The Contractor shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The Contractor is obligated to screen employees and subcontractors to determine whether they have been excluded from participation in Federal health care programs as outlined in Section D, Paragraph 70, Corporate Compliance.

The Contractor must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements. If the Contractor does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS. This action may include, but is not limited to, requiring the Contractor to hire additional staff and actions specified in Section D, Paragraph 80, Sanctions, of the contract.

The Contractor shall have staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies such as Arizona Department of Health Services (ADHS)/Office of Licensure on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardy (IJ) fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, ability to initiate new placements/services, and have the ability to perform status checks at affected facilities and perform ongoing monitoring, if necessary. The Contractor shall supply AHCCCS Clinical Quality Management (CQM) with the contact information for these staff, as specified in Attachment F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. CQM must be notified and provided backup contact information when the primary contact person will be unavailable.

For functions not required to be in State, the Contractor must notify AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables, prior to moving functions outside the State of Arizona. The notification must include an implementation plan for the transition.

The Contractor shall be responsible for any additional costs associated with on-site audits or other oversight activities which result when required systems are located outside of the State of Arizona.

An individual staff member is limited to occupying a maximum of two Key Staff positions listed below, unless prior approval is obtained by AHCCCS, DHCM. When submitting its functional organizational chart, as specified in Attachment F3, Contractor Chart of Deliverables, the Contractor must document, for each Key Staff position, the portion of time allocated to each Medicaid contract as well as all other lines of business. The Contractor shall also inform AHCCCS DHCM, in writing as specified in Attachment F3, Contractor Chart of Deliverables, when an employee leaves one of the **Key Staff** positions listed below. The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff. If, at any point, the Contractor fails to maintain compliance with contractual obligations, AHCCCS reserves the right to evaluate staffing allocations and require staffing enhancements in order to ensure adherence to established requirements.

At a minimum, the following staff is required:

Key Staff Positions

- a. **Administrator/CEO/COO** who is located in Arizona oversees the entire operation of the Contractor, and has the authority to direct and prioritize work, regardless of where performed.
- b. **Medical Director/CMO** who is located in Arizona and who is an Arizona-licensed physician in good standing. The Medical Director shall be actively involved in all major clinical and Quality Management and Medical Management components of the Contractor. The Medical Director shall ensure timely medical decisions, including after-hours consultation as needed (see Paragraph 27).
- c. **Chief Financial Officer/CFO** who is available to fulfill the responsibilities of the position and to oversee the budget, accounting systems and financial reporting implemented by the Contractor.
- d. **Pharmacy Coordinator/Director** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Contractor.
- e. **Dental Director** The Contractor must ensure the following for its subcontracted acute care health plans: The Dental Director must be an Arizona licensed general or pediatric dentist in good standing who is located in Arizona and is responsible for leading and coordinating the dental activities of the Contractor including review and denial of dental services, provider consultation, utilization review, and participation in tracking and trending of quality of care issues as related to dental services. The Dental Director must provide required communication between the Contractor and AHCCCS. The Dental Director may be an employee or Contractor of the plan but may not be from the Contractor's delegated dental subcontractor.
- f. **Corporate Compliance Officer** who is located in Arizona and who will implement and oversee the Contractor's compliance program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS, Office of the Inspector General. See paragraph 70 for more information.
- g. **Dispute and Appeal Manager** who is responsible for managing and adjudicating member grievances and appeals, and provider claim disputes, arising under the Grievance and Appeal System and for forwarding all requests for hearing to AHCCCS Office of Administrative Legal Services (OALS) with the requested information. The Dispute and Appeal Manager and any staff under this position who manage and adjudicate disputes and appeals must be located in Arizona. See Section D, Paragraph 22, Grievance and Appeal System.
- h. **Business Continuity Planning and Recovery Coordinator** as noted in ACOM Policy 104.
- i. **Contract Compliance Officer** who is located in Arizona and who will serve as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all contract deliverables; field and coordinate responses to AHCCCS inquiries, coordinate the preparation and execution of contract requirements such as Operational and Financial Reviews (OFRs), random and periodic audits and ad hoc visits.
- j. **Quality Management Manager** who is an Arizona-licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the

American Board of Quality Assurance and Utilization Review Providers. The QM Manager must be employed by the Contractor, located in Arizona, and have experience in quality management and quality improvement. Sufficient local staffing to meet the AHCCCS quality management contractual and policy requirements must also be in place. Staff must report directly to the Quality Management Coordinator. The primary functions of the Quality Management Manger position are:

- Ensure individual and systemic quality of care
 - Conduct comprehensive quality-of-care investigations
 - Conduct onsite quality management visits/reviews
 - Conduct Care Needed Today/Immediate Jeopardy investigations
 - Integrate quality throughout the organization
 - Implement process improvement
 - Resolve, track and trend quality of care grievances
 - Ensure a credentialed provider network
- k. **Performance/Quality Improvement Coordinator** who is located in Arizona and who has a minimum qualification as a CPHQ or CHCQM or comparable education and experience in health plan data and outcomes measurement. Any staff under this position must be sufficient to meet the AHCCCS quality improvement contractual and policy requirements and must be located in Arizona. The primary functions of the Performance/Quality Improvement Coordinator are:
- Focus organizational efforts on improving clinical quality performance measures
 - Develop and implement performance improvement projects
 - Utilize data to develop intervention strategies to improve outcomes
 - Report quality improvement/performance outcomes
- l. **Credentialing Coordinator** who is located in Arizona and who has appropriate education and/or experience to effectively complete all requirements of the position. The primary functions of the Credentialing Coordinator are:
- Serve as the single point of contact to AHCCCS for credentialing-related questions and concerns
 - Responsible for timely and accurate completion of all credentialing-related deliverables
 - Ensure all credentialing requirements, including timeframes, are adhered to by the Contractor
 - Provide a detailed, transparent description of the credentialing process to providers and serve as the single point of contact for the Contractor to address provider questions about the credentialing process
- m. **Maternal Child Health/EPSTD Coordinator** who is located in Arizona and who is an Arizona licensed nurse, physician or physician's assistant; or has a Master's degree in health services, public health, health care administration or other related field, and/or a CPHQ or CHCQM certification Any staff under this position must be sufficient to meet the AHCCCS MCH/EPSTD contractual and policy requirements and must be located in Arizona. Maternal Child Health (MCH)/EPSTD staff must either report directly to the MCH/EPSTD Coordinator or the MCH/EPSTD Coordinator must have sufficient ability to ensure that AHCCCS MCH/EPSTD requirements are met. Sufficient local staffing under this position must be in place to meet quality and performance measure goals. The primary functions of the MCH/EPSTD Coordinator are:
- Ensure receipt of EPSTD services
 - Ensure receipt of maternal and postpartum care
 - Promote family planning services
 - Promote preventive health strategies
 - Identify and coordinate assistance for identified member needs
 - Interface with community partners
- n. **Medical Management Manager** who is an Arizona-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations. This position is located in Arizona and manages all required medical management requirements under AHCCCS policies, rules and contract. Sufficient local staff under this position must be in place to meet medical management requirements. The primary functions of the Medical Management Manager are:
- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity

- Criteria
- Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted
 - Develop, implement and monitor the provision of care coordination, disease management and case management functions
 - Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
 - Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards
- o. **Behavioral Health Coordinator** who is a behavioral health professional as described in Health Services Rule A.A.C. R9-10-101, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are implemented. The primary functions of the Behavioral Health Coordinator are:
- Coordinate members behavioral health care needs including active involvement in all out of state placement decisions
 - Develop processes to review and enhance network to reduce out of state placements
 - Develop processes to coordinate behavioral health care and physical health care between all providers
 - Participate in the identification of best practices for behavioral health services
 - Coordinate and liaise for American Indians who exercise choice options regarding behavioral health
- p. **Provider Services Manager** who coordinates communications between the Contractor and its subcontractors and providers. This position is located in Arizona and ensures that providers receive prompt resolution to their problems or inquiries, appropriate education about participation in the AHCCCS program and maintain a sufficient provider network. Sufficient local staffing under this position must be in place to ensure appropriate provider responsiveness.
- q. **Claims Administrator** who shall ensure prompt and accurate provider claims processing. The primary functions of the Claims Administrator are:
- Develop and implement claims processing systems capable of paying claims in accordance with State and Federal requirements
 - Develop processes for cost avoidance
 - Ensure minimization of claims recoupments
 - Meet claims processing timelines
 - Meet AHCCCS encounter reporting requirements
- r. **Provider Claims Educator** who is located in Arizona and facilitates the exchange of information between the grievances, claims processing, and provider relations systems. The primary functions of the Provider Claims Educator are:
- Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc.
 - Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
 - Identify trends and guide the development and implementation of strategies to improve provider satisfaction
 - Frequently communicates (i.e., telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- s. **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of 5 years of management/supervisory experience in the health care field.
- t. **Information Systems (IS) Administrator** who is responsible for information system management including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all data and data exchange elements.

- u. **MSA Administrator** who is responsible for oversight of the Management Services Agreement (MSA) subcontractor and is the Contractor's Key Contact who is not employed by the MSA for AHCCCS coordination. This position is only required when the Contractor operates under a subcontract with a MSA.

Additional Required Staff

- v. **Prior Authorization staff** to authorize health care services. This staff shall include but is not limited to Arizona-licensed nurses, physicians and/or physician's assistants. The staff will work under the direction of an Arizona-licensed registered nurse, physician or physician's assistants.
- w. **Concurrent Review staff** who are located in Arizona and who conducts inpatient concurrent review. This staff shall consist of Arizona-licensed nurses, physicians, and/or physician's assistants.
- x. **Provider Services staff** who are located in Arizona and who enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management).
- y. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
- z. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.
- aa. **Case Management Supervisor(s)** to oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16.
- bb. **Case Managers** in sufficient numbers and who meet the qualifications defined in Section D, Paragraph 16 to perform assessment and care planning services for all enrolled members.
- cc. **IS Staff** to ensure timely and accurate information system management to meet system and data exchange requirements.
- dd. **Quality Management staff** who are located in Arizona and who ensure timely, comprehensive quality of care investigative processes including but not limited to onsite quality investigations.

The Contractor must submit to the following items as specified in Attachment F3, Contractor Chart of Deliverables and when there is a change in staffing or organizational functions:

1. An organization chart complete with the "key staff" positions. The chart must include the person's name, title, location and portion of time allocated to each Medicaid contract and other lines of business.
2. A functional organization chart of the key program areas, responsibilities and reporting lines.
3. A listing of all Key Staff to include the following:
 - a. Individual's name,
 - b. Individual's title,
 - c. Individual's telephone number,
 - d. Individual's email address,
 - e. Individual's location(s),
 - f. Documentation confirming applicable Key Staff functions are filled by individuals who are in good standing (for example, a printout from the Arizona Medical Board webpage showing the CMO's active license), and
 - g. A list of all Key Staff functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

In State Positions

- Administrator/CEO/COO
- Behavioral Health Coordinator
- Case Management Administrator/Manager
- Case Management Supervisors
- Case Managers
- Concurrent Review staff
- Contract Compliance Officer
- Corporate Compliance Officer

- Credentialing Coordinator
- Dental Director
- Dispute and Appeal Manager
- Maternal Child Health/EPSTD Coordinator
- Maternal Child Health/EPSTD staff
- Maternal Child Health/MCH staff
- Medical Director/CMO
- Medical Management Manager
- Performance/Quality Improvement Coordinator
- Performance/Quality Improvement staff
- Provider Claims Educator
- Provider Services Manager
- Provider Services staff
- Quality Management Manager
- Quality Management staff

Staff Training and Meeting Attendance

The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill their requirements of the position. AHCCCS may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of this contract and/or AHCCCS policies.

The Contractor must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals, and contract and State and Federal requirements specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

All transportation, prior authorization and member services representatives must be trained in the geography of any/all GSA(s) in which the Contractor holds a contract and have access to mapping search engines (e.g. MapQuest, Yahoo Maps, Google Maps) for the purposes of authorizing services in; recommending providers in, and transporting members to, the most geographically appropriate location.

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. AHCCCS may require attendance by subcontracted entities, as defined in Section D, Paragraph 33, Subcontracts, when deemed necessary. All meetings shall be considered mandatory unless otherwise indicated.

26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

The Contractor shall develop and maintain written policies and procedures for each functional area, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies and procedures. All policies and procedures shall be reviewed at least annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's Director or Administrator. Minutes reflecting the review and approval of the policies by an appropriate committee, chaired by the Contractor Chief Executive Officer/Administrator, Chief Medical Officer or Chief Financial Officer are also acceptable documentation. All medical and quality management policies shall be approved and signed by the Contractor's Medical Director.

All Administrative Directives developed by the Contractor shall be incorporated into the Contractor's Policy Manual as outlined on the AHCCCS approved work plan. The Contractor shall submit a quarterly report to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables, which will include the status of Administrative Directives applicable to ALTCS not yet incorporated into the Contractor's Policy Manual.

If AHCCCS deems a Contractor policy or process to be inefficient and/or place an unnecessary burden on the members or providers, the Contractor must work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS. In addition, if AHCCCS deems a Contractor lacks a policy or process necessary to fulfill the terms of this contract, the Contractor must work with AHCCCS to adopt a policy or procedure within a time period specified by AHCCCS.

27. RESERVED**28. NETWORK DEVELOPMENT**

It is critical for the Contractor to develop a provider network that is diverse and flexible to meet a variety of member issues both in the immediate as well as long range basis. A priority should be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting. Some critical issues to consider in the development of an effective network are the following:

- Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles of (as defined in Section D, paragraph 2)
- Member-Centered Case Management
- Consistency of Services
- Available and Accessible Services
- Most Integrated Setting
- Collaboration with Stakeholders
- Ensuring support of the member's informal support system (e.g., family caregivers).
- Developing HCBS and settings to meet the needs of members who have cognitive impairments, behavioral health needs and other special medical needs.
- Providing not only linguistic services but also developing services that are able to address, as needed, the culture, race, ethnic and religious facets in the process of meeting the needs of members as described in ACOM Policy 405 and Paragraph 69, Cultural Competency

Provider networks must be a foundation that supports an individual's need as well as the membership in general. To that end, the Contractor shall develop, maintain and monitor a provider network, including home and community based service providers and alternative residential settings, that is supported by written agreements which is sufficient to provide all covered services to ALTCS members. The Contractor shall ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation. The Contractor must provide a comprehensive network to ensure its membership has access at least equal to, or better than community norms. Services shall be accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those are available to non-ALTCS persons within the same service area [42 CFR 438.210.(a)(2)]. The Contractor is encouraged to have available non-emergent after-hours physician or primary care services within its network. If the network is unable to provide medically necessary services required under contract, the Contractor shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted. The Contractor shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(4) and (5)].

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers to maximize member choice. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. The Contractor shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions,

hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems.

There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis. The development of home and community based services shall include provisions for the availability of services on a 7-day-a-week basis and for extended hours, as directed by member needs [42 CFR 438.206(b)(1); 42 CFR 438.206 (c)(1)(i), (ii) and (iii)].

The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when Individual Family Service Plans identify and meet the requirement for medically necessary EPSDT covered services. Refer to AMPM Chapter 400, Exhibit 430-3.

The Contractor shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The requirements for the Network Development and Management Plan are found in ACOM Policy 415. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Contractor shall also submit as needed an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

ALTCS Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. The Contractor must have as part of their network development plan a component regarding paraprofessional work force development in alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. The Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care.

In accordance with the requirements specified in ACOM Policy 436 the network shall be sufficient to provide covered services within designated time and distance limits. This includes a network such that 90% of its members residing in Maricopa and Pima counties do not have to travel more than 10 miles or 15 minutes to visit a PCP, dentist, or pharmacy unless accessing those services through a Multi-Specialty Interdisciplinary Clinic (MSIC). The Contractor must obtain hospital contracts as specified in ACOM Policy 436.

AHCCCS may impose sanctions for material deficiencies in the Contractor's provider network.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the Contractor shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs consistent with its responsibilities under this contract nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If the Contractor declines to include individuals or groups of providers in its network, it must give the affected providers timely written notice of the reason for its

decision [42 CFR 438.12(a)(1)]. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

MSICs are established facilities providing interdisciplinary services for members with qualifying CRS conditions and are under contract with the CRS Contractor. Contractors are encouraged to contract with MSICs for specialty care. Pediatric specialists that work in the MSIC are in limited quantity in Arizona. Contracting with the MSICs provides Contractors an opportunity to increase access to these pediatric specialists.

Other: AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the state of Arizona. AHCCCS expects the Contractor to support these efforts. AHCCCS encourages the Contractor to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the state and to investigate opportunities for resident participation in the Contractor's medical management and committee activities. In the event of a contract termination between the Contractor and a Graduate Medical Education Residency Training Program or training site, the Contractor may not remove members from that program in such a manner as to harm the stability of the program. AHCCCS reserves the right to determine what constitutes risk to the program. Further, the Contractor must attempt to contract with graduating residents and providers that are opening new practices in, or relocating to, Arizona, especially in rural or underserved areas.

Gap in Critical Services: The Contractor is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps in care. The Contractor shall resolve gaps in critical services within two hours of a gap being reported. The Contractor shall have back-up caregivers available on-call to substitute for those times when an unforeseeable gap in critical service occurs.

The term "critical services" includes attendant care, personal care, homemaking, and respite care, and is inclusive of, but not limited to, tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. A "gap in critical services" is defined as the difference between the number of hours of home care worker critical services scheduled in each member's HCBS care plan and the hours of the scheduled type of critical services that are actually delivered to the member. Also see AMPM Chapter 1600, Policy 1620 for an explanation of critical services.

The Contractor shall implement policies and procedures to identify, correct, track, and report gaps in critical services; see ACOM Policy 413, AMPM Chapter 1600, and Attachment F3, Contractor Chart of Deliverables. These policies shall, at a minimum, cover the following areas:

- Information (verbally and in writing) to members on their right to receive services as authorized, including the right to have any gaps in critical services filled within two hours and the right to have a back-up caregiver to substitute when an unforeseeable gap in critical services occurs.
- Information to members on how to contact the Contractor, its Subcontractor or AHCCCS when one a critical service is not provided as scheduled.
- At the time of the initial and quarterly reassessment case managers are required to assess a member's needs, including a member's service preference level if a gap in critical services were to occur and develop a contingency plan in the event of a gap in a member's critical services.
- The Contractor's process for providing services in the event of a gap in critical services. This shall include a description of the process used to ensure that the Contractor or its Subcontractor timely provide a back-up caregiver in the event of an unforeseeable gap in critical service.
- Tracking and trending gaps in critical service and grievances as a result of gaps.

As specified in Attachment F3, Contractor Chart of Deliverables, the Contractor shall submit reports to AHCCCS outlining trends and corrective actions regarding gaps in critical services, grievances related to critical service gaps, and other reports as deemed necessary. See also Section D, Paragraph 16, Case Management.

29. NETWORK MANAGEMENT

The Contractor shall have policies on how the Contractor will [AMPM; 42 CFR 438.214(a)]:

- a. Communicate and negotiate with the network regarding contractual and/or program changes and requirements;
- b. Monitor network compliance with policies and Rules of AHCCCS and the Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;
- c. Evaluate the quality of services delivered by the network;
- d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;
- e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English;
- f. Process provisional credentials;
- g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;
- h. Provide training for its providers and maintain records of such training;
- i. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate; and
- j. Ensure that provider calls are acknowledged within three business days of receipt; resolved and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from AHCCCS).

The Contractor's policies shall be subject to approval by AHCCCS, Division of Health Care Management, and shall be monitored through operational audits.

Material Change to Provider Network: The Contractor is responsible for evaluating all provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's provider network [42 CFR 438.207 (c)]. All material changes to the provider network must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and/or network standards as described in this contract including, but not limited to, any change that would cause or is likely to cause more than 5% of members in a GSA or District to change the location where services are received or rendered.

The Contractor must submit the request for approval of a material change to the provider network with information including, but not limited to, how the change will affect the delivery of covered services, the Contractor's plans for maintaining the quality of member care, and communications to providers and members, as outlined in ACOM Policy 439 and as specified in Attachment F3, Contractor Chart of Deliverables. AHCCCS will review and respond to the Contractor within 30 days of the submission. A material change in the Contractor's network requires 30 days advance written notice from the Contractor to members and providers. For emergency situations, AHCCCS will expedite the approval process. In the event unforeseen circumstances prevent the Contractor from providing 30 days advance written notice to members and providers, the Contractor shall notify AHCCCS within one business day of identifying the material change to the provider network for AHCCCS determination of notification requirements.

The requirements regarding material changes to the provider network do not apply to the contract negotiation process between the Contractor and a provider.

See Section D, Paragraph 43, regarding material changes by the Contractor that may impact business operations.

See Section D, Paragraph 59 regarding material changes by the Contractor that may impact capitation rates.

The Contractor shall give hospitals and provider groups 90 days' notice prior to a contract termination without cause. Contracts between the Contractor and single practitioners are exempt from this requirement.

Provider/Network Changes Report: The Contractor must submit a Quarterly Provider/Network Changes Due to Rates Report as described in ACOM Policy 415 and Attachment F3, Contractor Chart of Deliverables

Homeless Clinics: Contractors in Maricopa and Pima County must contract with homeless clinics at the AHCCCS Fee-For-Service rate for Primary Care services. Contracts must stipulate that:

1. Only those members who request a homeless clinic as a PCP may be assigned to them; and
2. Members assigned to a homeless clinic may be referred out-of-network for needed specialty services.

The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining prior authorization, and resolving claims issues.

30. PROVIDER MANUAL

The Contractor shall develop, distribute and maintain a provider manual as described in ACOM Policy 416.

31. PROVIDER REGISTRATION

The Contractor shall ensure that each of its subcontractors register with AHCCCS as an approved service provider.

For specific requirements on Provider Registration refer to the AHCCCS website.

Effective July 1, 2012, the Contractor shall begin submitting registration packets, including certification, for each group home serving ALTCS members to AHCCCS Provider Registration. The Contractor shall have until December 31, 2012 to submit registration packets, including certification, for each existing group home serving ALTCS members. AHCCCS Provider Registration will assign an independent provider registration number to each group home. The Contractor shall also identify, by location, each group home registered under every DES/DDD Qualified Vendor Agreement.

The National Provider Identifier (NPI) will be required on all claim submissions and subsequent encounters (from providers that are eligible for a NPI). The Contractor shall work with providers to obtain their NPI.

Except as otherwise required by law or as otherwise specified in a contract between the Contractor and a provider, the AHCCCS Fee-For-Service provisions referenced in the AHCCCS Provider Participation Agreement located on the AHCCCS website (e.g. billing requirements, coding standards, payment rates) are in force between the provider and the Contractor.

32. PROVIDER AFFILIATION TRANSMISSION

The Contractor must submit information quarterly regarding its provider network. This information must be submitted in the format described in the Provider Affiliation Transmission (PAT) User Manual which can be found on the AHCCCS website. The Contractor shall also validate its compliance with minimum network

requirements against the network information provided in the PAT through the submission of a completed Minimum Network Requirements Verification Template (see ACOM 436 for Template). The PAT and the Minimum Network Requirements Verification Template must be submitted as specified in Attachment F3, Contractor Chart of Deliverables.

33. SUBCONTRACTS

The Contractor shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c)]. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract. The Contractor shall be held fully liable for the performance of all contract requirements and shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. Subject to such conditions, any function required to be provided by the Contractor pursuant to this contract may be subcontracted to a qualified person or organization [42 CFR 438.6]. All such subcontracts must be in writing [42 CFR 438.6(l)]. All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract.

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. The Contractor's local CEO must retain the authority to direct and prioritize any delegated contract requirements. In order to determine adequate performance, the Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

The Contractor shall maintain a fully executed original or electronic copy of all subcontracts, which shall be accessible to AHCCCS within five business days of the request by AHCCCS. All requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

AHCCCS may, at its discretion, communicate directly with the governing body or Parent Corporation of the Contractor regarding the performance of a subcontractor or Contractor respectively.

Minimum Subcontract Provisions: All subcontracts must reference and require compliance with the Minimum Subcontract Provisions. See Minimum Subcontract Provisions on the AHCCCS Website.

In addition, each subcontract must contain the following:

1. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor;
2. Identification of the name and address of the subcontractor;
3. Identification of the population, to include patient capacity, to be covered by the subcontractor;
4. The amount, duration and scope of medical services to be provided, and for which compensation will be paid;

5. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation;
6. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability;
7. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to the Contractor;
8. A description of the subcontractor's patient, medical, dental and cost record keeping system;
9. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM;
10. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS;
11. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population;
12. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage;
13. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members;
14. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract;
15. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation;
16. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor; and
17. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

In the event of a modification to the AHCCCS Minimum Subcontract Provisions the Contractor shall issue a notification of the change to its subcontractors within 30 days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first. See also ACOM Policy 416.

Administrative Services Subcontracts: Administrative Services subcontracts shall be submitted to AHCCCS, Division of Health Care Management for prior approval as specified in ACOM Policy 438 and Attachment F3, Contractor Chart of Deliverables. If at any time during the period of the subcontract, the subcontractor is found to be in non-compliance, the Contractor shall notify AHCCCS as specified in ACOM Policy 438 and Attachment F3, Contractor Chart of Deliverables. The Contractor will submit this in writing and provide the corrective action plan and any measures taken by the Contractor to bring the subcontractor into compliance.

The Contractor must submit an annual Administrative Services Subcontractor Evaluation Report as specified in ACOM Policy 438 and Attachment F3, Contractor Chart of Deliverables. The report shall include any findings of subcontract non-compliance and any corrective action plans and/or measures taken by the Contractor to bring the subcontractor into compliance.

Upon request, the Contractor shall submit to AHCCCS copies of Administrative Services Subcontracts Request for Proposals (RFPs) at the time they are formally issued to the Public and amendments to these contracts.

The Contractor shall require Administrative Services Subcontractors to adhere to screening and disclosure requirements as described in Paragraph 70, Corporate Compliance.

A merger, acquisition, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor requires prior approval of AHCCCS, as outlined in ACOM Policy 438.

AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA.

Provider Agreements: The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Specifically, the Contractor shall not contract with a provider and require that the provider not provide services for any other AHCCCS Contractor. In addition, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

The Contractor must make reasonable efforts to enter into a written agreement with any provider providing services at the request of the Contractor more than 25 times during the previous contract year and/or are anticipated to continue providing services for the Contractor. The Contractor must follow ACOM Policy 415 and consider the repeated use of providers operating without a written agreement when assessing the adequacy of its network.

For all subcontracts in which the Contractor and subcontractor have a capitated arrangement/risk sharing arrangement, the following provision must be included verbatim in every contract:

If <the Subcontractor> does not bill <the Contractor>, < the subcontractor's> encounter data that is required to be submitted to <the Contractor> pursuant to contract is defined for these purposes as a "claim for payment". <The Subcontractor's> provision of any service results in a "claim for payment" regardless of whether there is any intention of payment. All said claims shall be subject to review under any and all fraud and abuse statutes, rules and regulations, including but not limited to Arizona Revised Statute (A.R.S.) §36-2918, §36-2932, and §36-2957.

Nursing Facility subcontracts shall include a provision to ensure temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e) 3 and (g) 2. The provision must also require the subcontractor to ensure these registry personnel are fingerprinted as required by A.R.S. §36-411.

If the Contractor has a contract for specialty services with a nursing facility or assisted living facility, these contracts must include Work Statements that outline the special services being purchased, including admission criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description and other non-clinical services such as increased activities. In the event that a contract is terminated with a nursing facility or assisted living facility in a GSA with more than one ALTCS Contractor, the Contractor must adhere to the requirements outlined in ACOM Policy 421.

34. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing directives for adult members as specified in 42 CFR 438.3(j) and 42 CFR 422.128, and AMPM Policy 640 and AMPM Policy 930.

1. Each contract or agreement with a hospital, nursing facility, hospice, and providers of home health care or personal care services, must comply with Federal and State law on advance directives for adult members [42 CFR 438.3(j)(1)]. Requirements include:
 - a. Maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. §36-3205.C.1,

- b. Providing written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives including any conscientious objections [42 CFR 438.3(j)(3)],
 - c. Documenting in the member's medical record as to whether the adult member has been provided the information and whether an advance directive has been executed,
 - d. Preventing discrimination against a member because of his or her decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive, and
 - e. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health and personal care services, if any advanced directives are executed by members to whom they are assigned to provide services.
2. The Contractor shall require PCP's which have agreements with entities described in paragraph a. above, to comply with the requirements of subparagraph 1. (a.) through 1.(e.) above.
 3. The Contractor shall also require health care providers specified in subparagraph 1 above to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record and, provide education to staff on issues concerning advance directives.
 4. The Contractor shall provide written information to adult members and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231 regarding the following [42 CFR 422.128]:
 - a. A member's rights regarding advance directives under Arizona State law,
 - b. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience,
 - c. A description of the applicable state law and information regarding the implementation of these rights,
 - d. The member's right to file complaints directly with AHCCCS,
 - e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience; This statement, at a minimum must do the following:
 - Clarify institution-wide conscientious objections and those of individual physicians,
 - Identify state legal authority permitting such objections, and
 - Describe the range of medical conditions or procedures affected by the conscience objection, and
 - f. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.3(j)(4)].
 5. Written information regarding advance directives shall be provided to members at the time of enrollment with the Member Handbook. Refer to ACOM Policy 404 for member information and Member Handbook requirements.
 6. The Contractor is not relieved of its obligation to provide the above information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

35. SPECIALTY CONTRACTS

AHCCCS may at any time negotiate or contract on behalf of the Contractor and AHCCCS for specialized hospital and medical services. AHCCCS will consider existing Contractor resources in the development and execution of specialty contracts. AHCCCS may require the Contractor to modify its delivery network to accommodate the provisions of specialty contracts. AHCCCS may consider waiving this requirement in particular situations if such action is determined to be in the best interest of the State; however, in no case shall

reimbursement exceeding that payable under the relevant AHCCCS specialty contract be considered in capitation rate development or risk sharing arrangements, including reinsurance.

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty contractors to enhance the cost effectiveness of service delivery, medical management and adjudication of claims related to such payments provided under specialty contracts shall remain the responsibility of the Contractor. AHCCCS may provide technical assistance prior to the implementation of any specialty contracts.

For situations where AHCCCS has specialty contracts, including but not limited to, transplant services anti-hemophiliac agents and pharmaceutical related services), AHCCCS shall provide at least 60 days advance written notice to the Contractor prior to the implementation of any specialty contract.

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

In the absence of a contract between the Contractor and a hospital providing otherwise, the Contractor shall reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. §§36-2904 and 2905.01, and 9 A.A.C. 22, Article 7, which includes without limitation: reimbursement of the majority of inpatient hospital services with discharge dates on and after October 1, 2014, using the APR-DRG payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81; reimbursement of limited inpatient hospital services with discharge dates on and after October 1, 2014, using per diem rates described in A.A.C. R9-22-712.61; and, in Pima and Maricopa Counties, payment to non-contracted hospitals at 95% of the amounts otherwise payable for inpatient services.

The Contractor is encouraged to obtain subcontracts with hospitals in all GSAs. A Contractor serving out-of-state border communities (excluding Mexico) is strongly encouraged to establish contractual agreements with those out-of-state hospitals in counties that are identified by GSA in ACOM Policy 436. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

The Contractor may conduct prepayment, concurrent and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims may be subject to recoupment. If the Contractor fails to identify lack of medical necessity through prepayment and/or concurrent medical review, lack of medical necessity shall not constitute a basis for recoupment of paid hospital claims, including outlier claims, unless the Contractor identifies the lack of medical necessity through a post-payment medical review of information that the Contractor could not have discovered during a prepayment and/or concurrent medical review through the exercise of due diligence. The Contractor shall comply with Section D, Paragraph 44, Claims Payment/Health Information System.

For information on Value Based Purchasing Differential Adjusted Payments see Paragraph 87, Value-Based Purchasing.

37. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)]. Except for annual well woman exams, behavioral health and children's dental services, and consistent with the terms of the demonstration, covered services must be provided by or coordinated with a primary care provider.

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. The Contractor shall adjust the size of the PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance

standards. AHCCCS shall inform the Contractor when a PCP has a panel of more than 1,800 AHCCCS members, to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis.

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCP's with assigned members diagnosed with AIDS or as HIV-positive, shall meet criteria and standards set forth in the AMPM.

The Contractor shall ensure that providers serving EPSDT-aged members utilize the AHCCCS-approved EPSDT Tracking forms and standardized developmental screening tools and are trained in the use of the tools. EPSDT-aged members shall be assigned to providers who are trained on and who use AHCCCS approved developmental screening tools.

The Contractor shall offer members freedom of choice within its network in selecting a PCP, consistent with 42 CFR 438.6(m) and 438.52(d) and this contract. Any American Indian who is enrolled with the Contractor and who is eligible to receive services from a participating I/T/U provider may elect that I/T/U as his or her primary care provider, if that I/T/U participates in the network as a primary care provider and has capacity to provide the services per ARRA Section 5006(d) and SMD letter 10-001).^{ix} The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in ACOM Policy 404 for member information requirements. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

At a minimum, the Contractor shall hold the PCP responsible for the following activities [42 CFR 438.208(b)(1)]:

- a. Supervising, coordinating and providing care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral);
- b. Initiating referrals for medically necessary specialty care;
- c. Maintaining continuity of care for each assigned member; and
- d. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services including behavioral health;
- e. Utilizing the AHCCCS approved EPSDT Tracking form;
- f. Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider; and
- g. If serving children, for enrolling as a Vaccines for Children (VFC) provider,

The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty and referral services provided to assigned members by specialty physicians, and other health care professionals.

38. APPOINTMENT STANDARDS

The Contractor shall actively monitor and track compliance with appointment availability standards as required in ACOM Policy 417 [42 CFR 438.206]. The Contractor shall ensure that providers offer a range of appointment availability, per appointment timeliness standards, for intakes and ongoing services based upon

the clinical need of the member. The exclusive use of same-day only appointment scheduling and/or open access is prohibited within the contractor's network. The Contractor is required on a quarterly basis to conduct review of the availability of the below listed providers in sufficient quantity to ensure results are meaningful and representative of the Contractor's network and report this information as specified in Attachment F3, Contractor Chart of Deliverables.

For purposes of this section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the patient's health. The Contractor shall have procedures in place that ensure the following standards are met.

For **Primary Care Provider Appointments**, the Contractor shall be able to provide:

- a. Immediate Need appointments the same day or within 24 hours of the member's phone call or other notification, or as medically appropriate
- b. Urgent care appointments within two days
- c. Routine care appointments within 21 days

For **Specialty Provider Referrals**, the Contractor shall be able to provide:

- a. Immediate Need appointments within 24 hours of referral
- b. Urgent care appointments within 3 days of referral
- c. Routine care appointments within 45 days of referral

For **Dental Provider Appointments**, the Contractor shall be able to provide:

- a. Immediate Need appointments within 24 hours
- b. Urgent appointments within 3 days of request
- c. Routine care appointments within 45 days of request

For **Maternity Care Provider Appointments**, the Contractor shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:

- a. First trimester- within 14 days of request
- b. Second trimester within 7 days of request
- c. Third trimester within 3 days of request
- d. High risk pregnancies within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

For wait time in the office, the Contractor shall actively monitor and ensure that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the provider is unavailable due to an emergency.

For medically-necessary non-emergent transportation, the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor to be picked up prior to the completion of treatment. Also see Section D, Paragraph 86, Special Health Care Needs. The Contractor must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standards above for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

The Contractor must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department utilization. The Contractor is also encouraged to contract with or employ the services of non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.

The Contractor shall establish processes to monitor and reduce the appointment "no-show" rate by provider and service type. As best practices are identified, AHCCCS may require implementation by the Contractor.

The Contractor shall have written policies and procedures about educating its provider network about appointment time requirements. The Contractor must develop a corrective action plan when appointment standards are not met. In addition, the Contractor must develop a corrective action plan in conjunction with the provider when appropriate [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The Contractor is encouraged to include the standards in the provider subcontracts.

39. INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives

The Contractor must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479. These regulations prohibit physician incentive plans that directly or indirectly make payments to a doctor or a group as an inducement to limit or refuse medically necessary services to a member. The reporting requirements under 42 CFR 417.479 have been suspended. No reporting to CMS is required until the suspension is lifted.

The Contractor shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(i) upon request from AHCCCS or CMS and to AHCCCS members who request them. AHCCCS shall also review the Value-Based Purchasing (VBP) deliverables required under Section D, Paragraph 87, and may request supplemental information from the Contractor in fulfillment of the requirements in 42 CFR 417.479(h)(1) through 417.479(i).

The Contractor shall not enter into contractual arrangements that place providers at substantial financial risk as defined in 42 CFR 417.479 unless specifically approved in advance by the AHCCCS, Division of Health Care Management. In order to obtain approval when the contractual arrangements meet the definition of substantial financial risk, the following must be submitted to the AHCCCS, Division of Health Care Management 45 days prior to the implementation of the contract as specified in Attachment F3, Contractor Chart of Deliverables, [42 CFR 438.6(g)]:

1. The type of incentive arrangement
2. A plan for the member satisfaction survey;
3. Details of the stop-loss protection provided;
4. A summary of the compensation arrangement that meets the substantial financial risk definition; and
5. Any other items as requested by AHCCCS

Any Contractor-selected and/or developed pay for performance initiative that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS, Division of Health Care Management prior to implementation as specified in Attachment F3, Contractor Chart of Deliverables.

The Contractor shall also comply with all physician incentive plan requirements as set forth in 42 CFR 422.208, 422.210 and 438.6(h). These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

The Contractor shall have adequate written procedures regarding referrals to specialists, to include, at a minimum, the following:

- a. Use of referral forms clearly identifying the Contractor;
- b. Process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services;
- c. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services;
- d. Referral to Medicare;

- e. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners [42 CFR 438.206(b)(2)].
- f. For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
- g. Allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

The Contractor shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act and their implementing regulations which include but are not limited to 42 CFR Part 411, Part 424, Part 435 and Part 455. Sections 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services include:

- a. Clinical laboratory services
- b. Physical therapy services
- c. Occupational therapy services
- d. Radiology services
- e. Radiation therapy services and supplies
- f. Durable medical equipment and supplies
- g. Parenteral and enteral nutrients, equipment and supplies
- h. Prosthetics, orthotics and prosthetic devices and supplies
- i. Home health services
- j. Outpatient prescription drugs
- k. Inpatient and outpatient hospital services

41. ACCOMODATING AHCCCS MEMBERS

The Contractor shall ensure that members are provided covered services without regard to race, color, national origin, sex, sexual orientation, gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, age or disability [42 CFR 438.3(d)] [45 CFR Part 92].

Examples of prohibited practices include, but are not limited to, the following:

- a. Denying or not providing a member any covered service or access to an available facility;
- b. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary;
- c. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
- d. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental illnesses of the participants to be served.

The Contractor shall assure members the rights as delineated in 42 CFR 438.100.

The Contractor must ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the

Contractor must provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills. The Contractor must provide accommodations to members and individuals with disabilities at no cost to afford such persons an equal opportunity to benefit from the covered services. [45 CFR 92.202 – 92.205]

If the Contractor knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care, (i.e. the terms of the subcontract act to discourage the full utilization of services by some members) the Contractor will be in default of its Contract.

If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, it shall promptly intervene and require a corrective action plan from the provider. Failure to take prompt corrective measures may place the Contractor in default of its Contract.

42. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

The Contractor is encouraged to use Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs) and FQHC Look-Alikes in Arizona to provide covered services. FQHCs/RHCs and FQHC Look-Alikes are paid unique, cost-based Prospective Payment System (PPS) rates for non-pharmacy ambulatory Medicaid-covered services. The PPS rate is an all-inclusive per visit rate.^x

To ensure compliance with the requirement of 42 USC 1396b(m)(2)(A)(ix) that the Contractor's payments, in aggregate, will not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC:^{xi}

1. For dates of service from October 1, 2014 through March 31, 2015, the Contractor shall negotiate rates of payment with FQHCs/RHCs and FQHC Look-Alikes for non-pharmacy ambulatory services that are comparable to the rates paid to providers that provide similar services.
2. For dates of service on and after April 1, 2015, the Contractor shall pay the unique PPS rates, or negotiate sub-capitated agreements comparable to the unique PPS rates, to FQHCs/RHCs and FQHC Look-Alikes for PPS-eligible visits.

AHCCCS reserves the right to review a Contractor's rates with an FQHC/RHC and FQHC Look-Alikes for reasonableness and to require adjustments when rates are found to be substantially less than those being paid to other, non-FQHC/RHC/FQHC Look-Alikes providers for comparable services, or not equal to or substantially less than the PPS rates.

The Contractor may be required to submit member month information for Title XIX members for each FQHC/RHC/FQHC Look-Alikes as specified in Attachment F3, Contractor Chart of Deliverables. AHCCCS may perform periodic audits of the member information submitted. The Contractor should refer to the AHCCCS Financial Reporting Guide for ALTCS Program Contractors, for further guidance. The FQHCs/RHCs/FQHC Look-Alikes registered with AHCCCS are listed on the AHCCCS website.

See Section D, Scope of Services Paragraph 10, Prescription Medications for more information related to 340B Drug Pricing.

43. MATERIAL CHANGE TO BUSINESS OPERATIONS

The Contractor is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's business operations [42 CFR 438.207 (c)]. All material changes to the business operations must be approved in advance by AHCCCS, Division of Health Care Management. A material change to business operations is defined as any change in overall business operations (e.g., policy, process, protocol such as prior authorization or retrospective review) that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the

performance standards as described in this contract including, but not limited to, any changes that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA or District, as applicable.

The Contractor must submit the request for approval of a material change to business operations with information including, but not limited to, how the change will affect the delivery of covered services, the Contractor's plans for maintaining the quality of member care, and communications to providers and members, as outlined in ACOM Policy 439 and as specified in Attachment F3, Contractor Chart of Deliverables. AHCCCS will respond to the Contractor within 30 days of the submission. A material change in the Contractor's business operations requires 30 days advance written notice to providers and members.

The Contractor may be required to conduct meetings with providers to address issues (or to provide general information, technical assistance, etc.) related to Federal and State requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by AHCCCS.

See Section D, Paragraph 29, regarding material changes by the Contractor that may impact the provider network.

See Section D, Paragraph 73, for additional submission requirements regarding system changes and upgrades.

44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The Contractor shall develop and maintain claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data. These processes and systems shall result in information on areas including, but not limited to, service utilization and claim disputes and appeals [42 CFR 438.242(a)].

General Claims Processing Requirements

The Contractor must include nationally recognized methodologies to correctly pay claims including but not limited to:

- a. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services;
- b. Multiple Procedure/Surgical Reductions;
- c. Global Day E & M Bundling standards.

The Contractor's claims payment system must be able to assess and/or apply data related edits including but not limited to:

- a. Benefit Package Variations
- b. Timeliness Standards
- c. Data Accuracy
- d. Adherence to AHCCCS Policy
- e. Provider Qualifications
- f. Member Eligibility and Enrollment
- g. Over-Utilization Standards

The Contractor must produce a remittance advice related to the Contractor's payments and/or denials to providers and each must include at a minimum:

- a. The reason(s) for denials and adjustments
- b. A detailed explanation/description of all denials, payments and adjustments
- c. The amount billed
- d. The amount paid
- e. Application of COB and copays

f. Provider rights for claim disputes

Additionally, the Contractor must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. See Section D, Paragraph 73, Systems and Data Exchange Requirement, for specific standards related to remittance advice and EFT payment.

AHCCCS requires the Contractor to attend and participate in AHCCCS workgroups including Technical Consortium meetings to review upcoming initiatives and other technical issues.

Per A.R.S. §36-2904, unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than six months after the date of service or date of eligibility posting whichever is later, or pay a clean claim submitted more than 12 months after date of service or date of eligibility posting, whichever is later; except as directed by AHCCCS or otherwise noted in this contract. Regardless of any subcontract with an AHCCCS Contractor, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor), the provider may file a claim for payment with the responsible Contractor. The responsible Contractor shall not deny a claim on the basis of lack of timely filing if the provider submits a clean claim to the responsible Contractor no later than 60 days from the date of the recoupment, 12 months from the date of service, or 12 months from date that eligibility is posted, whichever date is later.

Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. §36-2904. Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

In accordance with the Deficit Reduction Act of 2005, Section 6085, SMD letter 06-010, and Section 1932 (b)(2)(D) of the Social Security Act, the Contractor is required to reimburse non-contracted emergency services providers at the AHCCCS Fee-For-Service rate.^{xii} This applies to in State as well as out of State providers.

In accordance with A.R.S. §36-2904 the Contractor is required to reimburse providers of hospital and non hospital services at the AHCCCS fee schedule in the absence of a contract or negotiated rate. This requirement applies to services which are directed out of network by the Contractor or to emergency services. For inpatient stays at urban hospitals pursuant to A.R.S. §36-2905.01 for non-emergency services, the Contractor is required to reimburse non-contracted providers at 95% of the AHCCCS fee schedule specified in A.R.S. §36-2903.01. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

The Contractor is required to reimburse providers for previously denied or recouped claims if the provider was subsequently denied payment by the primary insurer based on timely filing limits or lack of prior authorization and the member failed to initially disclose additional insurance coverage other than AHCCCS.

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim to the Contractor which includes the documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization; an EOB, policy or procedure, Provider Manual excerpt, etc.

For hospital clean claims, in the absence of a contract specifying otherwise, a Contractor shall apply a quick pay discount of 1% on claims paid within 30 days of receipt of the clean claim. For hospital clean claims, in the absence of a contract specifying other late payment terms, a Contractor is required to pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. §36-2903.01).

For all non-hospital clean claims, in the absence of a contract specifying other late payment terms, a Contractor is required to pay interest on payments made after 45 days of receipt of the clean claim (as defined in this contract). Interest shall be at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

Standardized claims for services must be submitted per A.A.C. R9-22-710, therefore:

1. Roster billing is not permitted for nursing facilities for dates of service on or after October 1, 2011;
2. The Contractor shall work with all other providers to eliminate roster billing and submit standardized claims with dates of service on or after October 1, 2012.

In the absence of a contract specifying other late payment terms, a claim for an authorized service submitted by a licensed skilled nursing facility, assisted living ALTCS provider or a home and community based ALTCS provider shall be adjudicated within 30 calendar days after receipt by the Contractor. A Contractor is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (A.R.S. §36-2943.D).

The Contractor shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

See ACOM Policy 203 for additional information regarding requirements for the adjudication and payment of claims.

Recoupments: The Contractor's claims processes, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims.

Any individual recoupment in excess of \$50,000 per provider, or Tax Identification Number within a contract year or greater than 12 months after the date of the original payment must be approved as specified in Attachment F3, Contractor Chart of Deliverables and as further described in ACOM Policy 412.

When recoupment amounts for a Provider TIN cumulatively exceed \$50,000 during a contract year (based on recoupment date), the Contractor must report the cumulative recoupment monthly to the designated AHCCCS Operations and Compliance Officer as outlined in the AHCCCS Claims Dashboard Reporting Guide and Attachment F3, Contractor Chart of Deliverables.

The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. AHCCCS may validate the submission of applicable voids and replacement encounters upon

completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. The Contractor should refer to ACOM Policy 412 and AHCCCS Encounter Manual for further guidance.

Appeals: If the Contractor or a Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while an appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

ICD-10 Readiness: In 2009 the Federal government published the final regulation that adopted the ICD-10 code sets as HIPAA standards (45 CFR 162.1002). As HIPAA covered entities, State Medicaid programs must comply with use of the ICD-10 code sets by the deadline established by CMS. The compliance date published in the final rule is October 1, 2013. However, in 2014 the compliance effective date was further delayed to October 1, 2015, though AHCCCS did not amend its requirement that the Contractor be ready to implement ICD-10 effective October 1, 2014.

Claims Processing Related Reporting: The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide and Attachment F3, Contractor Chart of Deliverables.

AHCCCS may require the Contractor to review claim requirements, including billing rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for specified requirements. AHCCCS shall determine and provide a format for the reporting of this data at the time of the request.

Claims System Audits: The Contractor shall develop and implement an internal ongoing claims audit function that will include, at a minimum, the following:

- a. Verification that provider contracts are loaded correctly
- b. Accuracy of payments against provider contract terms

Audits of provider contract terms must be performed on a regular and periodic basis and consist of a random, statistically significant sampling of all contracts in effect at the time of the audit. The audit sampling methodology must be documented in policy and the Contractor should review the contract loading of both large groups and individual practitioners at least once every five year period in addition to any time a contract change is initiated during that timeframe. The findings of the audits described above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

In addition, in the event of a system change or upgrade, the Contractor may also be required to initiate an independent audit of the Claim Payment/Health Information System, as specified in Attachment F3, Contractor Chart of Deliverables. The Division of Health Care Management will approve the scope of this audit, and may include areas such as a verification of eligibility and enrollment information loading, contract information management (contract loading and auditing), claims processing and encounter submission processes, and will require a copy of the final audit findings.

Recovery Audit Contractor Audits: A Recovery Audit Contractor (RAC) is a private entity that is contracted to identify underpayments and overpayments, and to recoup overpayments made to providers. The Affordable Care Act of 2010 required States to establish Medicaid RAC programs. CMS promulgated rules regarding the implementation of the Medicaid RAC requirements (42 CFR 455.500 et seq.), including the provision that

Medicaid RACs are only required to review Fee-For-Service claims until a permanent Medicare managed care RAC program is fully operational or a viable State managed care model is identified and CMS undertakes rules regarding managed care RAC efforts.

AHCCCS is exploring what opportunities may exist in the marketplace regarding a methodology for conducting a recovery audit of its services delivered through its managed care contracts (excluding reinsurance). The Contractor shall participate in any RAC activities mandated by AHCCCS, via contract amendment or policy, upon determination of the method of approach.

45. RESERVED

46. RESERVED

47. RESERVED

48. ACCUMULATED FUND DEFICIT

The Contractor must review financial statements for accumulated fund deficits on a quarterly and annual basis. If at any time during the term of this contract the Contractor determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. The Contractor, with AHCCCS, may request additional money from the Governor's Office of Strategic Planning and Budgeting.

AHCCCS may, at its option, impose enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLAN

If the Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, DHCM. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or cost allocations made.

If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner.

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 33, Subcontracts and Attachment F3, Contractor Chart of Deliverables.

50. ADVANCES, DISTRIBUTIONS, AND LOANS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees, including, but not limited to those to related parties or affiliates including another fund or line of business within its organization. The Contractor shall not, without prior approval of AHCCCS, make loans or advances to its providers in excess of \$50,000. All requests for prior approval and notifications are to be submitted to AHCCCS DHCM as specified in Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 418 for further information.

51. RESERVED**52. FINANCIAL VIABILITY STANDARDS**

The Contractor must comply with the AHCCCS established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: Medical Expense Ratio and Total Administrative Cost Percentage.

Sanctions may be imposed if the Contractor does not meet these financial viability standards. AHCCCS will take into account the Contractor's unique programs for managing care and improving the health status of members when analyzing medical expense and administrative ratio results. However, if a critical combination of the Financial Viability Standards is not met, additional monitoring, such as monthly reporting, may be required.

Financial Viability Standards:**Medical Expense Ratio**

Standard: At least 85%

Total medical expense less TPL (including case management) divided by total payments received from AHCCCS less premium tax

Total Administrative Cost Percentage

Standard: No greater than 8%

Total administrative expenses (excluding case management, premium tax and income taxes) divided by total payments received from AHCCCS less premium tax.

The Contractor shall comply with all financial reporting requirements contained in Attachment F3, Contractor Chart of Deliverables Requirements and the Financial Reporting Guide for ALTCS Program Contractors; a copy of which may be found on the AHCCCS website. The required reports are subject to change during the contract term and are summarized in Attachment F3, Contractor Chart of Deliverables.

53. RESERVED**54. MERGER, ACQUISITION, REORGANIZATION, JOINT VENTURE AND CHANGE IN OWNERSHIP**

When a state agency reorganization is required, resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature, the Contractor shall submit prior notification and a detailed transition plan to AHCCCS, as outlined in ACOM Policy 317 and Attachment F3, Contractor Chart of Deliverables. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to maintain and support the contract requirements, ensure services to members are not diminished, and major components of the organization and AHCCCS programs are not adversely affected by such reorganization. A state agency reorganization may require a contract amendment.

55. RESERVED**56. COMPENSATION**

Capitation Payments: The Contractor shall be compensated on a capitated basis. Actuaries established the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purposes of rebasing and/or updating the capitation rates:

- a. Utilization and unit cost data derived from adjudicated encounters
- b. Audited financial statements reported by the Contractor
- c. HCBS and Institutional inflation trends
- d. AHCCCS Fee-For-Service schedule pricing adjustments
- e. Programmatic or Medicaid covered service changes that affect reimbursement
- f. Additional administrative requirements for the Contractor
- g. Other changes to medical practices that affect reimbursement

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis of the capitation rates. Additional risk factors that may be considered in capitation rate development include:

- a. Reinsurance (as described in Section D, Paragraph 58, Reinsurance)
- b. Age/Gender
- c. Medicare enrollment

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary to maintain actuarially sound rates. The Contractor may cover services that are not covered under the State Plan or the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions approved by CMS; however those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)] (Section 1903(i) and 1903(i)(17) of the Social Security Act).^{xiii} Graduate Medical Education payments (GME) are not included in the capitation rates but paid out separately consistent with the terms of Arizona's State Plan.^{xiv} Likewise, because AHCCCS does not delegate any of its responsibilities for administering Electronic Health Record (EHR) incentive payments to the Contractor, EHR payments are also excluded from the capitation rates and are paid out separately by AHCCCS pursuant to Section 4201 of the HITECH Act, 42 USC 1396b(t), and 42 CFR 495.300 et seq.^{xv}

The capitation rate includes an assumed cost per member per month for the Contractor to provide reinsurance to its subcontracted health plans. This will be considered full reimbursement for all reinsurance cases of \$50,000 or less. For reinsurance claims of over \$50,000, the Contractor will be reimbursed at 75% of the allowable charges over the deductible limit of \$50,000. Reinsurance covers acute hospitalizations only. AHCCCS will use inpatient encounter information to determine the reinsurance payable to the Contractor.

Subject to the availability of funds, AHCCCS shall make payments to the Contractor in accordance with the terms of this contract provided that the Contractor's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of A.R.S. Title 36.

All funds received by the Contractor pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles.

Except for funds received from the collection of permitted copayments and third-party liabilities, the only source of payment to the Contractor for the services provided hereunder is the Arizona Long Term Care System Fund, as described in A.R.S. §36-2913. An error discovered by the State, with or without an audit, in the amount of fees paid to the Contractor will be subject to adjustment or repayment by the Contractor making a corresponding decrease in a current payment or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS must be notified and reimbursed within 30 days of identification.

The Contractor or its subcontractors shall collect any required copayments from members but services will not be denied for inability to pay the copayment. Except for permitted copayments, the Contractor or its subcontractors shall not bill or attempt to collect any fee from, or for, a member for the provision of covered services.

Targeted Case Management: The Contractor will be paid monthly on a capitated basis. This payment will be based on the number of recipients matched as of the first of each month. The targeted case management capitation payment will be made no later than 10 business days after receipt of the Contractor data transmission. AHCCCS will make payments to the Contractor in accordance with the terms as outlined in Attachment F4, Targeted Case Management, provided that the Contractor's performance is in compliance with the terms and conditions.

Requests for Federal Financial Participation (FFP): The method of compensation under this contract shall be capitation as described herein. AHCCCS shall transfer the capitation payments, both federal and state match, to ADES, in accordance with General Accounting Office guidelines, the Cash Management Improvement Act (CFR 31, Part 205) and the State's Cash Management Improvement Act contract provisions.

Establishment of IGA Fund: ADES shall, on an annual basis, transfer to AHCCCS the total amount appropriated for the state match for Title XIX ALTCS DD expenditures and for the ADES share of Medicare phase-down payments to CMS as required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). This transfer shall be made in its entirety prior to the first Title XIX disbursement. If ADES is unable to roll forward its entire fiscal year allotment prior to the due date of the first Title XIX disbursement, AHCCCS will accept the receipt of the first quarter's allotment for the first capitation payment. However, the remainder of the annual state match requirement must be received before subsequent payments are made. AHCCCS shall deposit the monies transferred into an Intergovernmental Agreement (IGA) Fund over which AHCCCS shall have sole disbursement authority.

Beginning in January 2006, AHCCCS will use monies in the IGA Fund to make monthly disbursements to CMS for the ADES share of Medicare phase-down payments made in accordance with the MMA for drug benefit costs assumed by Medicare for full dual eligible members. Payments amounts will be made in a manner specified by CMS. AHCCCS will notify ADES if additional monies are required to be deposited into the IGA Fund.

When AHCCCS draws FFP for qualifying ADES disbursements, AHCCCS will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to ADES.

If AHCCCS determines that additional monies are required, for the state match payments and/or the phase-down payments, AHCCCS shall notify ADES that additional monies must be deposited into the IGA Fund prior to making additional Title XIX disbursements.

If at the end of a fiscal year, and after the close of any administrative adjustments as defined in A.R.S. §35-190 and 191, monies remain in the IGA Fund, AHCCCS shall notify ADES and transfer these monies back to ADES. If it is determined that excess funds exist in the IGA Fund, ADES may request a withdrawal of monies prior to the end of the fiscal year and/or prior to the close of the administrative adjustment period.

Cost Settlement for Primary Care Payment Parity: The Patient Protection and Affordable Care Act (ACA) requires that the Contractor make enhanced payments for primary care services delivered by, or under the supervision of, a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. [11/06/2012 final rule, 42 CFR 438.6(c)(5)(vi), 42 CFR 447.400(a)]. The Contractor shall base enhanced primary care payments on the Medicare Part B fee schedule rate or, if greater, the payment rate that would be applicable in 2013 and 2014 using the CY 2009 Medicare physician fee schedule conversion factor. If no applicable rate is established by Medicare, the Contractor shall use the rate specified in a fee schedule established by CMS. [11/06/2012 final rule, 42 CFR 438.6(c)(5)(vi), 42 CFR 447.405] The Contractor shall make enhanced primary care payments for all Medicaid-covered Evaluation and Management (E&M) billing codes 99201 through 99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474, or their successor codes. [11/06/2012 final rule, 42 CFR 438.6(c)(5)(vi), 42 CFR 447.405(c)]^{xvi} AHCCCS has developed an enhanced fee schedule containing the qualifying codes using the 2009 Medicare conversion factor in compliance with the greater-of requirement.

The enhanced payments apply only to services provided on and after January 1, 2013 by qualified providers, who self-attest to AHCCCS as defined in the federal regulations. These reimbursement requirements for the enhanced payments apply to payments made for dates of service January 1, 2013 through December 31, 2014.

The Contractor shall reprocess all qualifying claims for qualifying providers back to January 1, 2013 dates of service with no requirements that providers re-submit claims or initiate any action. The Contractor shall not apply any discounts to the enhanced rates.

In the event that a provider retroactively loses his/her qualification for enhanced payments, the Contractor shall identify impacted claims and automatically reprocess for the recoupment of enhanced payments. It is expected that this reprocessing will be conducted by the Contractor without requirement of further action by the provider.

AHCCCS will make quarterly cost-settlement payments to the Contractor. The cost-settlement payment is a separate payment arrangement from the capitation payment. (CMS Medicaid Managed Care Payment for PCP Services in 2013 and 2014: Technical Guide and Rate Setting Practices) Cost Settlement payments will be based upon adjudicated/approved encounter data.^{xvii} This data will provide the necessary documentation to AHCCCS, sufficient to enable AHCCCS and CMS to ensure that primary care enhanced payments were made to network providers. [11/06/2012 final rule, 42 CFR 438.6(c)(5)(vi)(B)]^{xviii} The Contractor will be required to refund payments to AHCCCS for any reduced claim payments in the event that a provider is subsequently “decertified” for enhanced payments due to audit or other reasons.

Refer to ACOM Policy 207 for further details.

Health Insurer Fee: Section 9010 of the Patient Protection and Affordable Care Act (ACA) requires that the Contractor, if applicable, pay a Health Insurer Assessment Fee (HIF) annually beginning in 2014 based on its respective market share of premium revenues from the preceding year. Subject to the receipt of documentation from the Contractor regarding the amount of the Contractor’s liability for the HIF, AHCCCS shall make a capitation rate adjustment consistent with a methodology approved by CMS to approximate the cost associated with the HIF. The cost of the Assessment Fee will include both the Assessment Fee itself and the corporate income tax liability the Contractor incurs related to the Assessment Fee. The Contractor must submit the items specified in Attachment F3, Contractor Chart of Deliverables to the DHCM Finance Manager. See ACOM Policy 320 with further details.

For Fee Year 2017, the Federal Government has placed a suspension for HIF taxes that would be paid in 2017 based on revenue received in 2016. Therefore, AHCCCS will suspend Contractor submission of the Form 8963, Report of Health Insurance Provider Information, and ACOM Policy 320, Attachment B, Health Insurer Fee Liability Reporting Template, related to Fee Year 2017 due September 30, 2017. AHCCCS will not make HIF payments to the Contractor for fee year 2017. Additionally, AHCCCS will suspend Contractor submission of the copies of its federal and state filings for fee year 2017 due April 30, 2018.

57. ANNUAL SUBMISSION OF BUDGET

The Contractor shall submit to AHCCCS, by August 10th of each year, a copy of the DDD budget submittal to the Office of Strategic Planning and Budget (OSPB) due the following September related to the prior year actual expenditures, the current year expenditure estimate, and the subsequent year expenditure request. Any changes to these documents shall be submitted to AHCCCS upon submission to OSPB. These documents will be utilized by AHCCCS in preparation of the request of Federal Funds Expenditure Authority for the DES/DDD Program in the AHCCCS CMS-37.

58. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services as described in this paragraph and incurred for a member beyond an annual deductible. AHCCCS is self-insured for the reinsurance program and is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates. The reinsurance contract year is the year beginning on October 1 and ending on September 30. Refer to the AHCCCS Reinsurance Policy Manual for further details on the Reinsurance Program.

The table below represents deductible and coinsurance levels.

Reinsurance Case Type	Deductible	Coinsurance
Regular Reinsurance	\$50,000	75%
Catastrophic Reinsurance	NA	85%
Transplant and Other Case Types	See specific paragraphs below	See specific paragraphs below

Annual deductible levels apply to all members. 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.

Reinsurance Case Types

For all reinsurance case types, for services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the computation of reinsurance will be the lesser of the contracted/mandated amount or the Contractor paid amount.

Regular Reinsurance: The Contractor will be reimbursed at 75% of the allowable charges over the deductible limit of \$50,000 for regular inpatient reinsurance claims. Reinsurance covers acute inpatient hospitalizations only. Same-day admit-and-discharge services do not qualify for reinsurance. Reimbursement for these reinsurance benefits will be made to the Contractor each month.

Prior Period Coverage Reinsurance: PPC expenses are not covered for any members under the reinsurance program unless they qualify under transplant reinsurance.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs, and those members diagnosed with hemophilia, von Willebrand's Disease, or Gaucher's Disease, as follows:

Biotech Drugs: Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. The biotech drugs covered under reinsurance may be reviewed by AHCCCS at the start of each contract year. Refer to the Reinsurance Policy Manual for a complete list of the approved biotech drugs. When a generic equivalent of a biotech drug is available, AHCCCS will reimburse at the lesser of the biotech drug or its generic equivalent for reinsurance purposes, unless the generic equivalent is contra-indicated for a specific member.

Hemophilia: Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia.

Von Willebrand's Disease: Catastrophic reinsurance coverage is available for all members diagnosed with von Willebrand's Disease who are dependent on Plasma Factor VIII.

Gaucher's Disease: Catastrophic reinsurance is available for members diagnosed with Gaucher's Disease classified as Type I and are dependent on enzyme replacement therapy.

For additional detail and restrictions refer to the AHCCCS Reinsurance Policy Manual and the AMPM. There are no deductibles for catastrophic reinsurance cases. For member's receiving biotech drugs, AHCCCS will reimburse at 85% of the cost of the drug only. For those members diagnosed with hemophilia, von Willebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, whichever is lower, depending on the subcap/CN1 code indicated on the encounter.

AHCCCS holds a specialty contract for anti-hemophilic agents and related services for hemophilia. The Contractor may access anti-hemophilic agents and related pharmaceutical services for hemophilia or von Willebrand's under the terms and conditions of the specialty contract for members enrolled in their plans. In that instance, the Contractor is 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. A Contractor utilizing the contract will comply with the terms and conditions of the contract. A Contractor may use the AHCCCS contract or contract with a provider of their choice. 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.

The Contractor must notify AHCCCS, DHCM Medical Management, of cases identified for catastrophic reinsurance coverage, as specified in Attachment F3, Contractor Chart of Deliverables. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS.

All catastrophic claims are subject to medical review by AHCCCS.

Transplant Reinsurance: This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to the AMPM for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is to be paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of the Contractor's paid amount. A new component for follow-up care post-transplant has been added to the transplant contracts. Reinsurance for these components will follow the regular reinsurance reimbursement, including a deductible requirement. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The new follow-up care component will receive reinsurance coverage in accordance with regular reinsurance reimbursement, including a deductible requirement. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. The Contractor must notify AHCCCS, DHCM Medical Management when a member is referred to a transplant facility for evaluation for an AHCCCS covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS, DHCM Medical Management within 30 days of referral to the transplant facility for evaluation.

If a Contractor intends to use an out of state transplant facility for a covered transplant and AHCCCS already holds an in state contract for that transplant type, the Contractor must obtain prior approval from the AHCCCS Medical Director. If no prior approval is obtained, and the Contractor incurs costs at the out of state facility, those costs will not be eligible for either transplant or regular reinsurance.

Other Reinsurance: For all reinsurance case types other than transplants, the Contractor will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case reaches \$650,000. It is the responsibility of the Contractor to notify AHCCCS, DHCM Reinsurance Supervisor, once a case reaches \$650,000. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date of service will disqualify the related encounters for 100% reimbursement consideration.

Encounter Submission and Payments for Reinsurance

Encounter Submission: All reinsurance associated encounters, except as provided below for “Disputed Matters,” must reach a clean status within 15 months from the end date of service, or date of eligibility posting, whichever is later.

Encounters for claims which cross over contract years will not be eligible for reinsurance.

AHCCCS will not pay reinsurance on encounters for 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.

AHCCCS will not pay reinsurance on encounters containing any Prior Period Coverage (PPC) for regular, catastrophic and other reinsurance case types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

Disputed Matters: For encounters which are the subject of a member appeal, provider claim dispute, or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the longer 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 clean claim status. Therefore, reinsurance claims for disputed matters will be considered timely if the Contractor files such claims in clean claim 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.

Failure to submit encounters in clean claim status within the applicable timeframes specified above will result in the denial of reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.

The Contractor must void encounters for any claims that are recouped in full. For recoupments that result in a reduced claim value or any adjustments that result in an increased claim value, replacement encounters must be submitted. For replacement encounters resulting in an increased claim value, the replacement encounter must reach adjudicated status within 15 months of end date of service to receive additional reinsurance benefits. The Contractor should refer to Section D, Paragraph 74, Encounter Data Reporting, for encounter reporting requirements.

Payment of Regular and Catastrophic Reinsurance Cases: AHCCCS will reimburse the Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages and Medicare/TPL, payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the Contractor, minus the coinsurance and Medicare/TPL payment unless the costs are paid under a subcapitated arrangement. In subcapitated arrangements, the AHCCCS shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest.

Payment of Transplant Reinsurance Cases: Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the Contractor’s paid amount, subject to coinsurance percentages. The Contractor is required to submit all supporting service encounters for transplant services. 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 encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage. Refer to the Reinsurance Policy Manual for appropriate billing of transplant services.

Reinsurance Audits: AHCCCS may, at a later date, perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits and the Contractor will be given appropriate advance notice.

59. CAPITATION ADJUSTMENTS

Rate Adjustments: Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review capitation rates to determine if a capitation adjustment is needed for reasons including, but not limited to, the following:

- Program changes
- Legislative requirements
- Changes in trend assumptions
- Updated encounter experience
- Actuarial assumptions

If a capitation rate adjustment is determined necessary, the adjustment and assumptions may be discussed with the Contractor prior to modifying capitation rates. The Contractor may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review. The Contractor must seek prior approval from AHCCCS for any policy decisions which may create a fiscal impact of \$1,000,000 or more annually. The approval request shall be submitted to the AHCCCS DHCM Finance Unit 90 days prior to the effective date of the policy change.

Contractor Default: If the Contractor is in any manner in default in the performance of any obligation under this contract, AHCCCS may, at its option and in addition to other available remedies, adjust the amount of payment until there is satisfactory resolution of the default.

Change in Member Status: The Contractor shall reimburse AHCCCS and/or AHCCCS may deduct from future monthly capitation for any portion of a month during which the Contractor was not at risk due to, for example:

- a. Death of a member
- b. Inmate of a public institution
- c. Duplicate capitation paid for the same member
- d. Adjustment based on change in member's contract type
- e. Voluntary withdrawal

AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this Contract.

Inmate of a Public Institution Reporting: Several Counties are submitting daily files of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from the Contractor and placed in a "no-pay" status for the duration of their incarceration or their eligibility period if shorter. AHCCCS will provide the Contractor with incarceration information for the member on the Contractor's 834 file. The file will indicate an "IE" code for *ineligible* associated with the disenrollment. The file will also include a data element indicating the County of jurisdiction and "CTYPRI" as the new health plan of enrollment due to incarceration. Upon release from jail, the member will be enrolled using the current enrollment rules and hierarchy as follows: SMI designation, Native American on reservation, re-enroll with their previous Contractor if less than 90 days from disenrollment, or enrollment choice or auto-assign if more than 90 days from disenrollment. A member is eligible for covered services until the effective date of the member's "no-pay" status.

If the Contractor becomes aware of a member who becomes an inmate of a public institution and who is not identified in the AHCCCS reporting above, the Contractor must notify AHCCCS for an eligibility determination. Notifications must be sent via email to the following email address: MCDUJustice@azahcccs.gov

Notifications must include:

- a. AHCCCS ID
- b. Name
- c. Date of Birth (DOB)
- d. When incarcerated
- e. Where incarcerated

The Contractor does **not** need to report members incarcerated with the Arizona Department of Corrections.

60. MEMBER SHARE OF COST

ALTCS members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the share of cost, have a share of cost in the amount of \$0.00. Generally, only institutionalized ALTCS members have a share of cost (SOC); however, certain HCBS ALTCS members may be liable for a share of cost, particularly those who become eligible through a special treatment income trust [42 CFR 438.108]. See Arizona's Eligibility Policy Manual for Medical, Nutrition, and Cash Assistance for a complete list of SOC adjustments on the AHCCCS website.

The Contractor receives monthly capitation payments which incorporate an assumed deduction for the share of cost which members contribute to the cost of care. The Contractor is responsible for collecting their members' share of cost. The Contractor has the option of collecting the share of cost or delegating this responsibility to the provider. The Contractor may transfer this responsibility to nursing facilities, Institutions for Mental Disease for those 65 years of age and older, or Inpatient Psychiatric Facilities for those under 21 years of age, and HCBS Providers, and compensate these facilities net of the share of cost amount. If the Contractor delegates this responsibility to the provider, the provider contract must spell out complete details of both parties' obligations in share of cost collection. The Contractor or its subcontractors shall not assess late fees for the collection of the share of cost from members.

61. COPAYMENTS

The Contractor is required to comply with A.A.C. R9-22-711, ACOM Policy 431, and other directives by AHCCCS. The members covered under this contract are currently exempt from mandatory and non-mandatory (also known as nominal or optional) copayments. Those populations exempt from copayments or subject to non-mandatory copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108].

62. PEDIATRIC IMMUNIZATION AND THE VACCINE FOR CHILDREN PROGRAM

Through the Vaccine for Children (VFC) program the Federal and State governments purchase, and make available to providers at no cost, vaccines for AHCCCS children under age 19. Therefore, the Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Contractor shall contact AHCCCS, DHCM, Clinical Quality Management for guidance. Any provider licensed by the State to administer immunizations may register with Arizona Department of Health Services (ADHS) as a "VFC provider" to receive these free vaccines. The Contractor shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS. The Contractor shall comply with all VFC requirements and monitor contracted providers to ensure that physicians

are registered as VFC providers when acting as primary care provider (PCPs) for members under the age of 19 years.

Due to low numbers of children in their panels providers in certain geographic service areas (GSAs) may choose not to provide vaccinations. Whenever possible, members should be assigned to VFC providers within the same or a nearby community. When it is not possible, the Contractor must develop processes to ensure vaccinations are available through a VFC enrolled provider or through the appropriate County Health Department. In all instances, the antigens are to be provided through the VFC program. The Contractor must develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

Arizona State law requires the reporting of all immunizations given to children under the age of 19. Immunizations must be reported at least monthly to the ADHS Immunization Registry. Reported immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor must educate its provider network about these reporting requirements and the use of this resource.

63. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

AHCCCS is the payor of last resort unless specifically prohibited by applicable State or Federal law. 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 take reasonable measures to identify potentially legally liable third party sources.

If the Contractor discovers the probable existence of a liable third party that is not known to AHCCCS, or identifies any change in coverage, the Contractor must report the information within 10 days of discovery, as specified in Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the AHCCCS Technical Interface Guidelines.

The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §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 third party [42 CFR 434.6(a)(9)]. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract. The two methods used for 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, and AHCCCS Policy.

Cost Avoidance

The Contractor shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. For purposes of cost avoidance, establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established, the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor shall be subject to sanctions.

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the Contractor is responsible for making these payments in accordance with ACOM Policy 434.

Claims for inpatient stay for labor, delivery and postpartum care, including professional fees when there is no global OB package, must be cost avoided. [42 CFR 433.139]

Timely Filing: The Contractor shall not deny a claim for timeliness if the untimely claim submission results from a provider's efforts to determine the extent of liability.

Members Covered by both Medicare and Medicaid (Duals): See Section D, Paragraph 60, Medicare Services and Cost Sharing.

Members with a CRS Condition: Members under 21 years of age who are determined to have a qualifying CRS condition will be enrolled with the CRS Contractor. Members with private insurance or Medicare may use their private insurance or Medicare provider networks to obtain services including those for the CRS condition. The CRS Contractor is responsible for payment for services provided to its enrolled members according to CRS coverage type. See ACOM Policy 426 for CRS Contractor coverage responsibilities and coordination of benefits. If the member has Medicare coverage, ACOM Policy 201 shall apply.

Post-Payment Recoveries

Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable third party at the time services were rendered or paid for, was unable to cost-avoid, or post-payment recovery is required. In these instances, the Contractor must adjudicate the claim and then utilize post-payment recovery processes which include: Pay and Chase, Retroactive Recoveries Involving Commercial Insurance Payor Sources, and other third party liability recoveries. Refer to ACOM Policy 434 for further guidance.

Pay and Chase: The Contractor shall pay the full amount of the claim according to the AHCCCS Capped-Fee-For-Service Schedule or the contracted rate and then seek reimbursement from any third party if the claim is for the following:

- a. Prenatal care for pregnant women, including services which are part of a global OB Package;
- b. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program;
- c. Services covered by third party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement; or
- d. Services for which the Contractor fails to establish the existence of a liable third party at the time the claim is filed.

Retroactive Recoveries Involving Commercial Insurance Payor Sources: For a period of two years from the date of service, the Contractor shall engage in retroactive third party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the Contractor must seek recovery from the commercial insurance. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way.

The Contractor has two years from the date of service to recover payments for a particular claim, or to identify claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when the Contractor has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment. If AHCCCS determines that a Contractor is tagging claims that do not meet these requirements, AHCCCS may impose sanctions. After two years from the date of service, AHCCCS will direct recovery efforts for any claims not tagged by the Contractor.

AHCCCS will direct recovery efforts for retroactive recovery of claims not previously identified by the Contractor as having a reasonable expectation of recovery. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the Contractor.

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

See ACOM Policy 434 for details regarding encounter adjustments as a result of retroactive recoveries and the processes for identifying claims that have a reasonable expectation of recovery.

Other Third Party Liability Recoveries: The Contractor shall identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining through the use of trauma code edits, utilizing the codes provided by AHCCCS. The Contractor shall not pursue recovery in the following circumstances, unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

- Motor Vehicle Cases
- Other Casualty Cases
- Tort feasons
- Restitution Recoveries
- Worker's Compensation Cases

Upon identification of a potentially liable third party for any of the above situations, the Contractor shall, within 10 business days, report the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case, as specified in Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tort feason(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or Fee-For-Service payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or Fee-For-Service payments are involved. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

Total Plan Cases: In "total plan" cases, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916. The Contractor shall use the AHCCCS-approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery. The Contractor may retain up to 100% of its recovery collections if all of the following conditions exist:

- a. Total collections received do not exceed the total amount of the Contractor's financial liability for the member;
- b. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (i.e., lien filing, etc.); and,
- c. Such recovery is not prohibited by State or Federal law.

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS or AHCCCS' authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Settlement Notification Form, within 10 business days from the settlement date or in an AHCCCS-approved monthly file, as specified in Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 72, Sanctions.

Joint and Mass Tort Cases: AHCCCS' authorized representative is responsible for performing all research, investigation and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS' authorized representative by the Contractor. In joint and mass tort cases, AHCCCS' authorized representative is also responsible for negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Contractor will be responsible for their prorated share of the contingency fee. The Contractor's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Contractor.

Other Reporting Requirements

All TPL reporting requirements are subject to validation through periodic audits and/or operational reviews which may include Contractor submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to the Contractor.

Cost Avoidance/Recovery Report: The Contractor shall submit quarterly reports regarding cost avoidance/recovery activities, as specified in Attachment F3, Contractor Chart of Deliverables. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

Contract Termination: Upon termination of this contract, the Contractor will complete the existing third party liability cases or make any necessary arrangements to transfer the cases to AHCCCS' authorized TPL representative.

64. MEDICARE SERVICES AND COST SHARING

The Contractor must pay most Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor must limit their cost sharing responsibility according to A.A.C. R9-29-301 and A.A.C. R9-29-302 and as further outlined in ACOM Policy 201. Refer to Section D, Paragraph 10, Covered Services, for information regarding prescription medication for Medicare Part D.

Dual eligible members shall have choice of all providers in the network and shall not be restricted to those that accept Medicare.

As provided under section 1860D-14 of the Social Security Act, full-benefit dual eligible institutionalized individuals have no cost-sharing for covered Part D drugs under their PDP or MA-PD plan. Effective January 1, 2012, Section 1860D-14 of the Act also eliminates Part D cost-sharing for full-benefit dual eligible individuals who are receiving home and community-based services (HCBS) either through a home and community-based waiver authorized for a State under §1115 or subsection (c) or (d) of §1915 of the Act.

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year.

65. MEMBER BILLING AND LIABILITY FOR PAYMENT

AHCCCS registered providers may charge AHCCCS members for services which are excluded from AHCCCS coverage or which are provided in excess of AHCCCS limits according to the guidelines set forth in A.A.C R9-22-702.

Except for permitted calculated share of costs, the Contractor or its subcontractors must ensure that members are not held liable for:

- a. The Contractor's or subcontractor's debts in the event of the Contractor's or the subcontractor's insolvency [42 CFR 438.106(a)];
- b. Covered services provided to the member except as permitted under R9-22-702 [42 CFR 438.106(b)(1)]; or,
- c. Payments to the Contractor or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or the subcontractor provided the services directly [42 CFR 438.106(b)(2); 42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230].

66. SURVEYS

The Contractor may be required to perform surveys at AHCCCS' request. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. The final survey tool shall be approved in advance by AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables. The results and the analysis of the results shall be submitted to the DHCM as specified in Attachment F3, Contractor Chart of Deliverables. The Contractor shall utilize member survey findings to improve care for DDD members.

For non-AHCCCS required surveys, the Contractor shall provide notification as specified in Attachment F3, Contractor Chart of Deliverables, prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and analysis of the results of any Contractor initiated surveys shall be submitted to the DHCM as specified in Attachment F3, Contractor Chart of Deliverables. Surveys performed by the Contractor to evaluate plan satisfaction for previous members (exit surveys), are subject to the above notification requirement for non-AHCCCS required surveys and are not subject to Marketing Committee approval.

AHCCCS may conduct surveys of a representative sample of the Contractor's membership and providers. The results of AHCCCS conducted surveys will become public information and available to all interested parties on the AHCCCS website. The Contractor will be responsible for reimbursing AHCCCS for the cost of such surveys based on its share of AHCCCS enrollment.

As specified in Attachment F3, Contractor Chart of Deliverables, the Contractor is required to perform periodic surveys of its membership, as outlined in ACOM Policy 424, in order to verify that members have received services that have been paid for by the Contractor and to identify potential service/claim fraud [42 CFR 455.20 and 433.116].

67. PATIENT TRUST ACCOUNT MONITORING

The Contractor shall have a policy regarding on-site monitoring of trust fund accounts for institutionalized members to ensure that expenditures from a member's trust fund comply with Federal and State regulations. Suspected incidents of fraud involving the management of these accounts must be reported in accordance with Section D, Paragraph 70, Corporate Compliance.

If the Contractor identifies a patient trust account combined with other resources will exceed the \$2,000 resource limit or a balance nearing that limit, they should submit a Member Change Request (MCR) to the ALTCS eligibility office.

68. MARKETING

The Contractor shall comply with all Federal and State provisions regarding marketing including ACOM Policy 101 [42 CFR 438.104]. The Contractor shall submit all proposed marketing materials, activities, and participation in events that will involve the general public to the AHCCCS Marketing Committee as specified in Attachment F3, Contractor Chart of Deliverables and as outlined in ACOM Policy 101. All marketing materials that have been approved by the Marketing Committee must be resubmitted every two years for re-approval.

69. CULTURAL COMPETENCY

The Contractor shall ensure compliance with a Cultural Competency Plan which meets the requirement of ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the DHCM Operations Unit, as specified in Attachment F3, Contractor Chart of Deliverables. The Plan shall address cultural considerations and limited English proficiency for all services and settings, i.e., attendant care, assisted living facilities, etc. [42 CFR 438.206(c)(2)]

70. CORPORATE COMPLIANCE**Corporate Compliance Program**

The Contractor shall be in compliance with 42 CFR 438.608. The Contractor must have a mandatory Corporate Compliance Program, supported by other administrative procedures including a Corporate Compliance Plan that is designed to guard against fraud, waste, and abuse. The Contractor shall have written criteria for selecting a Compliance Officer and the job description clearly outlining the responsibilities and authority of the position. The Contractor's written Corporate Compliance Plan must adhere to Contract and ACOM Policy 103 and must be submitted annually to AHCCCS-OIG as specified in Attachment F3, Contractor Chart of Deliverables.

The compliance program shall be designed to both prevent and detect suspected fraud, waste, and abuse. The compliance program must include:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to and processes for complying with all applicable Federal and State rules, regulations, guidelines, and standards.
2. The Compliance Officer must be an onsite management official who reports directly to the Contractor's top management. Any exceptions must be approved by AHCCCS.
3. Effective lines of communication between the compliance officer and the Contractor's employees.
4. Enforcement of standards through well-publicized disciplinary guidelines.
5. Provision for internal monitoring and auditing, as well as provisions for external monitoring and auditing of subcontractors. The Contractor shall provide the external auditing schedule and executive summary of all audits to AHCCCS-OIG as specified in Attachment F3, Contractor Chart of Deliverables.
6. Provision for prompt response to problems detected.
7. The written designation of a Compliance Committee who is accountable to the Contractor's top management. The Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
8. Pursuant to the Deficit Reduction Act of 2005 (DRA), the Contractor, as a condition for receiving payments shall establish written policies for employees detailing:
 - a. The Federal False Claims Act provisions;
 - b. The administrative remedies for false claims and statements;
 - c. Any State laws relating to civil or criminal penalties for false claims and statements; and
 - d. The whistleblower protections under such laws.

9. The Contractor must require, through documented policies and subsequent contract amendments, that subcontractors and providers train their staff on the following aspects of the Federal False Claims Act provisions;
 - a. The administrative remedies for false claims and statements;
 - b. Any state laws relating to civil or criminal penalties for false claims and statements; and
 - c. The whistleblower protections under such laws.
10. The Contractor must establish a process for training existing staff and new hires on the compliance program and on the items in number 9 above. All training must be conducted in such a manner that can be verified by AHCCCS.
11. The Contractor must notify AHCCCS, DHCM Data Analysis and Research, as specified in Attachment F3, Contractor Chart of Deliverables of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

Fraud Waste, and Abuse: In accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and ACOM Policy 103, the Contractor, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding all allegations of fraud, waste or abuse involving the AHCCCS Program. The Contractor shall not conduct any investigation or review of the allegations of fraud, waste, or abuse involving the AHCCCS Program. Notification to AHCCCS-OIG shall be in accordance with ACOM Policy 103 and as specified in Attachment F3, Contractor Chart of Deliverables. The Contractor must also report to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, any credentialing denials including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. [42 CFR 455.17][42 CFR 455.1(a)(1)]. As stated in A.R.S. §13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material omissions is guilty of a Class 2 felony.

The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS-OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the AHCCCS-OIG upon request and at no cost. The AHCCCS-OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the AHCCCS-OIG request.

Once the Contractor has referred a case of alleged fraud, waste, or abuse to AHCCCS, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments. AHCCCS-OIG will notify the Contractor when the investigation concludes. If it is determined by AHCCCS-OIG to not be a fraud, waste, or abuse case, the Contractor shall adhere to the applicable AHCCCS policy manuals for disposition.

In addition the Contractor must furnish to AHCCCS or CMS within 35 days of receiving a request, full and complete information, pertaining to business transactions [42 CFR 455.105]:

- The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of request; and
- Any significant business transactions between the Contractor, any subcontractor, and wholly owned supplier, or between the Contractor and any subcontractor during the five year period ending on the date of the request.

Disclosure of Ownership and Control [42 CFR 455.100 through 106](SMDL09-001) (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act).^{xix}

The Contractor must obtain the following information regarding ownership and control [42 CFR 455.104]:^{xx}

1. The Name, Address, Date of Birth and Social Security Numbers of any individual with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 CFR 455.100-104)
2. The Name, Address, and Tax Identification Number of any corporation with an ownership or control interest in the Contractor, including those individuals who have direct, indirect, or combined direct/indirect ownership interest of 5% or more of the Contractor's equity, owns 5% or more of any mortgage, deed of trust, note, or other obligation secured by the Contractor if that interest equals at least 5% of the value of the Contractor's assets, is an officer or director of a Contractor organized as a corporation, or is a partner in a Contractor organized as a partnership (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act and 42 CFR 455.100-104). The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
3. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling
4. The name of any disclosing entity, other disclosing entity, fiscal agent or managed care entity, as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest
5. The Name, Address, Date of Birth and Social Security Number of any agent or managing employee (including Key Staff personnel as noted in Section D, paragraph 25) of the Contractor as defined in 42 CFR 455.101

Disclosure of Information on Persons Convicted of Crimes [42 CFR 455.101 through 106; 455.436] (SMDL09-001):

The Contractor must do the following:

1. Confirm the identity and determine the exclusion status of any person with an ownership or control interest in the Contractor, and any person who is an agent or managing employee of the Contractor (including Key Staff personnel as noted in Section D, Paragraph 25), through routine checks of Federal databases; and
2. Disclose the identity of any of these excluded persons, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

The Contractor shall, on a monthly basis, confirm the identity and determine the exclusion status through routine checks of:

- a. The List of Excluded Individuals (LEIE)
- b. The System for Award Management (SAM) formerly known as the Excluded Parties List (EPLS)
- c. Any other databases directed by AHCCCS or CMS

The Contractor shall provide the above-listed disclosure information to AHCCCS at any of the following times (Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act, and 42 CFR 455.104(c)(3)).^{xxi}

1. Upon the Contractor submitting the proposal in accordance with the State's procurement process;
2. Upon the Contractor executing the contract with the State;
3. Within 35 days after any change in ownership of the Contractor; and

4. Upon request by AHCCCS.

The results of the *Disclosure of Ownership and Control* and the *Disclosure of Information on Persons Convicted of Crimes* shall be held by the Contractor. Upon renewal or extension of the contract, the Contractor shall submit an annual attestation as specified in Attachment F3, Contractor Chart of Deliverables, that the information has been obtained and verified by the Contractor, or upon request, provide this information to AHCCCS. Refer to ACOM Policy 103 for further information.^{xxii}

The Contractor must immediately notify AHCCCS-OIG of any person who has been excluded through these checks in accordance as specified in Attachment F3, Contractor Chart of Deliverables.

Federal Financial Participation (FFP) is not available for any amounts paid to a Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:^{xxiii}

1. The Contractor is controlled by a sanctioned individual
2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act.
3. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:
 - a. Any individual or entity excluded from participation in Federal health care programs
 - b. Any entity that would provide those services through an excluded individual or entity (Section 1903(i)(2) of the Social Security Act, 42 CFR 431.55(h), 42 CFR 438.808, 42 CFR 1002.3(b)(3), SMD letter 6/12/08, and SMD letter 1/16/09).

The Contractor shall require Administrative Services Subcontractors adhere to the requirements outlined above regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes as outlined in 42 CFR 455.101 through 106, 42 CFR 455.436 and SMDL09-001. Administrative Services Subcontractors shall disclose to AHCCCS-OIG the identity of any excluded person.

In the event that AHCCCS-OIG, either through a civil monetary penalty or assessment, a global civil settlement or judgment, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery.

In accordance with Section 1128A(a)(6) of the Act; and 42 CFR section 1003.102(a)(2)(3) civil monetary penalties may be imposed against the Contractor, its subcontractors or providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to Sections 1128, 1128A, 1156, or 1842(j)(2) and (1903(i) and 1903(i)(2)(A)) of the Social Security Act.^{xxiv}

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) (Sections 1903(i) and 1903(i)(2)(B)) of the Social Security Act.^{xxv}

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom the state has failed to suspend payments during any period in which the state has notified the Contractor of a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments (Section 1903(i) and 1903(i)(2)(C)) of the Social Security Act).^{xxvi}

71. RECORDS RETENTION

The Contractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. The Contractor shall comply with all specifications for record keeping established by AHCCCS. All records shall be maintained to the extent and in such detail as required by AHCCCS rules and policies. Records shall include but not be limited to financial statements, records relating to the quality of care, medical records, prescription files and other records specified by AHCCCS.

The Contractor shall make available at all reasonable times during the term of this contract any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the production of requested information.

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

The Contractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

The Contractor shall comply with the record keeping requirements delineated in 42 CFR 438.3(u) and retain such records for a period of no less than 10 years.

For retention of patient medical records, the Contractor shall ensure compliance with A.R.S. §12-2297 which provides, in part, that a health care provider shall retain patient medical records according to the following:

1. If the patient is an adult, the provider shall retain the patient medical records for at least six years after the last date the adult patient received medical or health care services from that provider.
2. If the patient is under 18 years of age, the provider shall retain the patient medical records either for at least three years after the child's eighteenth birthday or for at least six years after the last date the child received medical or health care services from that provider, whichever date occurs later.

In addition, the Contractor shall comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If this Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this Contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Contractor for a period of five years after the date of final disposition or resolution thereof.

72. RESERVED

73. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

The Contractor is required to exchange data with AHCCCS relating to the information requirements of this contract and as required to support the data elements to be provided AHCCCS. All data exchanged must be in the formats prescribed by AHCCCS which includes those required/covered by the Health Insurance Portability and Accountability Act (HIPAA). Details for the formats may be found in the HIPAA Transaction Companion Guides & Trading Partner Agreements, the AHCCCS Encounter Manual and in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website.

The information exchanged with AHCCCS shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this contract. If any of these procedures, policies, rules, regulations or statutes are hereinafter changed both parties agree to conform to these changes following notification by AHCCCS.

Electronic Transactions: The Contractor is required to accept and generate all required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission of eligibility verifications, claims, claims status verifications or prior authorization requests; or the receipt of electronic remittance. The Contractor must be able to make claims payments via electronic funds transfer and have the capability to accept electronic claims attachments.

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations and control documents are required. The Contractor must have completed and submitted the EDI Trading Partner Agreement in order to exchange data with AHCCCS.

Each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

Contractor Responsibilities: The Contractor is responsible for any incorrect data, delayed submission or payment (to the Contractor or its subcontractors), and/or penalty applied due to any error, omission, deletion, or incorrect data submitted by the Contractor. Any data that does not meet the standards required by AHCCCS shall not be accepted by AHCCCS.

The Contractor is required to provide attestation that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606] as outlined by AHCCCS.

The Contractor is also responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCS. If any unreported inconsistencies are subsequently discovered, the Contractor shall be responsible for the necessary adjustments to correct its records at its own expense.

Member Data: The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in the AHCCCS prescribed electronic data exchange formats. Upon request, the Contractor shall provide to AHCCCS PCP assignments in an AHCCCS prescribed electronic data exchange format.

Claims Data: This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2903 and 2904 and AHCCCS rules A.A.C. R9-22 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

On a recurring basis (no less than quarterly based on adjudication date), AHCCCS shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services, during the member's enrollment period, from another contractor or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

In addition, the Contractor shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

1. Receive 60% of each claim type (professional, institutional and dental) based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically.
2. Produce and distribute 60% of remittances electronically.
3. Provide 60% of claims payments via EFT.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned after contract award. AHCCCS will work with the Contractor as they evaluate Electronic Data Interchange options.

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, payment or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and outlines adequate testing to be completed before implementation. The Contractor shall notify and provide the system change plan to AHCCCS for review and comment as specified in Attachment F3, Contractor Chart of Deliverables.

Health Insurance Portability and Accountability Act (HIPAA): The Contractor shall comply with the Administrative Simplification requirements 45 CFR Parts 160 and 162 that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulation as well as all subsequent requirements and regulations as published.

Data Security: The Contractor and its subcontractors (delegated agreements with managed care organizations) are required to have a security audit performed by an independent third party on an annual basis. The annual audit report must be submitted to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables.

The audit must include, at a minimum, a review of Contractor compliance with all security requirements as outlined in the AHCCCS Security Rule Compliance Summary Checklist, as specified in ACOM Policy 108. In addition, the audit must include a review of Contractor policies and procedures to verify that appropriate security requirements have been adequately incorporated into the Contractor's business practices, and the production processing systems.

The audit must result in a findings report and as necessary a corrective action plan, detailing all issues and discrepancies between the security requirements and the Contractor's policies, practices and systems. The corrective action plan must also include timelines for corrective actions related to all issues or discrepancies identified. The annual report must include the findings and corrective action plan and must be submitted to AHCCCS for review and approval. AHCCCS will verify that the required audit has been completed and the approved remediation plans are in place and being followed.

Health Information Exchange: The Contractor is required to contract with Health Information Network of Arizona (HINAz) as a data user.

To further the integration of technology based solutions and the meaningful use of electronic health records within the system of care, AHCCCS will increase opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing

business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates accelerating statewide Health Information Exchange (HIE) participation for all Medicaid providers and Contractors by:

- Supporting care coordination between physical and behavioral health providers
- Launching an HIE onboarding program for high volume Medicaid hospitals, Federally Qualified Health Centers, Rural Health Clinics and Look-a-Likes
- Supporting the acceleration of electronic prescribing by Arizona Medicaid providers
- Joining the State level HIE for governance, policy making, and information technology service offerings
- Supporting increased Contractor use of the Network (State HIE) to improve health outcomes
- Identifying value-based purchasing opportunities that link with a providers adoption and use of Health IT

The Contractor is expected to encourage that eligible hospitals and eligible professionals continue to move through the Meaningful Use continuum, accelerate provider statewide HIE participation, and increase use and support of the HIT/HIE. The Contractor is expected to collaborate with AHCCCS and Arizona Health-e Connection and The Network to target efforts to specific areas where HIT and HIE can bring significant change and progress including efforts focused on:

- Behavioral health
- Partnerships for integrated care
- High need/high cost members
- Coordination with the American Indian Health Program
- Coordination with the Qualified Health Plans
- Justice system transitions
- Care coordination
- Pharmacy management
- Quality improvement

74. ENCOUNTER DATA REPORTING

Complete, accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set Fee-For-Service and capitation rates, determine reconciliation amounts, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. The Contractor shall submit encounter data to AHCCCS for all services for which the Contractor incurred financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred, including services provided during prior period coverage. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1)][42 CFR 455.1(a)(2)].

New Contractors must successfully exchange encounter data for all applicable form types with AHCCCS no later than 120 days after the start of the contract or be subject to possible corrective actions up to and including sanctions.

Encounter Submissions: Encounters must be submitted in the format prescribed by AHCCCS. Encounter data must be provided to AHCCCS as outlined in the HIPAA Transaction Companion Guides & Trading Partner Agreements and the AHCCCS Encounter Manual, including, but not limited to, inclusion of data to identify the physician who delivers services to patients per Section 1903(m)(2)(A)(xi) of the Social Security Act.^{xxvii}

Professional, Institutional and Dental Encounters not involving services eligible for Federal Drug Rebate processing should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later.

Covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act; the State shall collect such rebates from manufacturers. (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMD letter 10-006)^{xxviii} To ensure AHCCCS compliance with this requirement, pharmacy related encounter data and other encounters involving services eligible for Federal Drug Rebate processing must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. The Contractor must report information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed (other than covered outpatient drugs that under subsection (j)(1) of Section 1927 of the Social Security Act [42 USCS § 1396r-8] are not subject to the requirements of that section) and such other data as required by AHCCCS (Section 1903(m)(2)(A)(xiii) of the Social Security Act and SMD letter 10-006).^{xxix}

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCS. Upon submission, the Contractor must provide attestation that the services listed were actually rendered.

The Contractor may be assessed sanctions for noncompliance with encounter submission completeness, accuracy and timeliness requirements.

Encounter Reporting: The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions and revisions of encounters. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual or as directed by AHCCCS and as further specified in Attachment F3, Contractor Chart of Deliverables.

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 18 months of approved, voided, plan-denied, pending and AHCCCS-denied encounters received and processed by AHCCCS. These files must be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

Encounter Supporting Data Files: AHCCCS provides the Contractor with periodic (no less than twice monthly) full replacement files containing provider and medical procedure coding information as stored in PMMIS. These files should be used to assist the Contractor to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information regarding the content and layouts of these files.

Encounter Corrections: The Contractor is required to monitor and resolve pending encounters, and encounters denied by AHCCCS

The Contractor is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission as described below. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters, including, approved, pending, denied and voided encounters, impact completeness, accuracy and timeliness rates. Rates below the established standards (pending encounters

that have pended for more than 120 days for example), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

Encounter Validation Studies: Per CMS requirements, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions. These studies may result in sanctions of the Contractor and/or require a corrective action plan for noncompliance with related encounter submission requirements.

The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS Data Validation Technical Document for further information.

AHCCCS may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with CMS. The Contractor will be notified in writing of any significant change in study methodology.

75. PERIODIC REPORTING REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data, and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 80, Sanctions.

Standards applied for determining adequacy of required reports are as follows:

- a. *Timeliness:* Reports or other required data shall be received on or before scheduled due dates.
- b. *Accuracy:* Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
- c. *Completeness:* All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, including but not limited to, report content, report frequency, and report submission, are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specified by AHCCCS, including those pertaining to subcontractor and provider reporting requirements. The Contractor shall be responsible for continued reporting beyond the term of the contract.

76. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information as requested no later than 20 days after the receipt of the request unless otherwise specified in the request itself.

If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed legal analysis to AHCCCS, within the timeframe designated by AHCCCS, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

77. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS, or the Federal government, to its members and all costs shall be the responsibility of the Contractor. All advertisements, publications and printed materials which are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCS.

78. ANNUAL SUBMISSION OF PROVIDER REIMBURSEMENT RATES

In accordance with A.R.S. §36-2959, the Contractor reports annually on the adequacy and appropriateness of reimbursement rates to providers. The Contractor shall submit a draft of the report to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables for AHCCCS to review and approve prior to the Contractor's publication of the report.

79. MONITORING AND OPERATIONAL REVIEWS

The Contractor shall comply with all reporting requirements contained in this Contract and AHCCCS policy. In accordance with CMS requirements, AHCCCS has in effect procedures for monitoring the Contractors' operations to ensure program compliance and identify best practices, including, but not limited to, evaluation of submitted deliverables, ad hoc reporting, and periodic focused and operational reviews.^{xxx}

These monitoring procedures will include, but are not limited to, operations related to the following:^{xxxi}

- a. Member enrollment and disenrollment;
- b. Processing grievances and appeals;
- c. Violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438;
- d. Violations of the conditions for receiving federal financial participation, as set forth in Subpart J of 42 CFR 438; and
- e. All other provisions of the contract, as appropriate. [42 CFR 438.66(a)]

Operational Reviews: In accordance with CMS requirements [42 CFR 434.6(a)(5)] and Arizona Administrative Code, [Title 9, A.A.C. Chapter 28. Article 5], AHCCCS, or an independent agent, will conduct periodic Operational Reviews to ensure program compliance and identify best practices [42 CFR 438.204].

The reviews will identify and make recommendations for areas of improvement, monitor the Contractor's progress towards implementing mandated programs or operational enhancements and provide the Contractor with technical assistance when necessary. The type and duration of the review will be solely at the discretion of AHCCCS.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the scheduled Operational Review. AHCCCS reserves the right to conduct reviews without notice to monitor contractual requirements and performance as needed.

AHCCCS may request, at the expense of the Contractor, to conduct on-site reviews of functions performed at out of State locations and will coordinate travel arrangements and accommodations with the Contractor.

In preparation for the reviews, the Contractor shall cooperate with AHCCCS by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. Should the review be conducted on-site, the Contractor shall provide the Review

Team with appropriate workspace, access to a telephone, electrical outlets, internet access and privacy for conferences.

The Contractor will be furnished a copy of the draft Operational Review report and given the opportunity to comment on any review findings prior to AHCCCS issuing the final report. The Contractor must develop corrective action plans based on these recommendations. The corrective action plans and modifications to the correction action plan must be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational Review to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the Operational Review Tool, draft Operational and Financial Review Report or final report to other AHCCCS Contractors. The Contractor may share the Operational Review Tool with their subcontracted acute care plans.

80. SANCTIONS

In accordance with applicable Federal and State regulations, AHCCCS rules A.A.C. R9-22-606 and A.A.C. R9-28-608, ACOM Policy 408 and the terms of this contract, AHCCCS may impose sanctions for failure to comply with any provision of this contract. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. R9-34-401 et seq.

Cure Notice Process: AHCCCS shall provide a written cure notice to the Contractor regarding the details of the non-compliance. If a notice to cure is provided to the Contractor, the cure notice will specify the period of time during which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCS will not impose a sanction.

AHCCCS may impose sanctions including but not limited to:

1. Civil monetary penalties
2. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and for A.R.S. §§36-2903 and 36-2932.
3. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll [42 CFR 438.702(a)(3); 42 CFR 438.722].
4. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
5. Additional sanctions allowed under statute or regulation that address areas of noncompliance

Refer to ACOM Policy 408 for details.

For Technical Assistance the Contractor shall note the following Technical Assistance Provisions:

1. Recognize AHCCCS' technical assistance to help the Contractor achieve compliance with any relevant contract terms or contract subject matter issues does not relieve the Contractor of its obligation to fully comply with contract requirements or any and all other terms in this Contract.
2. Recognize that the Contractor's acceptance of AHCCCS' offer or provision of technical assistance shall not be utilized as a defense or a mitigating factor in a contract enforcement action in which compliance with contract requirements or any and all other terms is at issue.
3. Recognize that AHCCCS not providing technical assistance to the Contractor as it relates to compliance with a contract requirement or any and all other terms, shall not be utilized as a defense or a mitigating

factor in a contract enforcement action in which compliance with contract requirements or any and all other terms is at issue.

4. Should a subcontractor to the Contractor participate in the technical assistance matter, in full or in part, the subcontractor participation does not relieve the Contractor of its contractual duties nor modify the Contractor contractual obligations.

81. MEDICAID SCHOOL BASED CLAIMING PROGRAM

Pursuant to an Intergovernmental Agreement with the Department of Education, and a contract with a Third Party Administrator, AHCCCS reimburses participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the member's Individual Education Plan (IEP) as medically necessary for the child to obtain a public school education. See AMPM Chapter 700.

Medicaid School Based (MSB) services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSB approved alternative setting. Currently, services include audiology, therapies (OT, PT and speech/language); behavioral health evaluation and counseling; nursing and attendant care (health aid services provided in the classroom) and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSB service and behavioral health services.

The Contractor's evaluations and determinations of medical necessity shall be made independent of the fact that the child is receiving MSB services. If a request is made for services that also are covered under the MSB program for a child enrolled with the Contractor, the request shall be evaluated on the same basis as any request for a covered service.

The Contractor and its providers must coordinate with schools and school districts that provide MSBC services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with special needs children, should coordinate with the appropriate school staff working with these members. Transfer of member medical information and progress toward treatment goals between the Contractor and the member's school or school district is required as appropriate and should be used to enhance the services provided to members.

82. PENDING ISSUES

The following constitute pending items that may be resolved after the issuance of this Contract or any Contract amendment. Any program changes due to the resolution of the issues will be reflected in future amendments to the Contract. Capitation rates may also be adjusted to reflect the financial impact of program changes. The items in this paragraph are subject to change and should not be considered all-inclusive.

AHCCCS and the Contractor are subject to legislative mandates, directives, regulatory changes, executive and court orders related to any term in this Contract that may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

Managed Care Regulations: On May 6, 2016 the Centers for Medicare & Medicaid Services (CMS) published final rules focused on advancing delivery system reform, strengthening quality and consumer protections, promoting accountability, and aligning Medicaid managed care rules with other health insurance coverage programs. The provisions of the rule will be implemented in phases throughout years 2016, 2017, and 2018.

The final rule provisions include significant operational changes to numerous areas of the Medicaid Program, including but not limited to the following:

1. Requirements for Long Term Services and Supports

2. Network development standards
3. Grievance and Appeal System
4. Enrollee rights
5. Member information
6. Quality improvement
7. Capitation rate development
8. Limitations on capitation payments for services provided to persons age 21-64 receiving services in an Institution for Mental Disease (IMD)

Mental Health Parity and Addiction Equity Act: On March 30, 2016 final rules were published providing that financial and treatment limitations on mental health and substance use disorder benefits may be no more restrictive and applied no more stringently than to medical/surgical benefits. On or before October 1, 2017, the Contractor shall demonstrate that services are delivered in compliance with mental health parity consistent with 42 CFR 438.900 et seq. Future information will be provided regarding deliverables and timelines to ensure compliance.

Section 1115 Waiver Demonstration: As of the writing of this Contract, the Section 1115 Waiver Demonstration for the period October 1, 2016 through September 30, 2021, is not yet approved by CMS. Therefore the Waiver approval may necessitate changes to the terms of this Contract which will be executed through a Contract amendment.

Home and Community Based Services Settings Rules: On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released final rules regarding requirements for home and community based services (HCBS) operated under section 1915 of the Social Security Act. The rules mandate certain requirements for alternative residential or community settings where Medicaid beneficiaries receive long term care services and supports. CMS states “The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living.”

While AHCCCS’ ALTCS program is operated under Section 1115 of the Act, CMS is requiring compliance with those regulations for all long term care home and community based settings. To that end, AHCCCS has established a plan for meeting those standards on a timeline consistent with its 1115 Waiver submission (effective October 2016). All HCBS residential and non-residential settings must come into compliance by the end of a five-year transition period (September 2021) with the HCBS Rules. These requirements impact ALTCS E/PD members receiving services in the following residential and non-residential settings:

Residential

- Assisted Living Facilities
- Behavioral Health Residential Facilities

Non-Residential

- Adult Day Health Programs
- Group-Supported Employment Programs

AHCCCS submitted the Arizona Systemic Assessment and Transition Plan to CMS for approval on September 30, 2015. AHCCCS will have five years to come into compliance with the rules under the Transition Plan. During the five-year transition period, AHCCCS will work with a variety of multi-stakeholder workgroups to implement the Plan. Additionally, AHCCCS will host focus groups at the onset of each transition plan year to receive input about progress made the previous year and provide input regarding planned actions for the upcoming year.

The Contractor is required to participate in the multi-stakeholder workgroups for each of the residential and non-residential setting types noted above and provide input on each phase of the five-year transition plan

including orientation of members, providers and case managers; policy and contract revisions and compliance monitoring tools and processes. Furthermore, Contractors will be primarily responsible for the following:

- Disseminating member and family member educational materials
- Executing provider and case manager training
- Monitoring site-specific settings for compliance
- Reporting site-specific setting compliance to AHCCCS

Visit the AHCCCS website for more detailed information on Arizona's Systemic Assessment and Transition Plan to comply with the HCBS Rules.

The five-year transition plan timeline and milestones are subject to change upon CMS approval.

Person-Centered Planning: In collaboration with members, families, providers and Contractors, AHCCCS will be creating uniform person centered planning policies, forms and practices for all ALTCS members. The new standards will support the successful implementation and monitoring of the State's compliance with the HCBS Rules on an individual member level. The development of the standards is currently underway and estimated to be completed by February 2019.

The Contractor will be required to participate in a multi-stakeholder workgroup to provide input on revisions to policies, forms and practices and competency-based training for case managers. Upon completion of the Person-Centered Planning project, the Contractor will be required to replicate the competency-based training for new case managers.

Section 1557 of the Affordable Care Act: Pursuant to 45 CFR Part 92, the Contractor is prohibited from discrimination on the basis of race, color, national origin, sex, age, or disability in health programs and activities, any part of which receives federal funding. Under the proposed rule, sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, sex stereotyping, and gender identity. AHCCCS is reviewing existing policies and system edits to implement necessary changes to conform to the law. The Contractor shall be required to adopt any such changes.

Administrative Simplification: Arizona Laws 2015, Chapter 19, Section 9 (SB 1480) enacts that from and after June 30, 2016, the provision of behavioral health services under the Division of Behavioral Health Services (DBHS) in the Department of Health Services is transferred to and shall be administered by the Arizona Health Care Cost Containment System (AHCCCS). From and after June 30, 2016, the AHCCCS administration succeeds to the authority, powers, duties and responsibilities of DBHS with the exception of the Arizona State Hospital. This act does not alter the effect of any actions or impair the valid obligations of DBHS taken before July 1, 2016. Administrative rules and orders that were adopted by DBHS continue in effect until superseded by administrative action by AHCCCS. Until administrative action is taken by AHCCCS, any reference to DBHS in rules and orders is considered to refer to AHCCCS. All administrative matters, contracts and judicial and quasi-judicial actions, whether completed, pending or in process, of DBHS on July 1, 2016 are transferred to and retain the same status with AHCCCS. AHCCCS and DBHS will work to administratively streamline contractual oversight and monitoring of the Tribal and Regional Behavioral Health Authorities (T/RBHAs) throughout Arizona, pursue continuous quality improvement, and reduce fragmentation in healthcare delivery to develop an integrated system of healthcare. This merger will not impact what services are offered to members or how services are delivered.

83. BUSINESS CONTINUITY AND RECOVERY PLAN

The Contractor shall develop a Business Continuity and Recovery Plan, as detailed in ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. All staff shall be trained on, and be familiar with, the Plan. This Plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at the Contractor's main place of ALTCS business
- Complete loss of use of the main site and satellite offices out of state
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCS in the event of a business disruption
- Periodic testing (at least annually)

The Business Continuity and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to AHCCCS as specified in Attachment F3, Contractor Chart of Deliverables.

The Contractor shall ensure its subcontracted acute care health plans prepare adequate business continuity and recovery plans and that the subcontractors review their plans annually, updating them as needed. The subcontractor plans shall, at a minimum, address the areas listed above as they apply to the subcontractors.

84. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers. Each member is entitled to one copy of his or her medical record at no cost annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

The Contractor is responsible for ensuring that a medical record (hard copy or electronic) is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

The Contractor shall have written policies and procedures for the maintenance of medical records to ensure those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment.

The Contractor shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with the AMPM.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other organization or agency. The Contractor may obtain a copy of a member's medical records without written approval of the member, if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request or more quickly if necessary.

Information related to fraud and abuse may be released, however, HIV-related information shall not be disclosed except as provided in A.R.S. §36-664, and substance abuse information shall only be disclosed consistent with Federal and State law, including but not limited to 42 CFR 2.1 et seq.

85. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to members' demographic, eligibility and enrollment data as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily

enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction update, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction, as outlined in the HIPAA Transaction Companion Guides, and Trading Partner Agreements, will be produced to provide contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as outlined in the AHCCCS Technical Interface Guidelines, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

86. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its *Quality Assessment and Performance Improvement Strategy* certain populations with special health care needs as defined by the State [42 CFR 438.208(c)(1)].^{xxxii}

Members with special health care needs are those members who have serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally. A member will be considered as having special health care needs if the medical condition simultaneously meets the following criteria:^{xxxiii}

- a. Lasts or is expected to last one year or longer, and
- b. Requires ongoing care not generally provided by a primary care provider.

AHCCCS has determined that the following populations meet this definition:^{xxxiv}

- a. Members who are recipients of services provided through the Children's Rehabilitative Services (CRS) program
- b. Members who are recipients of services provided through the contracted Regional Behavioral Health Authorities (RBHAs), and
- c. Members diagnosed with HIV/AIDS
- d. Arizona Long Term Care System:
 - Members enrolled in the ALTCS program who are elderly and/or have a physical disability, and

- Members enrolled in the ALTCS program who have a developmental disability.

AHCCCS monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational and Financial Reviews of Contractors and the review of required Contractor deliverables set forth in contract, program specific performance measures, and performance improvement projects.^{xxxv}

The Contractor shall have in place mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring, or transition to another AHCCCS program [42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals [42 CFR 438.240(c)(2)] [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to the member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3) and (c)(3)]. Members enrolled in the ALTCS Program who are elderly or have a physical disability or have a developmental disability are automatically identified as having special health care needs.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 208(c)(4)].

The Contractor shall have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these providers.

The American Academy of Pediatrics (AAP) describes care from a medical home as:

- Accessible
- Continuous
- Coordinated
- Family-centered
- Comprehensive
- Compassionate
- Culturally effective

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

87. VALUE-BASED PURCHASING

Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value based health care systems where members' experience and population health are improved, per-capita health care cost is limited to the rate of general inflation through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. The Contractor shall participate in payment VBP efforts.

Value-Based Purchasing Initiative: The purpose of a VBP initiative is to encourage Contractor activity in the area of quality improvement by aligning the incentives of the Contractor and provider through VBP strategies. For CYE 16 the Contractor shall implement a VBP initiative focused on decreasing quality of care concerns related to transportation services. Also during CYE 16, the Contractor shall continue development of its strategy regarding value-based purchasing for long term care services for employment for CYE 17 implementation.

Centers of Excellence: Centers of Excellence are facilities that are recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Identification of a Center of Excellence should be based on criteria such as procedure volumes, clinical outcomes, and treatment planning and coordination. Identification of appropriate conditions and/or procedures most suitable to a relationship with a Center of Excellence should be based on analysis of the Contactor's data which demonstrates a high degree of variance in cost and/or outcomes. To encourage Contractor activity which incentivizes utilization of the best value providers for select, evidenced based, high volume procedures or conditions, the Contractor shall submit a Centers of Excellence Report annually to AHCCCS, DHCM, as specified in Attachment F3, Contractor Chart of Deliverables. The report shall incorporate the CYE 17 implementation of one to two contracts with either the Centers of Excellence identified in the CYE 16 Executive Summary and/or other existing Centers of Excellence based on the criteria above. The Contractor shall identify the Centers of Excellence under contract in CYE 17 and, if different from those identified in the CYE 16 Executive Summary, shall include a description as to how these Centers were selected.

Centers of Excellence Report

The Centers of Excellence Report shall outline the Contractor's process to develop, maintain and monitor activities for Centers of Excellence and include at a minimum:

- Thorough description of the Contractor's initiatives to encourage member utilization
- Goals and outcome measures for the contract year
- Description of monitoring activities to occur throughout the year
- Evaluation of the effectiveness of the previous year's initiatives
- Summary of lessons learned and any implemented changes
- Description of the most significant barriers
- Plan for next contract year

E-Prescribing: E-Prescribing is an effective tool to improve members' health outcomes and reduce costs as delineated in ACOM Policy 321. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to: reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, and increased prescription accuracy. The Contractor shall increase its E-Prescribing rate of original prescriptions in accordance with ACOM Policy 321.

The NCPDP Prescription Origin Code and Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

VBP Differential Adjusted Payments: AHCCCS has introduced multiple VBP Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The Contractor shall adjust payments for specific providers and provider types as described below:

Nursing Facility: For CYE17, for qualified AHCCCS-registered Arizona Nursing Facility providers meeting criteria as set forth below, the Contractor is required to pass through an additional 1.0% increase in payments above the rates that the Contractor would otherwise pay, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria: Nursing Facilities that meet or exceed the Medicare Nursing Home Compare Arizona Average for the pneumococcal vaccine measure qualify for the VBP Differential Adjusted Payment increase.

- The pneumococcal vaccine measure is the percent of long-stay residents assessed and appropriately given the vaccine

- The facility's results on Medicare Nursing Home Compare for this quality measure will be compared to the accompanying Arizona Average results for the measure, for the most recently published rate as of June 1, 2016

Hospital: For CYE17, for both inpatient and outpatient services for qualified AHCCCS-registered Arizona Hospital providers (provider type 02) meeting criteria as set forth below, the Contractor is required to pass through an additional 0.5% increase in payments above the rates that the Contractor would otherwise pay, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

- The hospital must participate in the Network, the state's health information exchange, by June 1, 2016 as described in A.A.C. R9-22-712.71, and
- The hospital must have achieved Meaningful Use Stage 2 for Program Year 2015 as described in A.A.C. R9-22-712.71

Integrated Clinic: For CYE17, for qualified AHCCCS-registered Integrated Clinics (ICs) meeting criteria as set forth below, the Contractor is required to pass through an additional 10% increase in payments above the rates that the Contractor would otherwise pay for select physical health services, inclusive of any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified provider.

Criteria:

- Providers registered with AHCCCS as Integrated Clinics and licensed by the Arizona Department of Health Services as Outpatient Treatment Center which provide both behavioral health services and physical health services
 - The provider qualifies at any time during CYE17 for those dates of service in CYE17 that coincide with the provider's registration as an IC
- Physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code

[END OF SECTION D]

SECTION E. CONTRACT TERMS AND CONDITIONS**1. ADVERTISING AND PROMOTION OF CONTRACT**

The Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

2. APPLICABLE LAW

Arizona Law - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

3. ARBITRATION

The parties to this contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. §12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this contract. Delegation of less than all of the duties of this contract must conform to the requirements of Section D, Subcontracts.

5. RESERVED**6. AUDITS AND INSPECTIONS**

The Contractor shall comply with all provisions specified in applicable A.R.S. §35-214 and §35-215 and AHCCCS rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

7. AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this contract based on those changes.

8. CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Disputes, and be administered accordingly.

Contract amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS), and approval is withheld until all amendments are signed by the Contractor. When AHCCCS issues an amendment to modify the contract, the Contractor shall ensure contract amendments are signed and submitted to AHCCCS by the date specified by AHCCCS. The provisions of such amendment will be deemed to have been accepted on the day following the date AHCCCS requires an executed amendment, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

9. CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to, 42 CFR 431, Subpart F, A.R.S. §36-107, §36-2903 (for Acute), §36-2932 (for ALTCS), §41-1959 and §46-135, the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936), 45 CFR parts 160 and 164, and AHCCCS Rules.

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

The Contractor shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

12. CONFLICT OF INTEREST

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Contractor shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

14. CONTRACT

The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the contract until funds have been encumbered.

15. CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State and signed by a duly authorized representative of the Contractor.

16. COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by AHCCCS employees.

17. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor's Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO [42 CFR 438.604 et seq.].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by 9 A.A.C. Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and A.R.S. §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S §41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

21. EFFECTIVE DATE

The effective date of this contract shall be the Offer and Acceptance date referenced on page 1 of this contract.

22. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Contractor shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

23. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

24. INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

25. RESERVED

26. RESERVED

27. RESERVED

28. IRS W9 FORM

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W9 Form on file with the State of Arizona.

29. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in Federal and State Law and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the system.

30. LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

31. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

32. NON-DISCRIMINATION

In accordance with A.R.S. §41-1461 et seq. and Executive Order 2009-09, the Contractor shall provide equal employment opportunities for all persons, regardless of race, color, religion, creed, sex, age, national origin, disability or political affiliation. The Contractor shall comply with the Americans with Disabilities Act.

33. NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCS under this contract are not exclusive.

34. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this paragraph does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

35. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State Rules; the terms of this contract which consists of the RFP, the proposal of the successful Offeror, and any Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

36. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this contract, as otherwise allowed under this contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74.

37. RESERVED**38. RELATIONSHIP OF PARTIES**

The Contractor under this contract is an independent Contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

39. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any sums due the Contractor any expenses or costs incurred by AHCCCS or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract, including but not limited to expenses, costs and damages.

40. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or is unable to continue to perform this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

41. RESERVED**42. SEVERABILITY**

The provisions of this contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the contract.

43. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610(a)(b)] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

44. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR 438.700 et seq. and State Law A.R.S. §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Pursuant to 42 CFR 438.706, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

45. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this contract shall be one year, with annual options to extend. The contract cycle is July 1 through June 30 with an annual July 1 renewal. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment [42 CFR 438.610(c)(3)], and shall be at the sole option of AHCCCS.

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 30 days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. Failure of an existing Contractor to accept an amendment (or renew) may result in immediate suspension/termination of member assignment. If the Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

46. TERMINATION

AHCCCS reserves the right to terminate this contract in whole or in part by reason of force majeure, due to the failure of the Contractor to comply with any term or condition of the contract, including, but not limited to, circumstances which present risk to member health or safety, and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. The term force majeure means an occurrence that is beyond the control of AHCCCS and occurs without its fault or negligence. Force majeure includes acts of God and other similar occurrences beyond the control of AHCCCS which it is unable to prevent by exercising reasonable diligence. .

If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS immediately on demand.

AHCCCS may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

47. TERMINATION - AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

48. TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any

other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R.S. §38-511.

49. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS immediately upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

50. THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

51. TYPE OF CONTRACT

Fixed-Price, stated as capitated per member per month, except as otherwise provided.

52. WARRANTY OF SERVICES

The Contractor warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

[END OF SECTION E]

SECTION F. ATTACHMENTS

ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

Contract/RFP No. YH6-0014

SECTION F. ATTACHMENTS

ATTACHMENT F1: ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

The Contractor shall have a written policy delineating its Grievance and Appeal System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall also furnish this information to enrollees within 12 days after the Contractor receives notice of the enrollment and annually thereafter. The Contractor shall also provide this information to all providers and subcontractors at the time of contract. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to enrollees describing the Grievance and Appeal System including the grievance process, the appeal process, enrollee rights, Grievance and Appeal System requirements and timeframes, shall be in each prevalent non-English language occurring within the Contractor's service area and in an easily understood language and format.

Written documents, including but not limited to, the Notice of Action, the Notice of Extension of Notice of Action, the Notice of Appeal Resolution and Notice of Extension for Resolution, shall contain information in the prevalent non-English language(s), prominently displayed in large bold print on the first page of the document. The information shall advise the enrollee that the written documents are available in the prevalent non-English language(s) and in alternative formats along with an explanation of how enrollees may obtain this written information in the prevalent non-English language(s) and alternative formats. However, if prior to issuing a document in English, the Contractor receives information orally or in writing that the enrollee has a limited English proficiency in a prevalent non-English language, the Contractor shall translate the document in the applicable prevalent non-English language before providing it to the enrollee.

The Contractor shall also inform enrollees that oral interpretation services are available in any language, and alternative communication formats are available for enrollees who have hearing or vision impairment.

For additional information regarding the enrollee Notice of Action process, the Contractor should refer to ACOM Policy 414 and 42 CFR Part 438. **Failure to comply with any of these provisions may result in an imposition of sanctions.**

At a minimum, the Contractor's Grievance and Appeal System Standards and Policy shall specify:

1. That Contractor shall maintain records of all grievances and appeals and requests for hearings.
2. That the Contractor has a mechanism for tracking receipt, acknowledgement, investigation and resolution of grievances, appeals and requests for hearing within the required timeframes.
3. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to a hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal and requests for hearings.
4. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone.

SECTION F. ATTACHMENTS

ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

Contract/RFP No. YH6-0014

5. That the Contractor shall acknowledge receipt of each grievance and appeal. For grievances, the Contractor is not required to acknowledge receipt of the Grievance in writing, however, if the enrollee requests written acknowledgement, the acknowledgement must be made within five business days of receipt of the request. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.
6. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.
7. The definition of action [42 CFR 438.400(b)] and that an enrollee, or their designated representative, may file an appeal of an action taken by the Contractor. Actions include:
 - a. Denial or limited authorization of a requested service, including the type or level of service;
 - b. Reduction, suspension, or termination of a previously authorized service;
 - c. Denial, in whole or in part, of payment for a service;
 - d. Failure to provide services in a timely manner, as defined by the State;
 - e. Failure to act within the timeframes provided in 42 CFR 438.408(b) required for standard and expedited resolution of appeals and standard disposition of grievances; or
 - f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.
8. The definition of appeal as the request for review of an action, as defined above [42 CFR 438.400(b)].
9. That the Contractor shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the enrollee's condition or disease.
10. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions. There are no time limits for filing an enrollee grievance.
11. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with the AHCCCS.
12. That the Contractor shall not delegate the Grievance and Appeal System requirements to its providers.
13. That the Contractor shall address identified issues as expeditiously as the person's condition requires and must resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on enrollee grievances cannot be appealed.
14. That the Contractor responds in writing, if an enrollee requests a written explanation of the resolution, and the response must be mailed within 10 business days of resolution of the grievance.
15. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.
16. Information explaining that a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.

SECTION F. ATTACHMENTS

ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

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17. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.
18. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.
19. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.
20. That the Contractor extends the timeframe for resolution of an appeal when not requested by the enrollee, the Contractor shall provide the enrollee with written notice of the reason for the delay.
21. The definition of a service authorization request as an enrollee's request for the provision of a service [42 CFR 431.201].
22. The definition of a standard authorization request For standard authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's best interest [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.
23. The definition of an expedited authorization request. For expedited authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 3 business days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest [42 CFR 438.210(d)(2)].
24. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the Contractor must give the enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
25. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider must be written.
26. That the Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least five days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action

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ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

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provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:

- a. The Contractor receives notification of the death of an enrollee
 - b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information)
 - c. The enrollee is admitted to an institution where he is ineligible for further services
 - d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address
 - e. The enrollee has been accepted for Medicaid in another local jurisdiction
27. That the Notice of Action must explain: 1) the action the Contractor has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.
28. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
29. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
30. That if the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. The Contractor must make reasonable efforts to give the enrollee prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.
31. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or b) the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service, 3) the services were ordered by an authorized provider and 4) the enrollee requests a continuation of benefits.

SECTION F. ATTACHMENTS

ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

Contract/RFP No. YH6-0014

For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction, or suspension which has been appealed.

32. That the Contractor continues extended benefits originally provided to the enrollee until any of the following occurs: 1) the enrollee withdraws the appeal, 2) the enrollee has not specifically requested continued benefits pending a hearing decision within 10 days of the Contractor mailing of the appeal resolution notice, or 3) AHCCCS issues a state fair hearing decision adverse to the enrollee.
33. That for appeals, the Contractor provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that the Contractor informs the enrollee of the limited time available in cases involving expedited resolution.
34. That for appeals, the Contractor provides the enrollee and his representative the opportunity before and during the appeals process to examine the enrollee's case file including medical records and other documents considered during the appeals process.
35. The Contractor shall provide written Notice of Appeal Resolution to the enrollee and the enrollee's representative or the representative of the deceased enrollee's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of enrollees: a) the enrollee's right to request a State fair hearing (including the requirement that the enrollee must file the request for a hearing in writing) no later than 30 days after the date the enrollee receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds the Contractor.
36. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:
 - a. Enrollee's name
 - b. Enrollee's AHCCCS I.D. number
 - c. Enrollee's address
 - d. Enrollee's phone number (if applicable)
 - e. Date of receipt of the appeal
 - f. Summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution
37. The following material shall be included in the file sent by the Contractor:
 - a. The Enrollee's written request for hearing
 - b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records
 - c. The Contractor's Notice of Appeal Resolution
 - d. Other information relevant to the resolution of the appeal
38. That if the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

SECTION F. ATTACHMENTS

ATTACHMENT F1

ENROLLEE GRIEVANCE AND APPEAL SYSTEM STANDARDS

Contract/RFP No. YH6-0014

39. That if the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation.

40. That if the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor or Director's Decision and applicable statutes, Rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for un-timeliness if they are submitted within the 90 day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

41. That if the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor may recover the cost of those services from the enrollee.

42. That the Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement.

[END OF ATTACHMENT F1]

SECTION F. ATTACHMENTS

ATTACHMENT F2

PROVIDER CLAIM DISPUTE STANDARDS

Contract/RFP No. YH6-0014

ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

The Contractor shall have in place a written claims dispute system policy for its subcontractors and non-contracted providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. **Failure to comply with any of these provisions may result in the imposition of sanctions.**

The claims dispute policy shall include the following provisions:

1. That the Provider Claim Dispute Policy shall stipulate that all claim disputes must be adjudicated in Arizona, including those claim disputes arising from claims processed by an Administrative Services Subcontractor.
2. The Provider Claims Dispute System Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claims dispute policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
3. The Provider Claims Dispute System Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.
4. That the Provider Claim Dispute Policy must specify a physical local address in Arizona for the submission of all provider claim disputes and hearing requests.
5. That specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.
6. That the Contractor shall develop and maintain a tracking log for all claims disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claims dispute, resolution of the claim dispute, and the date of resolution.
7. That claim disputes are acknowledged in writing and within five business days of receipt.
8. Claim disputes are thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
9. All documentation received by the Contractor during the claim dispute process is dated upon receipt.
10. All claim disputes are filed in a secure, designated area and are retained for five years following the Contractor's decision, the AHCCCS decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.
11. A copy of the Contractor's Notice of Decision "Decision" shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and the Contractor agree to a longer period. The Decision must include and describe in detail, the following:
 - a. The nature of the claim dispute.
 - b. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member name, pertinent dates of service, dates and specific reasons for the Contractor denial / payment of the claim, and whether or not the provider is a contracted provider.

SECTION F. ATTACHMENTS

ATTACHMENT F2

PROVIDER CLAIM DISPUTE STANDARDS

Contract/RFP No. YH6-0014

- c. The reasons supporting the Contractor's Decision, including an explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.
 - d. The provider's right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Contractor's decision.
 - e. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.
10. If the provider files a written request for hearing, the Contractor must ensure that all supporting documentation is received by the DES, Division of Services and Support, Appellate Services Administration (DES/DSS/ASA), no later than five business days from the date the Contractor receives the provider's written hearing request. The file sent by the Contractor must contain a cover letter that includes:
- a. The provider's name
 - b. The provider's address
 - c. The member's name and AHCCCS Identification Number
 - d. The provider's phone number (if applicable)
 - e. The date that the claim dispute was received by the Contractor
 - f. A summary of the actions undertaken by the Contractor to resolve the claim dispute and basis for the determination

If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor must review the matter to determine why the request for hearing was filed and resolve the matter when appropriate.

11. The following material shall be included in the file sent by the Contractor:
- a. Written request for hearing filed by the provider
 - b. Copies of the entire file which includes pertinent records; and the Decision
 - c. Other information relevant to the Decision
12. If the Contractor's Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claims(s) in a manner consistent with the Decision along with any applicable interest within 15 business days of the date of the Decision.

If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

[END OF ATTACHMENT F2]

ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor’s responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM on the next business day.

If the Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DBF TPL UNIT	Ad Hoc	Third Party Liability Reporting - Involving Commercial Insurance Payor Sources: TPL Leads File or Via the TPL Referral Web Portal	Within 10 days of discovery	Section D	Paragraph 58	AHCCCS Technical Interface Guidelines	AHCCCS ISD or the AHCCCS TPL Contractor (HMS)	AHCCCS SFTP or the TPL Referral Web Portal: https://ecenter.hmsy.com/

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DBF TPL UNIT	Ad Hoc	Third Party Liability Reporting - Other Third Party Liability Recoveries: For Determination of a Mass Tort, Total Plan Case, or Joint Case	Within 10 days of discovery	Section D	Paragraph 63	AHCCCS Technical Interface Guidelines	AHCCCS TPL Contractor	Email, Fax, or mail submission
DBF TPL UNIT	Ad Hoc	Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)	20 th day of the month	Section D	Paragraph 63	ACOM Policy 434	AHCCCS TPL Management Analyst	Email, Fax, or mail submission

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DBF TPL UNIT	Ad Hoc	Total Plan Case Settlement Reporting via the Settlement Notification Form (When reporting, Contractors must use the monthly file or the ad hoc form)	Within 10 business days from the settlement date	Section D	Paragraph 63	ACOM Policy 434 Attachment A	AHCCCS TPL Management Analyst	Email, Fax, or mail submission
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Actions Reported to the NPDB or a Regulatory Board	Within one business day	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Adverse Action Reporting (Including Limitations and Terminations)	Within one business day	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Advise of Significant Incidents/Accidents Including Abuse, Neglect and Unexpected Death	Within 1 day of awareness	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Requests	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Communication of Adverse Action to Provider	Within one business day	Section D	Paragraph 23	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Credentialing and Re-credentialing Denials	Within 1 business day	Section D	Paragraph 70	AMPM 950	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	HCAC and OPPC	Upon identification by Contractor	Section D	Paragraph 20; Paragraph 21	AMPM Chapter 900; AMPM Chapter 1000	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Immunization Audit	As requested by AHCCCS	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Performance Improvement Project Reports – Baseline, Interim, Final, and Updates as Requested	Refer to AMPM	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Physician Incentives: Contractor-Selected and/or Developed Pay for Performance Initiatives	Prior Approval Required	Section D	Paragraph 39	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Physician Incentives: Contractual Arrangements with Substantial Financial Risk	45 days prior to implementation of the contract	Section D	Paragraph 39	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Ad Hoc	Stillbirth Supplement Request	Immediately following procedure	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Dental Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	EPSDT Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Maternity Care Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Baseline	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Performance Improvement Project Re-Measurement	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Annually	Quality Assessment/Performance Improvement Plan and Evaluation	December 15th	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Monthly Pregnancy Termination	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Monthly	Sterilization Reporting	30 days after the end of the month	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server, password protected with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Credentialing Quarterly Report	45 days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	EPSDT Improvement and Adult Quarterly Monitoring Report	30days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	Key Staff: Staff Primary and Back-Up Contact Information for Urgent Issue Resolution	30 days after the end of each quarter	Section D	Paragraph 25	N/A	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Quarterly	QM Quarterly Report	60 Days after the end of each quarter	Section D	Paragraph 20	AMPM Chapter 900	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM CLINICAL QUALITY MANAGEMENT	Semi-Annually	Semi-Annual Report of Number of Pregnant Women who are HIV/AIDS Positive	30 days after the reporting periods of: [10/1 through 3/31] & [4/1 through 9/30]	Section D	Paragraph 10	AMPM Chapter 400	DHCM Clinical Quality Management Unit	FTP server with email notification to CQM Manager
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Corporate Compliance: CMS Compliance Issues Related to HIPAA Transaction and Code Set Complaints or Sanction	Immediately upon discovery	Section D	Paragraph 70	N/A	DHCM Encounter Administrator	Email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Ad Hoc	Medical Records or Supporting Documentation	As specified in the requesting letter	Section D	Paragraph 74	AHCCCS Data Validation Technical Document	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Annually	AHCCCS Security Rule Compliance Report	June 1 st	Section D	Paragraph 73	ACOM Policy 108	DHCM Data Analysis and Research Manager	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Monthly	Corrected Pended Encounter Data	Monthly, according to established schedule	Section D	Paragraph 74	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Monthly	New Day Encounter	Monthly, according to established schedule	Section D	Paragraph 74	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Encounter Submission and Tracking	45 days after the end of each quarter	Section D	Paragraph 74	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Overrides	45 days after the end of each quarter	Section D	Paragraph 74	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM DATA ANALYSIS AND RESEARCH	Quarterly	Plan Voids	45 days after the end of each quarter	Section D	Paragraph 74	AHCCCS Encounter Manual	DHCM Encounter Administrator	FTP server
DHCM FINANCE	Ad Hoc	Equity Distributions	Submit for approval prior to effective date	Section D	Paragraph 50	N/A	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Corporate Cost Allocation Plans and Adjustment in Management Fees	Prior approval required	Section D	Paragraph 49	N/A	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Ad Hoc	Health Insurer Fee: No fee due (if Annual Reporting Does Not Apply) Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 56	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Ad Hoc	Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Automatic Clearing House (ACH) Vendor Authorization Form	45 days prior to the effective date and commencement of operations	Section D	Paragraph 54	ACOM Policy 317	DHCM Financial Consultant	FTP server with email notification
DHCM FINANCE	Ad Hoc	Submission of Budget for Targeted Case Management	Upon request	Section D	Attachment F4, Targeted Case Management	N/A	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Draft Audit	120 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Reconciliation to Final Audit	150 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Annual Related Party Transaction Statement	150 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Annual Submission of Budget	August 10th	Section D	Paragraph 57	N/A	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Draft Annual Financial Reporting Package	120 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Health Insurer Fee: Federal and State Income Tax Filings Suspended for 04/30/2018	April 30 th of the year following the fee year	Section D	Paragraph 56	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Health Insurer Fee: Liability Reporting Template Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 56	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Annually	Health Insurer Fee: Report of Health Insurance Provider Information (IRS Form 8963) Suspended for 09/30/2017	September 30 th of each fee year	Section D	Paragraph 56	ACOM Policy 320	DHCM Finance Manager	FTP server with email notification
DHCM FINANCE	Annually	Final Annual Financial Reporting Package	150 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Final Management Letter	150 days after year end	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Annually	Summary of Contract Rates for Long Term Care and Home and Community Based Services	December 1st	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Cost Avoidance/Recovery Report	Due 45 days after the reporting quarter. (Oct - Dec: Due Feb 14; Jan - March: Due May 15; Apr - June: Due August 14; July - Sept: Due November 14)	Section D	Paragraph 63	AHCCCS Program Integrity Reporting Guide	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	FQHC Member Information	60 days after the end of each quarter	Section D	Paragraph 42	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Premium Tax Reporting	March 15th, June 15th, September 15th, December 15th	Section D	Paragraph 75	ACOM Policy 304	DHCM Finance Program Monitor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM FINANCE	Quarterly	Quarterly Financial Reporting Package: Copy of Acute Care Subcontractor's Financial Reporting Package	60 days after the end of each quarter	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Quarterly Financial Reporting Package: DES/DDD	60 days after the end of each quarter	Section D	Paragraph 52	AHCCCS Financial Reporting Guide For ALTCS Program Contractors	DHCM Program Compliance Auditor	FTP server with email notification
DHCM FINANCE	Quarterly	Verification of Receipt of Paid Services	Due the 15th day after the end of the quarter that follows the reporting quarter. (Oct. – Dec: Due April 15; Jan. – March: Due July 15; April – June: Due Oct. 15; July – Sept: Due Jan. 15)	Section D	Paragraph 66	ACOM Policy 424	DHCM Program Compliance Auditor	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM MEDICAL MANAGEMENT	Annually	Case Management Plan	December 15th	Section D	Paragraph 16	AMPM Chapter 1600	DHCM Case Management	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	HIV Specialty Provider List	December 15th	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	MM Plan, Evaluation and Work Plan	December 15th	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	Non-Transplant and Catastrophic Reinsurance	By October 30 of each contract year and when newly enrolled in the plan or newly diagnose	Section D	Paragraph 58	AMPM Chapter 1000; AHCCCS Reinsurance Policy Manual	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Annually	Targeted Case Management Plan	December 15	Attachment F4	Paragraph 1	AMPM Chapter 1600	DHCM Case Management	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Quarterly Inpatient Hospital Showings	15 days after the end of each quarter	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Quarterly	Transplant Log	15 days after the end of each quarter	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM MEDICAL MANAGEMENT	Semi-Annually	High Need/High Cost Coordination Summary	January 15 and July 15	Section D	Paragraph 21	AMPM Chapter 1000	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Semi-Annually	Emergency Department Diversion Summary	October 15 and April 15	Section D	Paragraph 21	AMPM Chapter 1020	DHCM Medical Management Unit	FTP server with email notification
DHCM MEDICAL MANAGEMENT	Semi-Annually	Pharmacy and/or Prescriber - Member Assignment Report	April 15 and October 15	Section D	Paragraph 21	AMPM 310-FF	DHCM Medical Management Unit	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontractor Non-Compliance Reporting	Within 30 days of discovery	Section D	Paragraph 33	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontracts	60 days prior to the beginning date of the subcontract	Section D	Paragraph 33	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Administrative Services Subcontracts - Request For Proposals (RFPs)	When formally issued to the public	Section D	Paragraph 33	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	AHCCCS Required Survey Results	45 days after the completion	Section D	Paragraph 66	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Appointment Availability Review Methods	30 days prior to implementation of the proposed method	Section D	Paragraph 38	ACOM Policy 417	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Centers of Excellence Report	December 31	Section D	Paragraph 87	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Claim Recoupments >12 Months from Original Payment	Upon identification by Contractor	Section D	Paragraph 38	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Completed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Documents required after AHCCCS Approval	Within 120 days of the completed merger, acquisition, reorganization, joint venture, or change in ownership	Section D	Paragraph 54	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Data Processes for Recoupments	120 days from receipt of approval	Section D	Paragraph 38	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Final Survey Tool	90 days prior to the intended start	Section D	Paragraph 19	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	ID Cards requiring AHCCCS Approval	30 days prior to dissemination	Section D	Paragraph 7	ACOM Policy 433	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Independent Audits of Claims Payment/Health Information Systems	Upon request by AHCCCS	Section D	Paragraph 44	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Staff: Key Position Change	Within 7 days of learning of resignation	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Key Staff: Notification of Moving Functions Out of State	60 days prior to proposed change	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Marketing Materials	21 days prior to dissemination	Section D	Paragraph 68	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov
DHCM OPERATIONS	Ad Hoc	Material Change to Business Operations	60 days prior to expected implementation of the change	Section D	Paragraph 43	ACOM Policy 439	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Material Change to Provider Network	60 days prior to expected implementation of the change	Section D	Paragraph 29	ACOM Policy 439	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Member Handbook (Final Approved Version)	On or before the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Member Information Materials	15 days prior to release	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Non-AHCCCS Required Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	Section D	Paragraph 66	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Notification	180 days prior to the effective date	Section D	Paragraph 54	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Transition Plan Initial Documents	180 days prior to the effective date	Section D	Paragraph 54	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Proposed Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Transition Plan Final Documents	90 days prior to the effective date	Section D	Paragraph 54	ACOM Policy 317	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Ad Hoc	Provider Advances and Loans	10 days prior to disbursement of Funds	Section D	Paragraph 50	ACOM Policy 418	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Single Claim Recoupments >\$50,000	30 days prior to initiating the recoupment, or earlier if the information is available	Section D	Paragraph 38	ACOM Policy 412	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	System Change Plan	Six months prior to expected implementation	Section D	Paragraph 44	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Ad Hoc	Unexpected Change to Provider Network	Within one business day	Section D	Paragraph 29	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Administrative Services Subcontractor Evaluation Report	Within 90 days of the start of the contract year	Section D	Paragraph 33	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Annual Website Certification	45 days after the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Business Continuity and Recovery Plan Summary	15 days after the start of the contract year	Section D	Paragraph 83	ACOM Policy 104	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Cultural Competency Plan Assessment	45 days after the start of the contract year	Section D	Paragraph 69	ACOM Policy 405	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Functional Organization Chart	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Listing of All Key Staff	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Key Staff: Organization Chart	15 days after the start of the contract year	Section D	Paragraph 25	N/A	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Marketing Attestation Statement	60 days after the start of the contract year	Section D	Paragraph 68	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Member Handbook	May 1 and 30 days prior to any changes	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Member Information Attestation Statement	45 days after the start of the contract year	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Provider Network Development and Management Plan	December 15 th	Section D	Paragraph 28	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Social Networking Administrator (Name and Contact Information)	Within 90 days of the start of the contract year and within 30 days of any changes	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Annually	Social Networking Applications Listing with URLs	Within 90 days of the start of the contract year and within 30 days of any changes	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Annually	Social Networking Attestation	Within 90 days of the start of the contract year	Section D	Paragraph 17	ACOM Policy 425	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	*Claims Dashboard	30th day of the month following the reporting period	Section D	Paragraph 44	AHCCCS Claims Dashboard Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Grievance and Appeal System Report	Tenth day of the 2nd Month following the month Being Reported	Section D	Paragraph 22	AHCCCS Grievance and Appeal System Reporting Guide	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Monthly	Marketing Activities Report	24th of the month for the previous months activities	Section D	Paragraph 68	ACOM Policy 101	DHCM Marketing Committee	Email to: MarketingCommittee@azahcccs.gov
DHCM OPERATIONS	Quarterly	Appointment Availability Review	15 days after the end of each quarter	Section D	Paragraph 38	ACOM Policy 417	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Administrative Directives	10 days after the end of each quarter (October, January, April, July)	Section D	Paragraph 26	N/A	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Quarterly	Gap in Critical Services Log	October 15, January 15, April 15, July 15	Section D	Paragraph 28	ACOM Policy 413	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Minimum Network Requirements Verification Template	February 1, May 1, August 1, November 1	Section D	Paragraph 32	ACOM Policy 436	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider Affiliation Transmission	October 15, January 15, April 15, July 15	Section D	Paragraph 28	AHCCCS Provider Affiliation Transmission Manual	DHCM Operations Executive Staff Assistant	FTP server with email notification
DHCM OPERATIONS	Quarterly	Provider/ Network Changes Due To Rates	21 days after the end of each quarter	Section D	Paragraph 29	ACOM Policy 415 Attachment D and Attachment E	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Semi-Annually	Gap In Critical Services Report	Nov 15th; May 15th	Section D	Paragraph 28	ACOM Policy 413	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM OPERATIONS	Semi-Annually	Member Newsletter	30 days prior to intended publication date	Section D	Paragraph 17	ACOM Policy 404	DHCM Operations and Compliance Officer	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
DHCM OPERATIONS	Semi-Annually	Therapeutic and HCBS Services Gap Reporting Roster	October 15th; April 15th	Section D	Paragraph 29	ACOM Policy 415	DHCM Operations and Compliance Officer	FTP server with email notification
DHCM REIMBURSEMENT	Annually	Annual Submission of Provider Reimbursement Rates	August 1 st	Section D	Paragraph 78	N/A	DHCM Reimbursement Administrator	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Annually	Attestation of Disclosure Information: Ownership and Control and Persons Convicted of a Crime	15 days after the start of the contract year	Section D	Paragraph 70	ACOM Policy 103	Office of Inspector – Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Annually	Corporate Compliance Plan	15 days after the start of the contract year	Section D	Paragraph 70	ACOM Policy 103	Office of Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Exclusions Identified Regarding Persons Convicted of a Crime	Immediately upon identification	Section D	Paragraph 70	N/A	Office of Inspector - Inspector General	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Merger, Acquisition, Reorganization, Joint Venture, and Change in Ownership: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information	45 days prior to the effective date and commencement of operations	Section D	Paragraph 54	ACOM Policy 317	Office of Inspector - Inspector General	FTP server with email notification
OFFICE OF INSPECTOR GENERAL	Ad Hoc	Report Alleged Fraud/Waste/Abuse of the AHCCCS Program	Immediately upon identification	Section D	Paragraph 70	ACOM Policy 103	Office of Inspector	As noted on reporting form
OFFICE OF INSPECTOR GENERAL	Semi-Annually	Corporate Compliance: Audit Summary	July 15 and January 15	Section D	Paragraph 70	N/A	Office of Inspector General	FTP server with email notification

Area	Timeframe	Report	When Due	Contract Section	Contract Paragraph	Reference/Policy	Send To	Submitted Via
OFFICE OF INSPECTOR GENERAL	Semi-Annually	Corporate Compliance: External Auditing Schedule	April 15 and October 15	Section D	Paragraph 70	N/A	Office of Inspector General	FTP server with email notification

[END OF ATTACHMENT F3]

ATTACHMENT F4: TARGETED CASE MANAGEMENT

The Contractor shall provide targeted case management services for the Contractor's clients who are financially eligible for the Title XIX and Title XXI acute care program but who do not meet the functional eligibility requirements of the ALTCS program. The non-ALTCS DES/DDD recipients who become eligible for case management services under this amendment are entitled to case management services but must receive their acute care services through the AHCCCS health plans. Recipients shall have a choice of case managers available from the Contractor. Recipients may refuse case management services however; this will result in disenrollment from targeted case management.

1. TARGETED CASE MANAGEMENT SERVICES FOR NON-ALTCS RECIPIENTS

The case management responsibilities as described in Chapter 1600, Section 1640 of the AHCCCS Medical Policy Manual shall apply to DES/DDD recipients enrolled with an AHCCCS acute care Contractor (non-ALTCS members). The Contractor shall submit their ALTCS Case Management Plan to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, a written plan describing the implementation and monitoring of Targeted Case Management.

“Case manager” means a person who is either a degreed social worker, licensed registered nurse, or one with a minimum of two years' experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. The Contractor shall ensure adequate staffing to meet case management requirements. If case management staffing is not adequate to meet the needs of the recipients, the Contractor shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must be sufficient to cover case manager absenteeism and turnover. AHCCCS will review caseload sizes during the annual Targeted Case Management Services Review.

The Contractor shall implement a systematic method of monitoring its case management program. This internal monitoring shall be conducted at least quarterly by the Contractor. The Contractor shall compile a written report of the monitoring activity to include an analysis of the aggregated data and a description of the continuous improvement strategy the Contractor has taken to resolve identified deficiencies. This information shall be made available upon request by AHCCCS.

2. PAYMENT

Payment to the Contractor for targeted case management services must not duplicate payments made to public agencies or private entities under other program for this same purpose and will be made by AHCCCS on a capitated basis as a pass through of Federal funds received by AHCCCS. See Paragraph 56, Compensation for a description of the pass-through process

To determine the number of recipients, the Contractor will submit data to AHCCCS, by the 10th working day of each month, using CONNECT, which is a direct process to transmit the match file. The data will be processed through a series of edits designed to match Social Security Number, name, sex, and date of birth. If the Contractor client passes through the match criteria, then the client's enrollment and eligibility will be verified. Only currently eligible and enrolled clients will be reported as matched. AHCCCS will only pay for targeted case management services for those clients considered matched on the monthly transmission.

Recipient records reported by the Contractor that do not result in a match will be identified on a “potential match” report. This report will be sent to the Contractor for further research. The Contractor will not be paid for clients considered a potential match. Resubmitted records which result in a match will be paid as of the first of the month in which the match was made.

All funds received by the Contractor pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles.

3. ON-SITE REVIEWS

In accordance with A.A.C. R9-28 Article 5, AHCCCS will conduct an operational review of targeted case management services every year for the purpose of, but not limited to, ensuring program compliance. The type and duration of the review will be solely at the discretion of AHCCCS and will include, but not be limited to, Case Management Services Review. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor the Contractor's progress towards implementing mandated programs and provide the Contractor with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least four weeks advance notice of the date of the on-site review. AHCCCS may conduct a review in the event the Contractor undergoes a reorganization or makes changes in three or more key staff positions within a 12-month period.

In preparation for the reviews, the Contractor shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance materials that AHCCCS may request. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. The Contractor personnel as identified in advance shall be available to the Review Team at all times during AHCCCS on-site review activities. While on-site, the Contractor shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

The Contractor will be furnished a draft copy of the Review Report and given an opportunity to comment on any review findings prior to AHCCCS finalizing the report. Where there are outstanding deficiencies, the Contractor may be required to submit a corrective action plan without the opportunity to comment on the draft report.

Recommendations made by the Review Team to bring the Contractor into compliance with federal, state, AHCCCS, and/or RFP requirements, must be implemented by the Contractor. AHCCCS may conduct a follow-up review or require a corrective action plan to determine the Contractor's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial review.

The Contractor shall submit a corrective action plan to improve areas of non-compliance identified in the review. Once the corrective action plan is approved by AHCCCS, it shall be implemented by the Contractor. Modifications to the corrective action plan must be agreed to by both parties.

4. ANNUAL SUBMISSION OF BUDGET

The Contractor shall submit to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, an estimate of the costs of providing targeted case management services pursuant to this contract. The cost estimates must be fully supported by documentation stating the nature of the costs and the methods and data used to develop the estimates.

If at any time during the term of this contract the Contractor determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. AHCCCS, with the Contractor, may request additional money from the Governor's Office of Strategic Planning and Budgeting.

Requests for FFP: Requests for Federal Financial Participation (FFP) from the Contractor and the pass through of these funds to the Contractor from AHCCCS shall both adhere to the mandatory Cash Management Improvement Act (CMIA) of 1990 as established by the General Accounting Office of the Arizona Department of Administration (GAO/ADOA).

5. SANCTIONS

If the Contractor violates any provision stated in law, AHCCCS Rules, AHCCCS policies and procedures, or this contract, AHCCCS may impose sanctions in accordance with the provisions of this contract, applicable law and regulations. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and the amount of payment to be withheld.

[END OF ATTACHMENT F4]

ENDNOTES

Effective March 1, 2015 via contract amendment, the contract language associated with the endnotes below was incorporated into the contract pursuant to CMS contract Managed Care compliance requirements.

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[END OF ENDNOTES]