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CAPITATION RATES AND CONTRACTOR SPECIFIC INFORMATION

APIPA shall provide services described in this Attachment. In consideration for these services, APIPA will be paid as described in Paragraph 53, Compensation of this Attachment. For the term of October 1, 2012 through September 30, 2013, APIPA will be paid a statewide blended capitation rate of $369.61 for CRS eligible AHCCCS members.

DEFINITIONS

The definitions contained in Section C, Definitions, of the contract apply with the following additions:

CRS RECIPIENT	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS covered Services.
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.
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.
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 MSICs to provide a specific set of services including evaluation, monitoring, and treatment for CRS related conditions on a periodic basis.
GENETICS	The studies of how particular traits are passed from parents to children. Identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule.
GUARDIANSHIP	A person authorized under state or other law to act on behalf of the member in making health-related decisions. Examples: a parent acting on behalf of an un-emancipated minor or a parent who has petitioned for guardianship for their 18-21 year old member.
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.
INTERDISCIPLINARY TEAM	Physician and non-physician professionals, the Member and Family Members who collaborate in planning, delivering and evaluating health care services.
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.

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.
MINOR	An individual who is: 1. Under the age of 18 years; 2. Incompetent as determined by a court of competent jurisdiction; or 3. Incapable of giving consent for medical services due to a limitation in the individual's cognitive function as determined by a physician.
MULTI-SPECIALTY	The use of more than one specialty physician or dentist in the treatment of a Member.
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 the Member's CRS condition.
NOTICE OF APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
OFFICE OF CIVIL RIGHTS (OCR)	The office is part of the US Department of Health and Human Services (HHS). Its HIPAA responsibilities include oversight of the privacy requirements.
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.
PARENT ACTION COUNCIL (PAC)	A local, parent-driven council consisting of members including parents of a child who is or has been a CRS Member, Adults who are or were CRS Members and the CRS Contractor. PAC members may also include professionals and members of advocacy groups. The PAC is established in accordance with A.R.S. §36-265.
PRUDENT LAYPERSON	A person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment, which society requires of its members for the protection of their own interest and the interests of others.
SERVICE PLAN	A document that is developed consistent with applicable Evidence Based Practice Guidelines, which combines the various elements of treatment plans with needed family support services and care coordination activities to provide a map of the steps to be taken for each Member in achieving treatment and quality of life goals.
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 FISCAL YEAR (FY)	The budget year-State fiscal year: July 1 through June 30.
STATEWIDE	Of sufficient scope and breadth to address the health care service needs of Members throughout the State of Arizona.
TELEMEDICINE	The delivery of diagnostic, consultation and treatment services that occur in the physical presence of the member on a real time basis through interactive audio, video and data communications, as well as the transfer of medical data on a store and forward basis for diagnostic or treatment consultations.
TRANSITION PLAN	A plan developed for each Member in accordance with AHCCCS Policy, which includes developmentally-appropriate strategies to transition from a pediatric to an Adult system of health care and a plan that addresses changing work, education, recreation and social needs.
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.

INTRODUCTION

This Attachment describes the responsibilities for provision of services under the Children's Rehabilitative Services (CRS) program. The CRS Contractor shall adhere to all requirements of Section D of this contract except as exempted. In instances where language contained in this attachment differs from Section D, the language in Attachment J will replace the requirements of Section D only with regard to administration of the CRS program and services provided to CRS-enrolled recipients. The CRS Contractor is exempted from any requirement in Section D, not applicable to services described in Paragraph 10 of the attachment.

The CRS Contractor shall manage the care for what are often complicated medical conditions. Examples of conditions covered under the CRS program include – but are not limited to – the following:

- Cerebral Palsy,
- Club feet,
- Dislocated hips,
- Cleft palate,
- Scoliosis,
- Spina Bifida,
- Cystic Fibrosis,
- Heart conditions due to congenital deformities,
- Metabolic disorders,
- Muscle and nerve disorders,
- Neurofibromatosis, and
- Sickle Cell Anemia

Under contract with AHCCCS, the Contractor shall deliver Covered Services in a manner consistent with the AHCCCS mission, philosophy and objectives. The Contractor shall manage care to promote more appropriate utilization of services, minimize the need for emergency care and improve quality of care.

The Contractor shall provide and/or arrange for and manage the timely delivery of well-coordinated, multi-specialty, interdisciplinary, Covered Services by a network of qualified providers to Recipients in all regions of the State. The system will provide Recipients access (or virtual access through telemedicine) to a statewide network of multi-specialty providers in a variety of service settings including MSICs, clinic-like settings (e.g., Field Clinics, Virtual Clinics) and community-based pharmacies, therapies, lab and diagnostic services. The effective use of innovative delivery strategies and technology will increase Recipients' options for choice among providers and enhance the coordination of multi-specialty, interdisciplinary care, when indicated.

Network design shall preserve continuity of care, existing member-provider relationships and member/family choice when feasible. The Contractor shall implement proven strategies that ensure Recipients ready access to effective, person- and family-centered, culturally and linguistically appropriate care.

The Contractor shall use data-driven approaches to inform, support and perform key contract service delivery, managed care and network requirements; including multi-specialty, interdisciplinary care, family support services, integrated medical records, timely Service Plan implementation, planning for adulthood, care coordination, network adequacy, medical management/utilization management, and quality management. The Contractors commitment to Recipient rights, family involvement and continuous quality improvement shall be evident in all policies, practices and decision-making. The Contractor's management team shall identify and implement Evidence Based Practice Guidelines and Best Practices; industry leading tools; technology; and strategies that improve clinical and administrative outcomes and reduce unnecessary costs.

1. TERM OF CONTRACT

The contract Award Date for the CRS Services Attachment to this contract shall be the date the State Procurement Officer executes the Offer and Acceptance. Performance to recipients shall commence on January 1, 2011 (contract Effective Date). The contract term for this Attachment shall begin with the contract Effective Date and shall continue for a period of one and three-quarters (1.75) years thereafter, unless terminated or extended. The contract has been extended through September 30, 2013.

Contract Termination: In the event that the contract or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist AHCCCS in the transition of its members to the other Contractor, and shall abide by standards and protocols set forth in Paragraph 9, Transition of Members. In addition, AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. The Contractor shall make provision for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. Upon request, the Contractor shall submit a detailed plan for the transition of members in the event of contract expiration or termination. The name and title of the Contractor's transition coordinator shall be included in the transition plan. The Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process, and shall be responsible for the following:

a. Notification of subcontractors and members.
b. Payment of all outstanding obligations for medical care rendered to members until AHCCCS is satisfied that the Contractor has paid all such obligations The Contractor shall provide a monthly claims aging report including IBNR amounts due the 15th day of the month, for the prior month.
c. Providing Quarterly and Audited Financial Statements up to the date of contract termination. The financial statement requirement will not be absolved without an official release from AHCCCS.
d. Continuing encounter reporting until all services rendered prior to contract termination have reached adjudicated status and data validation of the information has been completed, as communicated by a letter of release from AHCCCS.
e. Cooperation with reinsurance audit activities on prior contract years until release has been granted by AHCCCS.
f. Cooperating with AHCCCS to complete and finalize any open reconciliations until release has been granted by AHCCCS. AHCCCS will work to complete any pending reconciliations as timely as possible, allowing for appropriate lag time for claims run-out and/or changes to be entered into the system.
g. Supplying quarterly Quality Management and Medical Management reports will be submitted as required by Section D, Paragraphs 23, Quality Management, and 24, Medical Management, as appropriate to provide AHCCCS with information on services rendered up to the date of contract termination. This will include quality of care (QOC) concern reporting based on the date of service
h. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by AHCCCS.
i. Maintaining a Performance Bond as long as the Contractor has AHCCCS-related liabilities of $50,000 or more outstanding or 15 months following the termination date of this contract, whichever is later. At that time, a formal request to release the performance bond, as well as a balance sheet, must be submitted.
j. Indemnify AHCCCS for any claim by any third party against the State or AHCCCS arising from the Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract.
k. Returning to AHCCCS, any funds advanced to the Contractor for coverage of members for periods after the date of termination. Funds must be returned to AHCCCS within 30 days of termination of the contract.

l. Providing a monthly accounting of Member Grievances and Claim Disputes and their disposition.
m. Preserving and making available all records for a period of five years from the date of final payment under contract. Records covered under HIPAA must be preserved and made available for six years per 45 CFR 164.530(j)(2).

The above list is not exhaustive and additional information may be requested to ensure that all operational and reporting requirements have been met. Any dispute by the Contractor, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E, *Contract Terms and Conditions, Disputes.*

2. ELIGIBILITY FOR SERVICES

The CRS Contractor serves individuals with chronic and disabling, or potentially disabling medical conditions who:

a. Are under the age of 21;
b. Are residents of Arizona;
c. Are citizens or qualified aliens;
d. Have been diagnosed with a verifiable CRS medical condition in accordance with Arizona Administrative Code R9-7-202;
e. Require multi-specialty physician services.

The Contractor shall develop and maintain policies that contain all medical eligibility criteria in accordance with AMPM policies. The Contractor shall ensure that each subcontractor is issued a copy of the medical policy manual on an annual basis and the current manual, and all periodic updates made during the contract year, shall be accessible on the Contractor's website.

Referral processes:

The Contractor shall maintain a process for AHCCCS Health Plans/Program Contractors to refer members to the CRS program. The Contractor shall make referral forms available to the Health Plans/Program Contractors. The Contractor shall be responsible to determine medical eligibility for the CRS program, based on qualifying diagnosis and supporting documentation. Any qualified provider - regardless of CRS affiliation - or any AHCCCS Contractor, may submit a referral for CRS services.

Disposition of Referrals:

The Contractor shall follow the processes outlined in ACOM Policy 426, with regard to determining eligibility with the following possible outcomes:

a. The applicant is eligible;
b. The applicant is not eligible;
c. Further information is needed to determine eligibility; or
d. A physical examination is needed to determine the presence of a CRS medical condition. The physical examination must be scheduled within 30 calendar days of the decision.

Notification Requirements:

For those instances where a determination of medical eligibility/ineligibility for the CRS program can be made based on the information available, the notification requirements of this section apply.

When an applicant is determined eligible for CRS, notification will be made to the following parties:

a. Applicant
b. Referral Source
c. AHCCCS – Upon identification of the member as a CRS recipient, the Contractor will notify AHCCCS through the appropriate Recipient Roster Reconciliation tape. AHCCCS will make appropriate update to the AHCCCS Contractors' enrollment files.
d. Health Plan/Program Contractor – The Contractor will notify the Health Plan/Program Contractor of enrollment, through a documented process, of the:
    i. Recipient's CRS Qualifying Diagnosis;
    ii. Enrollment Effective Date; and
    iii. Assigned CRS Specialty Clinic.

When an applicant is determined ineligible for CRS, notification will be made to the following parties:

a. Applicant – the applicant shall receive a notification of denial, in writing, that contains the statement of denial; the reasons for the denial and any information regarding potential gaps in documentation that may be resolved; and outlines all appeal rights and processes; within fourteen (14) calendar days of the determination of ineligibility.
b. Referral Source – The Contractor shall inform the referral source, in writing, within five (5) working days of the determination of ineligibility.
c. Health Plan/Program Contractor – The Contractor shall inform the Health Plan/Program Contractor within five (5) working days of the determination of ineligibility.

All ***appeals*** of CRS Eligibility Determination are heard in a State Fair Hearing. These appeals shall follow the processes outlined in the ACOM Policy 426.

If further information is needed in order to make a determination of medical eligibility for the CRS program, the Contractor will issue notifications to the following:

a. Applicant – The applicant shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty (30) days from the date of the notice).
b. Referral Source - The referral source shall receive written notification within fourteen (14) days of the need for further information specifying: the information needed; possible methods of fulfillment; and the timeframe for submitting the information (thirty (30) days from the date of the notice).

If a physical examination is needed to determine the presence of a CRS qualifying medical condition, notice shall be provided to:

a. Applicant – upon deciding that a physical examination is needed to determine the presence of a CRS qualifying medical condition, the Contractor shall notify the applicant within fourteen (14) calendar days of receipt of the referral/application of the need for the examination, indicate a scheduled appointment date and time for the evaluation (must occur within (30) days of the notification), and outline the possible outcomes should the applicant not complete the indicated steps.

Enrollment of a Title XIX/XXI applicant who is deemed medically eligible to receive CRS services, shall be effective on the same date as the eligibility determination is made by the CRS Contractor.

The Contractor shall perform a quarterly review of the appropriateness of eligibility determinations. The review will examine a statistically valid sample of both approved and denied applications. The results of the review will be documented and contain an explanation of the sampling methodology used. The Contractor will submit a reporting of the quarterly review no later than 45 day after the close of the sampled period as shown in the Reporting Requirements Table, located in Paragraph 67 of the Attachment. Upon request, the Contractor shall submit documentation used in the validation process to AHCCCS for monitoring and oversight purposes.

The Contractor shall monitor and report the timeliness of Eligibility Determinations, steps in the enrollment process, and access to services that are listed in the recipient's Initial Service Plan (ISP).

The Contractor shall submit a New Member Enrollment Report.

3. EXEMPT

4. EXEMPT

5. EXEMPT

6. EXEMPT

7. RECIPIENT IDENTIFICATION CARDS

The Contractor is responsible for paying the costs of, and producing, CRS Recipient identification cards.

8. MAINSTREAMING OF RECIPIENTS

(REFER TO SECTION D)

9. TRANSITION OF RECIPIENTS

CRS Recipients often require care over extended periods of time. Therefore, transitions from the Children's to the Adult system of care; from one Contractor to another; between levels of inpatient and outpatient care; from physician to physician; often are needed. The CRS Contractor shall comply with the AMPM and the ACOM Policy standards for member transitions between Contractors or GSAs, participation in or discharge from CRS or CMDP, to or from an ALTCS Contractor and upon termination or expiration of a contract. The exiting Contractor shall be responsible for performing all transition activities at no cost. Accordingly, the Contractor shall implement specific policies and procedures to preserve the continuity of care during such transitions.

Transition and Discharge Coordination:
The Contractor shall ensure continuity of care upon discharge from hospitals, clinics, or from the CRS program.

The Contractor shall coordinate continued care with a recipient's Health Plan/Program Contractor and/or Primary Care Physician, as appropriate, upon a recipient's discharge from a hospital; advising the Contractor or PCP of all CRS services provided during the stay, their duration, the date of completion for any short term service, continued need for stay beyond treatment of the CRS condition, and any follow up care indicated.

Additionally, the CRS Contractor will provide required recipient notifications, as detailed in ACOM Policy 409, in instances where inpatient stay specific to the CRS condition is no longer medically necessary but continued care unrelated to the condition is indicated.

Exiting from the CRS Program:

Pediatric to Adult transition - The Contractor shall develop a Pediatric to Adult Transition Plan for each recipient by age twenty (20). The Transition Plan shall be developed with recipients, families, and their providers. The Plan shall include strategies to address barriers to transitioning from a pediatric- to an adult-oriented system of care. The Plan should be age-appropriate and periodically updated to address the Recipient's current needs and identify an adult-care PCP prior to transition out of the CRS program.

In addition to health care, developmentally-appropriate discussions related to work, education, recreation, and social needs should be part of the planning for adulthood. All teens, including those with cognitive disabilities, should be included in planning for adulthood in a way that is meaningful to them.

The Contractor shall adhere to policies in the AMPM Chapter 520, regarding Pediatric to Adult Transition Plans. Utilizing the Enrollment Transition Information (ETI) form, the Contractor shall notify the Recipient's Health Plan/Program Contractor to begin coordination of care for the Recipient, ninety (90) days prior to the Recipient's twenty-first (21) birthday as required in the AMPM and ACOM policies for member transition.

Service completion – Upon the completion or closure of a course of treatment related to a CRS condition, recipients may no longer require the multi-specialty, interdisciplinary care, provided in the CRS Scope of Services. The CRS Contractor is responsible for notifying the Recipient's Health Plan/Program Contractor and/or Primary Care Physician and providing current medical records to the Health Plan/Program Contractor no later than sixty (60) days prior to the intended termination of CRS Services for the Recipient, regardless of the Recipient's age.

Other terminations – Upon notification that a member ceases to qualify for the CRS program, the CRS Contractor is responsible for notifying the Recipient's Health Plan/Program Contractor and/or Primary Care Physician within thirty (30) days of notification as specified in ACOM Policy 426.

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the AHCCCS Transition staff and staff from other Contractors and Acute Health Plans to ensure a safe and orderly transition.
The relinquishing Contractor is responsible for timely notification to 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 for coordinating care with the relinquishing Contractor in order that services are not interrupted, and for providing the new member with Contractor and service information, emergency numbers and instructions about how to obtain services.

10. SCOPE OF SERVICES

CRS Covered Services are described in the Arizona Administrative Code (http://azsos.gov/publications) Title 9, Chapter 7, Article 4.

The CRS Contractor shall provide medically necessary CRS covered services to AHCCCS members, excluding outpatient emergency services, even when the provider that furnishes the service has an agreement with the CRS Contractor. A complete description of AHCCCS covered services can be found in the AMPM. Not all AHCCCS covered services are covered by CRS.

CRS services shall be provided in Family-Centered, culturally competent, multi-specialty, interdisciplinary, healthcare and managed care system that contains the following elements:

a. Provision of medically necessary covered services, covered family support services, eligibility assessments and a timely enrollment process;
b. A process for using a centralized, integrated medical record that is accessible to the Contractor and services providers; consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care;
c. A process for developing and implementing a Service Plan accessible to the Contractor and service providers that is consistent with Federal and State privacy laws that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation;
d. Development of Transition Plans to facilitate transition into adulthood;
e. Management of appropriate and quality services through Quality Management, Utilization Management, Network Physician Credentialing, Member Services information, Referrals, Grievances and Appeals processes, and Provider Services and Claim Processing.
f. Collaboration with individuals, groups, organizations and agencies charged with the administration, support or delivery of services for children with special health care needs; including AHCCCS Health Plans/Program Contractors, Primary Care Physicians (PCPs) and Specialists.
g. Continuous quality improvement approaches to operations that are based on accurate and complete data collection and monitoring.

The Contractor will establish, monitor and maintain a statewide provider network in accordance with Paragraph 27 of Section D, and this Attachment, that can provide the services of this Attachment in well-coordinated, family centered, culturally and linguistically appropriate, multi-specialty, interdisciplinary settings.

The ***Covered Services*** in this section are covered under the following conditions:

1. The service is medically necessary;
2. Related to the CRS eligible condition; and
3. Provided in accordance with Medical Management/Utilization Management criteria established in AHCCCS policy.

Covered Services include:

a. Audiology
b. Dental and orthodontia services
c. Diagnostic testing and laboratory services
d. Home health
e. Inpatient services
f. Medical Equipment
g. Nursing
h. Nutrition
i. Occupational therapy
j. Outpatient Services
k. Pharmacy services
l. Physician services
m. Physical therapy
n. Prosthetic and Orthotic Devices
o. Psychological Services
p. Psychiatric services
q. Social Work services
r. Speech Language Pathology services
s. Vision services
t. Support Services (as outlined in R9-7-501 through R9-7-506)

Multi-Specialty, Interdisciplinary Care

The Contractor shall deliver multi-specialty, interdisciplinary Covered Services through a combination of established Multi-Specialty Interdisciplinary Clinics (MSICs), Field Clinics, Virtual Clinics, and community settings. MSICs permit members of the treatment team, the Recipient and his or her family members to meet face-to-face to evaluate and plan treatment. Types of required MSICs are provided in Paragraph 27 of the Attachment and determined by the covered services of this Paragraph. Field Clinics are provided by specialty providers who travel to locations closer to the homes of Recipients who are not conveniently located near MSICs. Virtual Clinics may also be implemented where treatment team members in community settings collaborate and conduct treatment planning through the use of Telemedicine and an Integrated Medical Record. Regardless of the setting, the Contractor shall develop and implement organizational structures and procedures that promote collaboration and consultation among multi-specialty treatment team members.

Care Coordination and Service Plans

The Contractor is responsible for delivering effective care coordination as described in AHCCCS AMPM Chapter 500 and confirming that treatment is carried out as providers intended, and minimizing unnecessary disruption to Recipients' lives. When coordinating care, the Contractor shall protect each Recipient's privacy in accordance with HIPAA privacy requirements in 42 C.F.R. and 45 C.F.R. Parts 160 and 164 Subparts A and E, to the extent applicable.

Interagency Collaboration

In general, CRS provides specialty services related to the Recipient's CRS Condition, but does not cover other routine, preventive or acute non-specialized medical services. Accordingly, coordination with AHCCCS Acute and ALTCS Program Contractors and the American Indian Health Plan regarding issues of coverage and reimbursement is necessary to avoid administrative barriers with the potential to negatively impact timely service delivery.

11. SPECIAL HEALTH CARE NEEDS

In accordance with Article 3, Arizona Revised Statutes (A.R.S.) §§36-261 and 36-262 and Article 13, A.R.S. §§36-797.43 and .44, the purpose of this contract is for the Contractor to administer the Children's Rehabilitative Services (CRS) program to eligible Recipients as described in this contract. The CRS program specializes in administering needed services for individuals with chronic and disabling or potentially disabling health conditions.

The Contractor shall provide and/or arrange for and manage the timely delivery of well-coordinated, multi-specialty, interdisciplinary Covered Services by a network of qualified providers to Recipients in all regions of the State. Network design shall preserve continuity of care, existing member-provider relationships and member/family choice when feasible. Based on the Contractor's experience with and expertise in the delivery and management of publicly funded services for children with special health care needs similar to those treated in the CRS program, the Contractor shall implement proven strategies that ensure Recipients ready access to effective, person- and Family-Centered, culturally and linguistically appropriate care, delivered in a manner consistent with Evidence Based Practice Guidelines and Best Practices throughout Arizona.

The Contractor shall use data-driven approaches to inform, support and perform key contract service delivery, managed care and network requirements including multi-specialty, interdisciplinary care, family support services, integrated medical records, timely Service Plan

implementation, planning for adulthood, care coordination, network adequacy, medical management/utilization management (MM/UM) and quality management (QM). The Contractor's commitment to Recipient rights, family involvement and continuous quality improvement shall be evident in its policies, practices and decision-making. The Contractor's management team shall identify and implement industry-leading tools, technology, and strategies that improve clinical and administrative outcomes and reduce unnecessary costs.

The Contractor shall administer a single, Statewide, organized, seamless service delivery system and organization. The system will provide Recipients access (telemedicine or virtual access) to a statewide network of multi-specialty providers in a variety of service settings including MSICs, clinic-like settings (e.g., Field Clinics, Virtual Clinics) and community-based pharmacies, therapies, lab and diagnostic services. The effective use of innovative delivery strategies and technology will increase Recipients' options for choice among providers and enhance the coordination of multi-specialty, interdisciplinary care when indicated.

12. EXEMPTED

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

(REFER TO SECTION D)

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM

(REFER TO SECTION D)

15. PEDIATRIC IMMUNIZATIONS AND THE VACCINES FOR CHILDREN PROGRAM

The CRS Contractor will provide reimbursement for the administration of appropriate immunizations provided during CRS visits and will follow all requirements of Section D, Paragraph 15.

16. STAFF REQUIREMENTS AND SUPPORT SERVICES

The Contractor shall have organization, management, and administrative systems capable of meeting contract requirements. The Contractor shall maintain a significant and sufficient local presence (within Arizona) throughout the term of the contract or this Attachment; and a positive public image. This local presence includes staff designated below with an asterisk.

The Contractor will submit the following accounting of fulfillment of the requirements of this paragraph thirty (30) days prior to the initiation of a contract Amendment, or on an annual basis including the following:

1. A CRS-Specific Organizational Chart that includes the names of individuals filling all Key Staff roles and the number of employees filling the Additional Staff Requirement positions.
2. A CRS-Specific Crosswalk of the Contractor's staff titles and AHCCCS required staff positions; which includes names, titles, AHCCCS title, and contact information.

Key Staff

The Medical staff positions in sections (b), (i), (j), (k), (r), and (s) should be filled with qualified staff that have specific expertise in the delivery of services to children with special health care needs.

a. ***Administrator/CEO/COO** or designee must be available, during working hours, to fulfill the responsibilities of the position and to oversee the entire operation of the Contractor. The Administrator shall devote sufficient time to the Contractor's operations to ensure adherence to program requirements and timely responses to AHCCCS.

b. ***Medical Director/CMO** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all major clinical programs and QM and MM components of the Contractor. The Medical Director shall devote sufficient time to the Contractor operations to ensure timely medical decisions, including after-hours consultation as needed.

c. **Chief Financial Officer/CFO** who is available, full time, to fulfill the responsibilities of the position and to oversee the budget, accounting systems, and financial reporting implemented by the Contractor.

d. **Pharmacy Director/Coordinator** 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 subcontractor of the Plan.

e. ***Compliance Officer** who will implement and oversee the Contractor's compliance program. The Compliance Officer shall be a management official, available to all employees, with the designated and recognized authority to access records and make independent referrals to the AHCCCS Office of the Inspector General. See Section D, Paragraph 62, Corporate Compliance.

f. ***Dispute and Appeal Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System; including member grievances, appeals, requests for hearing, and provider claim disputes.

g. **Business Continuity Planning Coordinator** as noted in the ACOM Policy 104.

h. ***Contract Compliance Officer** 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:

- Coordinating the tracking and submission of all contract deliverables;
- Field and coordinate responses to AHCCCS inquiries;
- Coordinating the preparation and execution of contract requirements such as OFRs, random and periodic audits, and ad hoc visits.

i. ***Quality Management Coordinator** 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 Coordinator must have experience in quality management and quality improvement.

The primary functions of the Quality Management Coordinator position are:

- Ensure individual and systemic quality of care;
- Integrate quality throughout the organization;
- Implement process improvement;
- Resolve, track and trend quality of care grievances;
- Ensure a credentialed provider network.

j. **Performance/Quality Improvement Coordinator** who has a minimum qualification as a CPHQ or CHCQM or comparable education; and experience in data and outcomes measurement.

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.

k. ***Medical Management Coordinator** who is an Arizona licensed registered nurse, physician, or physician's assistant – if required to make medical necessity determinations; or have a Master's level degree in health services, health care administration, or business administration

– if not required to make medical necessity determinations, who manages all required Medicaid management requirements under AHCCCS policies, Rules and contract.
The primary functions of the Medical Management Coordinator are:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
- Ensure appropriate concurrent review and discharge planning of inpatient stays;
- 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.

l. Member Services Manager who shall coordinate communication with members.
The primary functions of the Member Service Manager are to:

- Serve in the role of member advocate;
- Coordinate issues with appropriate areas within the organization;
- Resolve member inquiries/problems;
- Meet standards for resolution and telephonic performance measures.

m. *Provider Services Manager and staff to coordinate communications between the Contractor and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution to their problems or inquires and appropriate education about participation in the CRS program and maintain a sufficient provider network.

n. Claims Administrator who will ensure appropriate handling of Claims for Payment.
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 the necessity for claim recoupments/recoveries;
- Meet claims processing timelines;
- Meet AHCCCS encounter reporting requirements.

o. *Telemedicine Coordinator who shall be responsible for oversight, administration and implementation of Telemedicine services and equipment in compliance with state and Federal laws and the requirements of this contract and all incorporated references. The Telemedicine Coordinator will ensure that Telemedicine is available and utilized when appropriate to ensure geographic accessibility of services to recipients. This person shall also be responsible to assist in the expansion of Telemedicine services, when indicated and appropriate. This individual shall have experience and expertise applicable to this position and its responsibilities.

p. Cultural Sensitivity Coordinator who shall be responsible for designing, implementing, and adjusting the CRS program health delivery system operations to meet the cultural needs of recipients and their families. The position requires significant experience and expertise in the identification of health service delivery components and processes that value and promote health and improved quality of life in diverse cultures.

q. *Ombudsman/Client Advocate Manager who shall be responsible for the coordination and dissemination of communication regarding advocacy on behalf of CRS recipients. This position shall be filled with a full time staff member experienced in working with parents, advocates, and governmental entities that have responsibility for children with disabilities.

Additional Staff Requirement

r. Prior Authorization Staff to authorize health care services 24-hours per day, 7-days per week. This staff should include an Arizona-licensed nurse, physician, or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician, or physician's assistant.

s. ***Concurrent Review Staff** to conduct inpatient concurrent review. The staff shall consist of an Arizona-licensed nurse, physician, or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician, or physician's assistant.

t. ***Clerical and Support Staff** to ensure appropriate handling of the Contractor's operations.

u. **Member Services Staff** to enable members to receive prompt resolution of their inquiries/problems. This staff will be trained in program specifics and sufficient to maintain administrative performance standards required by this contract and Attachments.

v. ***Provider Services Staff** to ensure that providers receive prompt responses and assistance (see Section D, Paragraph 29, Network Management, for more information). This staff will be trained in program specifics and sufficient to maintain administrative performance standards required by this contract and Attachments.

w. **Claims Processing Staff** to ensure the timely and accurate processing of original claims, resubmissions, and overall adjudication of claims. This staff shall be trained in payment Rules related to the CRS program and shall be sufficient to maintain administrative performance standards required by this contract and Attachments.

x. **Encounter Processing Staff** to ensure timely and accurate processing, submission, and resolution of encounter data and reporting.

Staff Training and Meeting Attendance

The Contractor shall ensure that all staff members have appropriate training, education, experience and orientation to fulfill the requirements of the position. The Contractor must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals; contract requirements 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.

The Contractor shall provide the appropriate staff representation for attendance and participation in meetings and/or events scheduled by AHCCCS. All meetings shall be considered mandatory unless otherwise indicated.

17. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

(REFER TO SECTION D)

18. RECIPIENT INFORMATION

The CRS Contractor shall be held to submission, review and approval requirements of Section D, Paragraph 18; ACOM Policy 404; and the additional stipulations of this Paragraph.

The Contractor shall produce and provide the following printed information to each recipient/representative or household within 12 business days of receipt of notification of the enrollment date [42 CFR 438.10(f)(3)]. The Contractor may provide the information in written format or via written notification that the Member Handbook information is available on the Contractor's website per ACOM Policy 404 as applicable:

A CRS recipient handbook, which, at a minimum, shall include the items, listed in the ACOM, Policy 404, and Section D of this contract including the following CRS specific information:

1. How to access covered services
2. Available treatment options for covered conditions;
3. Information to facilitate family members as decision-makers in the treatment planning process;
4. Provider network directory and information regarding how to select or change a clinic, provider or Contractor (if applicable). The Contractor may provide a description of the

provider network in written format or via written notification that the information is available on the Contractor's website per ACOM Policy 404 as applicable.

5. Information regarding the unique needs of children with CRS Conditions and the CRS program for public/private health care insurers, health care providers and students, regional and national health organizations, community groups and organizations and public health and school personnel.

The Contractor shall review and update the Recipient Handbook at least annually as specified in ACOM Policy. The handbook must be submitted to AHCCCS, DHCM for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution.

A description of the Contractor's provider network

The Contractor will, on an annual basis, inform all CRS recipients of their right to request the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)]:

1. An updated recipient handbook at no cost to the recipient; and,
2. The network description

This information may be sent in a separate written communication or included with other written information such as in a recipient newsletter.

19. SURVEYS

Unless waived by AHCCCS, the Contractor shall perform its own annual general or focused recipient survey. The Contractor shall submit the proposed recipient survey tool, sample and distribution methodology and a timeline to AHCCCS for review and approval no later than 90 days prior to the intended start of the survey. The Contractor shall include questions related to appointment waiting time. AHCCCS may require inclusion of certain questions. The results and the analysis of the results shall be submitted to the DHCM Operations within 45 days of the completion of the survey. If requested, survey results should be reported separately by Title XIX and Title XXI categories. The Contractor shall ensure that subcontractors utilize recipient survey findings to improve care for Title XIX and Title XXI members. The results of these surveys are public information and must be available to all interested parties upon request.

20. CULTURAL COMPETENCY

(REFER TO SECTION D)

21. MEDICAL RECORDS

The CRS Contractor shall be held to the standards of Section D, Paragraph 21, Medical Records, with regard to maintenance and review of medical records for CRS recipients. In addition, the stipulations of this Paragraph apply specifically to the CRS Contractor's performance in this subject area.

The Contractor shall have written policies and procedures to ensure that an Integrated Medical Record for each Recipient is maintained for ready access by a multi-specialty treatment team. An Integrated Medical Record shall contain all of the information necessary to facilitate the coordination and quality of care delivered by multiple providers in multiple locations at varying times. In addition, the Contractor shall implement Electronic Medical Records and Health Information Exchange within the CRS network of providers.

The Contractor shall retain medical records in compliance with A.R.S. §§12-2291 and 2297, which requires, among other things, that children's medical records be retained for at least three

(3) years after the child's eighteenth (18th) birthday or for at least six (6) years after the last date the child received medical or health care services from the Provider, whichever date occurs later.

Following termination of this Attachment, AHCCCS shall designate a provider to whom the Contractor shall transfer the medical and other records of all Recipients within fifteen (15) days of the contract termination date. The Contractor shall also supply an alphabetical list of Recipients with the Contractor's assigned medical record number and CRS identification number.

22. ADVANCE DIRECTIVES

(REFER TO SECTION D)

23. QUALITY MANAGEMENT (QM)

The Contractor shall provide quality medical care and services 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 processes. The Contractor shall execute processes to assess, plan, implement and evaluate quality management and performance improvement activities, as specified in the AMPM, that include at least the following [42 CFR 438.240(a)(1) and (e)(2)] and CFR 42 447.26]:

The Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AMPM and Section D, Paragraph 23, of this contract. Activities undertaken in the Quality Management function in performance of the services in the Attachment may be tracked, trended, and analyzed through identical mechanisms to those used for other lines of Arizona Medicaid business, but must be separately identifiable within the Health Information System; uniquely reported through deliverables and requested ad hoc reporting; and all focused discussion must be separately recorded in meeting minutes. 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 900 requirements). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.

Performance Standards [42 CFR 438.240(a)(2), (b)(2) and (c)]:

All Performance Standards described below apply to all recipients. The Contractor must meet AHCCCS stated Minimum Performance Standards. However, it is equally important that the Contractor continually improve its performance measure outcomes from year to year. The Contractor shall strive to meet the goal established by AHCCCS.

The Contractor must use the annual quality management program evaluation to report any statistically significant drop in the Contractor's performance level - for any measure. If the Contractor has a significant drop in any measure, it will be required to submit a corrective action plan and may be subject to sanctions.

AHCCCS has established two levels of performance:

Minimum Performance Standard – A Minimum Performance Standard is the minimally expected level of performance by The Contractor. If The Contractor does not achieve this standard, or the rate for any indicator declines to a level below the AHCCCS Minimum Performance Standard, The Contractor will be required to submit a corrective action plan and may be subject to sanctions.

Goal – The Goal is the ultimate benchmark to be achieved. If The Contractor has already achieved or exceeded the Minimum Performance Standard for any performance measure,

The Contractor must strive to meet the goal for that measure. If The Contractor has achieved the Goal, it is expected to maintain this level of performance in future years.

The Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions on The Contractor if it does not meet the Minimum Performance Standard and does not show statistically significant improvement in any performance measure rate and/or require The Contractor to 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 from The Contractor if a statistically significant decrease in its rate is shown, even if it meets or exceeds the Minimum Performance Standard.

The corrective action plan must be received by AHCCCS within 30 days of receipt of notification from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up on site reviews (on-site or via submission of documents from the Contractor and meeting(s) as requested by AHCCCS) to verify compliance with a corrective action plan.

The following table identifies the Minimum Performance Standards and Goals for each Measure:

CRS Performance Measures

Performance Measure	Minimum Performance Standard	Goal
Timeliness of Eligibility Determination	90%	98%
Timeliness of Initial Service Plan Development	95%	100%
First CRS Service	75%	90%

The Performance Measures are defined as follows:

Timeliness of Eligibility Determination – The percent of AHCCCS members for whom a determination of eligibility was made (i.e., eligible or ineligible) and who were notified in writing of the decision within 14 calendar days of a complete CRS Referral Form* received by the CRS subcontractor, or for whom a determination of eligibility could not be made from the CRS Referral Form and who were notified in writing within 14 calendar days of receipt of the Referral Form that additional information or a medical evaluation was required.**

*A complete CRS Referral Form is one that includes information in all the required fields to be submitted on the form, as specified in the AMPM.

** The Contractor must show documentation of internal monitoring of the accuracy of the determination process, as/when requested by AHCCCS.

Denominator: All AHCCCS-enrolled children (up to 21 years) referred for CRS services during the measurement period.

Numerator: All children in the denominator whose written Notice of Eligibility Determination (NOED) was mailed within 14 calendar days of a complete CRS Referral Form received by the CRS Contractor, or whose written notice that additional information or an initial medical evaluation was required was mailed within 14 calendar days of a CRS Referral Form received by the Contractor.

Measurement Period: October 1, 2011, through September 30, 2012

Data Collection and Validation Process: The Contractor will collect denominator and numerator data from its CRS data systems for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV or text file). At a minimum, The Contractor will provide each member's AHCCCS ID number, name, date of birth, the date the CRS Referral Form was received by the CRS Contractor, the date that the CRS Contractor sent the first written Notice of Eligibility Determination was mailed, and whether the individual was or was not eligible. The Contractor also will provide a data dictionary or other information to AHCCCS necessary to calculate/validate the Contractor's results.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request the Contractor to provide medical chart or other hard copy documentation, such as copies of NOED letters, for validation purposes, or perform such validation through on-site visits.

Timeliness of Initial Service Plan Development: The percent of AHCCCS members for whom an initial service plan (ISP) for CRS services was completed on or before the date of positive eligibility determination by the Contractor.

Denominator: All AHCCCS-enrolled children (up to 21 years) who were determined eligible for CRS services during the measurement period.

Numerator: All children in the denominator for whom an ISP was completed on or before the date of positive eligibility determination by the Contractor.

Measurement Period: October 1, 2011 through September 30, 2012

Data Collection and Validation Process: The Contractor will collect denominator and numerator data from its CRS data system for all AHCCCS members who meet the denominator criteria and provide the information to AHCCCS in a predetermined electronic format (such as Excel, d-BASE IV, or text file). At a minimum, the Contractor will provide each member's AHCCCS ID number, name, date of birth, the date of positive eligibility determination and the date that an ISP was completed. The Contractor also will provide a data dictionary or other information to AHCCCS necessary to calculate/validate the Contractor's results.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request the Contractor to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

First CRS Service: The percent of AHCCCS members who receive their first CRS service by the date specified on the ISP or within 90 calendar days of the date of positive eligibility determination.

Denominator: All AHCCCS-enrolled children (up to 21 years) who were determined eligible for CRS services during the measurement period and who were continuously enrolled for at least 90 days after eligibility determination.

Numerator: All children in the denominator who received their first CRS service by the date specified on the ISP or within 90 calendar days of the date of positive eligibility determination, whichever comes first.

Measurement Period: October 1, 2011, through September 30, 2012

Data Collection and Validation Process: The Contractor will collect denominator and numerator data from its CRS data system for all AHCCCS members who meet the denominator criteria and provide the information to AHCCS in a predetermined electronic format (such as Excel, d-BASE IV, or text file). At a minimum, the Contractor will provide each member's AHCCCS ID number, name, date of birth, the date identified on the ISP by which the first CRS service should be provided, and the actual date the first CRS service was provided. . The Contractor also will provide a data dictionary or other information to AHCCCS necessary to calculate/validate the Contractor's results. AHCCCS may, as an alternate method of collecting data, identify services provided to members in the denominator from its encounter data.

AHCCCS will identify a statistically significant random sample of members who meet the numerator criteria and either request the Contractor to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on site visits.

Performance Improvement Program:

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following [42 CFR 438.240(a)(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; and,
4. Planning and initiation of activities for increasing or sustaining improvement.

The Contractor must submit the self selected proposed PIP methodology to AHCCCS for review and approval by December 15th annually.

The Contractor will conduct the following Performance Improvement Project (PIP):

- Electronic Health Records (eHR) PIP – The purpose of this project is to increase the availability of integrated health information through the use of Electronic Health Records (eHR).

The Contractor shall report the status and results of each project annually to AHCCCS [42 CFR 438.240(d)(2)]. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year [42 CFR 438.240(d)(2)].

24. MEDICAL MANAGEMENT (MM)

The CRS Contractor will be held to the Medical Management standards set forth in Section D, Paragraph 24, Medical Management in their entirety with the consideration of the exceptions and additional requirements listed in this Paragraph.

Initial Service Plan:

The Contractor shall develop a Service Plan for Recipients Enrolled in CRS prior to the contract Effective Date at the time of the Recipient's eligibility re-determination as required in Policy. The Service Plan is a document that combines the various elements of multiple treatment plans with needed family support services and care coordination activities to provide a map of the steps to be taken for each Recipient to achieve treatment and quality of life goals.

Upon Enrollment, the Contractor's Medical Director shall identify the date by which the Recipient shall receive the next Medically Necessary Service(s) in an initial Service Plan. Initial services shall be delivered no later than forty-five (45) days post-enrollment, unless alternative time lines are specified in the Service Plan that are supported by CRS Clinical Evidence Based Practice Guidelines and/or a Recipient's recent treatment history. The only required elements for an Initial Service Plan are the immediate medically necessary CRS service(s) as determined by the Contractor's medical Director or designee and the timeline by which the services must be provided.

A complete service plan will be developed within sixty (60) days of the initial medical visit. This service plan will be comprehensive of the entire needs of the child including the clinics in which the child is enrolled. The Contractor will assure that the database identifying the clinics is current in their system.

Care Coordination:

Subsequently, the Contractor shall require a Care Coordinator to maintain and implement the Service Plan as needed for each Recipient based on the treatment plans developed by the treatment team. The Service Plan shall identify specific agencies or organizations with which treatment must be coordinated and address Recipient-specific barriers to treatment, such as use of out-of-network providers or a Recipient's or family's ability to travel, in compliance with Policy.

The Contractor shall ensure that medical records (copies or summaries of relevant information) of each Title XIX and Title XXI member are forwarded to the Recipient's PCP as needed to support quality medical management and prevent duplication of services. At a minimum, the Contractor or its Subcontractors shall provide notification in writing to the referring physician and the Health Plan/Program Contractor within 30 days of the first service. The Contractor shall also ensure that the updated medical records are forwarded to the Member's PCP.

The Contractor shall establish policies and procedures for ensuring implementation and monitoring of coordination between its employees, Subcontractors, AHCCCS Health Plans, ALTCS Program Contractors, and other State agencies. The Contractor and AHCCCS shall monitor to ensure compliance with these coordination requirements through periodic case file review, trends in Grievance, Appeal and problem resolution data, and other Quality Management activities.

Monitoring and Updating the Service Plan:

In addition, the Service Plan shall identify the individual or entity responsible for service implementation and the dates by which the service shall be initiated. The Contractor shall monitor the Service Plan for timely development and update it as Recipients' needs change. The Contractor shall assist the Recipient and his or her family with adherence to the Plan through scheduling appointments, obtaining transportation, navigating Prior Authorization requirements, advocacy with the school district, or other Case Management strategies as needed.

25. ADMINISTRATIVE PERFORMANCE STANDARDS

(REFER TO SECTION D)

26. GRIEVANCE SYSTEM

(REFER TO SECTION D)

27. NETWORK DEVELOPMENT

The CRS Contractor will be held to all standards of Section D, Paragraph 27, Network Development with regard to building a network capable of providing all covered services to its recipients in a sustainable, accessible, and culturally sensitive manner.

In addition to the requirements of Section D of the contract, the CRS-specific network shall be designed to meet the following standards:

Geographic Accessibility:

The Contractor's network shall provide a geographically dispersed network with convenient access to services for Recipients. Because pediatric sub-specialists are in short supply and concentrated in urban areas, the Contractor shall implement strategies to improve Recipient access to pediatric subspecialties, as well as other provider types for which there are shortages, regardless of the Recipient's place of residence. Access shall be no more restrictive than that available to the general population.

The Contractor's network shall include:

- At least one (1) Multi Specialty Interdisciplinary Clinic (MSIC) sites in the Phoenix metropolitan area, at least one (1) MSIC site in the Tucson metropolitan area, at least one (1) MSIC site in the Prescott/Sedona/Flagstaff area, and at least one (1) MSIC site in the Yuma area. The Contractor shall assess the needs of its Recipients throughout the State and consider the efficient use of its provider resources providing MSICs at additional sites. The types of MSICs and their staffing are included in Exhibit C;

- Physician, laboratory, x-ray and therapy services available onsite at the MSIC and through a network of community-based providers closer to Recipients' homes;

- Innovative service delivery mechanisms such as Field Clinics and Virtual Clinics that incorporate the use of Telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State.

- At least two (2) hospitals in the metropolitan Phoenix area and at least two (2) hospitals within the Tucson metropolitan area.

- Community-based, family support providers in urban, suburban and rural areas of the State.

- Across State border, community-based providers within the United States for Recipients in communities where the normal pattern of receiving health care services includes the use of providers in neighboring states.

Network Capacity

The Contractor shall implement methodologies to maintain, improve and fully utilize its network capacity. Methodologies include, but are not limited to:

- Implementing Field Clinics and Virtual Clinics;
- Using Telemedicine, incorporating up-to-date technology;

- Partnering with community organizations to recruit providers to Arizona and into the network;
- Partnering and collaborating with AHCCCS Contractors regarding transportation to appointments within the Contractor's network that become available in less than seventy-two (72) hours; and
- Providing support to providers in the use of innovative strategies to increase their capacity for Recipients.

Local and State Parent Action Council

The Contractor shall include members and their families in meaningful input to the program in order to provide feedback on performance and the need for improvement. The input may take many forms including but not limited to member surveys, focus group review of material, participation in meetings of executive leadership, complaint data, public forum, etc.

28. EXEMPT

29. NETWORK MANAGEMENT

The CRS Contractor will be held to all standards set forth in Section D, Paragraph 29, Network Management with regard to management of the CRS-specific network built under Paragraph 27 of this Attachment and in accordance with ACOM Policies. Additional focus and requirement for the CRS Contractor is provided in this Paragraph.

The Contractor shall maintain and monitor a network of providers that is supported by written agreements, which is sufficient to provide adequate access to all services covered under the contract [42 CFR 438.206(b)(1)]. In establishing and maintaining the network, The Contractor must consider the following [42 CFR 438.206(b)(1)]:

- Anticipated number of CRS recipients;
- Expected utilization of services, considering recipient characteristics and health care needs;
- Number and types (in terms of training, experience and specialization) of providers required to provide the contracted services;
- Network providers who are not accepting new CRS recipients; and,
- The geographic location of providers and recipients, considering distance, travel time, the means of transportation used by CRS recipients and whether the location provides physical access for CRS recipients with disabilities.

The Contractor shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network. This notification shall include (1) information about how the provider network change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the access to and quality of member care, if the provider network change is likely to affect the delivery of covered services.

See Section D, Paragraph 55 regarding material changes by the Contractor that may impact capitation rates.

30. EXEMPT

31. EXEMPT

32. EXEMPT

33. APPOINTMENT STANDARDS FOR CRS RECIPIENTS

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 and its subcontractors shall have procedures in place that ensure the following standards are met:

1. For a CRS recipient with a medically urgent need, the CRS recipient must be seen according to the needs of the member and no later than 72 hours of the request.
2. All other clinic appointments scheduled within 45 calendar days or less of referral or in accordance with the member's Service Plan, depending on the need of the CRS recipient's medical condition.

The Contractor shall actively monitor the adequacy of its subcontractors' appointment processes and reduce the unnecessary use of alternative methods i.e., emergency room visits [42 CFR 438.206(c)(1)(i)]. The Contractor shall actively monitor and ensure that a recipient's waiting time for a scheduled appointment is no more than 45 minutes, except when the provider is unavailable due to an emergency.

If another AHCCCS Contractor is required to render any CRS covered service due to The Contractor's failure to meet medically necessary appointment standards, The Contractor shall be financially responsible for those services as specified in the AMPM Chapter 400, Children's Rehabilitative Services Medically Necessary Appointment Policy.

Missed appointments shall be rescheduled in a timely manner. In the event a recipient misses an appointment, The Contractor shall work with the family to ensure the appointment is rescheduled no later than 45 days unless medical judgment warrants an earlier appointment.

The Contractor shall have written policies and procedure about educating its provider network regarding appointment time requirements. The Contractor must develop a corrective action plan when appointment standards are not met. If appropriate, the corrective action plan should be developed in conjunction with subcontractor(s) [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. The Contractor shall be subject to sanction for failure to address subcontractors that do not meet appointment standards. Appointment standards shall be included in the Policies and Procedure Manual. The Contractor is encouraged to include the standards in the provider subcontract.

If a CRS recipient needs medically necessary non-emergency transportation, The Contractor shall notify and coordinate with the health plan or program Contractor to arrange transportation for AHCCCS members.

34. EXEMPT

35. PROVIDER POLICY AND PROCEDURE MANUAL

The CRS Contractor is required to maintain a separate Policy and Procedure Manual for network providers. The Manual must be compliant with ACOM, Policy 416.

36. PROVIDER REGISTRATION

(REFER TO SECTION D)

37. SUBCONTRACTS AND SUBCONTRACTOR MANAGEMENT

(REFER TO SECTION D)

38. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

The CRS Contractor is held to all standards and requirement of Section D, Paragraph 38, Claim Payment/Health Information System, with the exception that processing rates are:

- 90% of all clean claims are paid within 30 days of receipt of the clean claim; and
- 99% are paid within 60 days of receipt of the clean claim.

39. EXEMPT

40. EXEMPT

41. EXEMPT

42. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

(REFER TO SECTION D)

43. MANAGEMENT SERVICES AGREEMENT AND COST ALLOCATION PLAN

(REFER TO SECTION D)

44. EXEMPT

45. EXEMPT

46. PERFORMANCE BOND OR BOND SUBSTITUTE

(REFER TO SECTION D)

47. AMOUNT OF PERFORMANCE BOND

(REFER TO SECTION D)

48. ACCUMULATED FUND DEFICIT

(REFER TO SECTION D)

49. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

(REFER TO SECTION D)

50. 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: Current Ratio; Equity per Member; Medical Expense Ratio; and the 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 the Contractor fails to achieve the standard in a critical combination of Financial Viability Standards, or if the Contractor's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required.

FINANCIAL VIABILITY STANDARDS

Current Ratio	Current assets divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%). Standard: At least 1.00 If current assets include a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.
Equity per Member	Unrestricted equity, less on-balance sheet performance bond, divided by the number of members enrolled at the end of the period. Standard: At least $150 per member Additional information regarding the Equity per Member requirement may be found in the Performance Bond and Equity per Member Requirements policy in the ACOM Policy 305.
Medical Expense Ratio	Total medical expenses less TPL divided by the sum of total capitation + reconciliation settlements + Reinsurance less premium tax Standard: At least 85%
Administrative Cost Percentage	Total administrative expenses divided by the sum of total capitation + reconciliation settlements + Reinsurance less premium tax Standard: No greater than 13%

The Contractor shall comply with all financial reporting requirements contained in Attachment F, Periodic Report Requirements and the AHCCCS Reporting Guide for Acute Health Care Contractors with the Arizona Health Care Cost Containment System, 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 F, Periodic Report Requirements.

51. EXEMPT

52. EXEMPT

53. COMPENSATION

Capitation Payments:

AHCCCS will pay a per-recipient per-month capitation rate for all prospective recipient months as determined by AHCCCS, including partial recipient months. AHCCCS will make monthly capitation payments for each CRS recipient on the first of the month based on the previous month's AHCCCS/CRS recipient count. Payment shall be made not later than the end of the month for the previous month for which payment is due.

After the close of the final month of the contract, reconciliation will be made for the final month's recipient months adjusted by the payments made during the first month of the contract.

The Contractor will be paid a statewide blended capitation rate. Capitation rates represent the cost of providing covered CRS services to the CRS recipient. The capitation received shall represent payment in full for any and all covered services provided to the recipient, including administrative costs.

Reconciliation of Costs to Reimbursement: AHCCCS will reconcile the Contractor's medical costs to net capitation paid to the Contractor for dates of service during the contract year being reconciled. Refer to the CRS Reconciliation Policy for further details.

For services or pharmaceuticals, in instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement, the amount to be used in the capitation rate setting process and reconciliations will be the lesser of the contracted/mandated amount or the Contractor paid amount.

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

An error discovered by the State with or without an audit in the amount of fees paid will be subject to adjustment or repayment by the Contractor by making a corresponding decrease in a current payment or by making an additional payment by AHCCCS to the Contractor.

Payments made by AHCCCS are conditioned upon the receipt by AHCCCS of applicable, accurate and complete reports required to be submitted under this contract.

54. PAYMENTS TO CONTRACTORS

(REFER TO SECTION D)

55. CAPITATION ADJUSTMENTS

Except for changes made specifically in accordance with this contract, the rates set forth in this Attachment shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review the effect of a program changes, legislative requirements, Contractor experience, actuarial assumptions, and/or Contractor specific capitation factors to determine if a capitation adjustment is needed. In these instances the adjustment and assumptions will 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 CRS Contractor is responsible for notifying AHCCCS of program and/or expenditure changes initiated by the Contractor during the contract period that may result in material changes to the current or future capitation rates.

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.

56. MEMBER BILLING AND LIABILITY FOR PAYMENT
(REFER TO SECTION D)

57. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered services, as described below, for a Title XIX or Title XXI eligible CRS member with an acute medical CRS condition with expenditures beyond an annual deductible level. AHCCCS funds the reinsurance program through a deduction to capitation rates.

Refer to the AHCCCS Reinsurance Processing Manual for further details on the Reinsurance Program.

Reinsurance Case Types
For all reinsurance case types, 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

Regular reinsurance covers partial reimbursement of covered inpatient facility medical services. See the table below for applicable deductible levels and coinsurance percentages. The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered inpatient services incurred above the deductible. The deductible is the responsibility of the Contractor.

The following table represents deductible and coinsurance levels:

Annual Deductible	Coinsurance
$75,000	75%

For contract year beginning October 1, 2012, and annually thereafter, the deductible levels above may increase by $5,000.

Catastrophic Reinsurance

The reinsurance program includes a special Catastrophic Reinsurance program. This program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with Gaucher's Disease. For additional detail and restrictions refer to the AHCCCS Reinsurance Processing Manual and the AMPM. There are no deductibles for catastrophic reinsurance cases. For those members diagnosed with 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, depending on the subcap code. For members receiving certain biotech drugs listed below, only the drug costs will be covered under the Catastrophic Reinsurance Program. All catastrophic claims are subject to medical review by AHCCCS.

The Contractor shall notify AHCCCS Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of

1. Initial diagnosis,
2. Enrollment with the Contractor, and
3. Beginning of each contract year, by October 30.

Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria:

1. Severity of medical condition, including prognosis; and
2. The average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

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

Biotech Drug Reinsurance:
Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor when used in the treatment of a CRS covered condition. Catastrophic reinsurance will cover the drug cost only. Refer to the AHCCCS Reinsurance Processing Manual for a list of covered drugs. The Biotech Drugs covered under reinsurance may be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug cost or its generic equivalent for reinsurance purposes.

Other Reinsurance:
For all reinsurance case types, Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case total value meets or exceeds $650,000 (total health plan paid amount including the deductible). Once this level is met, the Contractor must notify, via email, the AHCCCS Reinsurance Supervisor in order to receive enhanced Reinsurance benefits. Reinsurance Case Approved Amounts over $650,000 are transferred to a newly manually created case per the request of the Contractor. The Contractor is required to split encounters as necessary once the reinsurance case reaches $650,000. Failure to notify AHCCCS or failure to split and adjudicate encounters appropriately within 15 months from the end date or 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 claim status within 15 months from the end date of service, or date of eligibility posting, whichever is later. Association of an encounter to a reinsurance case does not guarantee eligibility for reinsurance reimbursement.

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 65, Encounter Data Reporting, for encounter reporting requirements.

Payment of Regular and Catastrophic Reinsurance Cases: AHCCCS will reimburse a 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, 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.

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 Contractors will be given appropriate advance notice.

58. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

The Contractor will be held to the requirements and standards of Section D, Paragraph 58, Coordination of Benefits, with the following amendment:

Cost Avoidance/Recovery Report: The Contractor shall report on a quarterly basis a summary of their cost avoidance/recovery activity. The report shall be submitted in a format as specified in the AHCCCS Program Integrity Reporting Guide.

59. COPAYMENTS

The CRS Contractor is required to apply copayments as per ACOM Policy 431 and other direction by AHCCCS. Most of the AHCCCS members remain exempt from copayments while others are subject to optional or mandatory copayments. Those populations exempt or subject to optional copayments may not be denied services for the

inability to pay the copayment [42 CFR 438.108]. However, for those populations subject to mandatory copayments services may be denied for the inability to pay the copayment. Any copayments collected shall belong to the CRS Contractor or its subcontractors.

60. MEDICARE SERVICES AND COST SHARING

(REFER TO SECTION D)

61. EXEMPT

62. CORPORATE COMPLIANCE

(REFER TO SECTION D)

63. RECORDS RETENTION

The CRS Contractor will be held to the requirements set forth in Section D, Paragraph 63, Records Retention, with the following additional requirement:

All records must be maintained until 3 years after the member has exceeded the age of 18 years or for at least six (6) years after the last date the child received medical or health care services from the Provider, whichever date occurs later.

64. DATA EXCHANGE REQUIREMENTS

(REFER TO SECTION D)

65. ENCOUNTER DATA REPORTING

(REFER TO SECTION D)

66. RECIPIENT/MEMBER DATA EXCHANGE

Recipient/ Member Monthly Data: The Contractor shall transmit on at least a monthly basis, via electronic transfer, the names and other required data for the recipients currently CRS eligible or who were CRS eligible at any time in the prior six months for which CRS covered services were provided. This automated notification process shall include information in the prescribed format including:

a. Information to identify member
b. Effective dates of CRS entitlement
c. Assigned Risk level
d. Primary Diagnosis code

67. PERIODIC REPORT REQUIREMENTS (CRS TABLES)

Annual Reports

REPORT	REPORTING PERIOD	DUE DATE	AHCCCS CONTACT
Written Description of Covered Services (Sec. D., ¶10, Scope of Services)	Annual	October 1	DHCM, CQM
Medical Eligibility Criteria	Annual	October 1, and upon	DHCM, CQM

Policy (Sec. D., ¶2, Eligibility for Services)		revision	
Business Continuity and Recovery Plan Summary (Business Continuity and Recovery Plan Policy)	Annual	October 15	DHCM Operations and Compliance Officer
Cultural Competency Plan and Assessment of Effectiveness (Sec. D., ¶20, Cultural Competency)	Annual	November 14	DHCM Operations and Compliance Officer
Provider Network Development and Management Plan (Sec. D., ¶29, Network Management)	Annual	November 14	DHCM Operations and Compliance Officer
CRS Organizational chart and related documents (Sec. D., ¶16, Staff Requirements and Support Services)	Annual	November 30	DHCM Operations and Compliance Officer
Recipient Handbook (Sec. D., ¶18, Recipient Information)	Annual	Within four weeks of receiving the annual amendment and upon any changes prior to distribution	DHCM Operations and Compliance Officer s
Annual Subcontractor Assignment and Evaluation Report (Sec. D. ¶37, Subcontracts)	Annual	January 1	DHCM Operations and Compliance Officer
Recipient Survey Tool, Sample, Distribution Methodology and Timeline (Sec. D., ¶19, Survey)	Annual	90 days prior to the intended start	DHCM Operations and Compliance Officer
Recipient Survey Results and Analysis (Sec. D., ¶19, Survey)	Annual	Within 45 days of the completion	DHCM Operations and Compliance Officer
Draft Annual Audit Report (Reporting Guide for Acute Care Contractors)	Annual	90 days after end of fiscal year	DHCM, Financial Manager
Final Annual Audit Report (Reporting Guide for Acute Care Contractors)	Annual	120 days after end of fiscal year	DHCM, Financial Manager
Performance Improvement Project Proposal (Initial/baseline year of the project) (Sec. D., ¶23, Quality Management)	Annual	December 15	DHCM, CQM
Performance Improvement Project Re-measurement Report	Annual	December 15	DHCM, CQM

(Sec. D., ¶23, Quality Management)			
Performance Improvement Project Final Report (Sec. D., ¶23, Quality Management)	Annual	December 15	DHCM, CQM
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with Document)	Annual	March 15, 2011, December 15, 2012	DHCM, CQM
Medical Management Plan (Sec. D, ¶24, Medical Management)	Annual	December 15	DHCM, Medical Management
Annual HIPAA Security and Privacy Audit Review (Sec D, ¶64, Data Exchange Requirements)	Annual	90 days after the beginning of the contract year (**Suspended**)	Operations and Compliance Officer
Annual Website Certification (Sec D, ¶ 18 Recipient Information)	Annual	Within 45 days after the beginning of the contract year	Operations and Compliance Officer

Quarterly Reports

REPORT	REPORTING PERIOD	DUE DATE	AHCCCS CONTACT
Quarterly QM Report	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30	45 days after the end of each quarter	DHCM, CQM
Quarterly Eligibility Determination Review (Sec. D., ¶2, Eligibility for Services)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30	45 days after the end of each quarter	DHCM, CQM
Quarterly Inpatient Hospital Showing	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30	November 14 Feb. 15 May 15 August 14	DHCM, Medical Management
Quarterly Financial Report Package (Reporting Guide For Acute Health Care Contractors)	July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30	60 days after the end of the quarter	DHCM, Financial Manager
Premium Tax Reporting (ACOM Policy 304)	Jan 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	March 15th, June 15th, September 15th and December 15th	DHCM, Finance Manager
Quarterly Verification of Receipt of Paid Services (Section D, ¶19 and ACOM Policy 424)	Oct. – Dec. due April 15 Jan. – March due July 15 April – June	Due the 15th day after the end of the quarter that follows the	DHCM, Finance Manager

	due Oct. 15 July – Sept. due Jan. 15	reporting quarter	
Quarterly Cost Avoidance/Recovery Report (Section D, ¶ 58 and the AHCCCS Program Integrity Reporting Guide)	Oct - Dec due Feb 14 Jan – March due May 15 Apr – June due August 14 July – Sept due Nov 14	Due 45 days after the reporting quarter	DHCM Finance Manager
Quarterly Provider/Network Changes Due To Rates (ACOM Policy 415)	Oct – Dec due Jan 15 Jan – March due April 15 April – June due July 15 July – Sept due Oct 15	15 days after the end of each quarter	DHCM Operations and Compliance Officer
Encounter Submission and Tracking	Quarterly	15 days after the end of each quarter	DHCM, Encounter Administrator
Plan Overrides	Quarterly	15 days after the end of each quarter	DHCM, Encounter Administrator
Plan Voids	Quarterly	15 days after the end of each quarter	DHCM, Encounter Administrator

Monthly Reports

REPORT	REPORTING PERIOD	DUE DATE	AHCCCS CONTACT
Corrected Pended Encounter Data (Attachment E, Encounter Submission Requirements)	Monthly	Monthly according to established schedule	DHCM, Encounter Administrator
New Day Encounter (Attachment E, Encounter Submission Requirements)	Monthly	Monthly according to established schedule	DHCM, Encounter Administrator
Claims Dashboard	Monthly	15th day of each month following the reporting period	DHCM, Operations and Compliance Officer
Administrative Measures	Monthly	15th day of each month following the reporting period	DHCM, Operations and Compliance Officer
Grievance System Report	Monthly	See Grievance System Reporting	DHCM, Operations and Compliance Officer

		Guide for frequency	
CRS Member Summary Report	20 days after the end of the month	Specifications shall be determined after review of needs/use of the data	Clinical Quality Management Administrator

Ad Hoc Reports

REPORT	DUE DATE	AHCCCS CONTACT
Changes in CRS Key Staff, (Sec. D., ¶11, Staff Requirements and Support Services)	Within 7 days of change	DHCM, Operations and Compliance Officer
CRS Subcontracts (Sec. D., ¶37, Subcontracts)	At least 60 days prior to the beginning date of the contract	DHCM, Operations and Compliance Officer
Network Impairment Notice, (Sec. D., ¶29, Network Management)	Within 1 day of awareness	DHCM, Operations and Compliance Officer
Subcontractor Non-Compliance and the Corrective Measures Taken, (Sec. D. ¶37, Subcontracts and Subcontractor Management)	Within 5 working days of any action taken	DHCM, Acute Care Operations
Eligible Person Fraud/Abuse Report, (Sec. D., ¶62, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
Provider Fraud/Abuse Report, (Sec. D., ¶62, Corporate Compliance and Attachment A, ¶13, Fraud and Abuse)	Within 10 working days of discovery	Office of Program Integrity Manager
Medical Records for Data Validation, (Sec. D., ¶66 Encounter Data Reporting)	90 days after the request received from AHCCCS	DHCM, Encounter Administrator
Third Party Liability Identification, (Sec. D., ¶58, Coordination of Benefits)	Within 10 days of discovery	DBF Contracts & Purchasing
Third Party Liability Changes (Sec. D., ¶58, Coordination of Benefits)	Upon discovery	DBF Contracts & Purchasing
System Change Notification and Project Plan (Sec. D, ¶38, Claims Payment/Health Information System)	Six months prior to expected implementation	DHCM, Operations and Compliance Officer

68. REQUESTS FOR INFORMATION

(REFER TO SECTION D)

69. DISSEMINATION OF INFORMATION

(REFER TO SECTION D)

70. EXEMPT

71. OPERATIONAL AND FINANCIAL REVIEWS

(REFER TO SECTION D)

72. SANCTIONS

AHCCCS shall impose on The Contractor any financial penalties or disallowances imposed on the State by the Federal government related to The Contractor's performance under this Agreement. The imposition of these sanctions upon The Contractor shall not be levied until such time as the Federal government shall have actually imposed sanctions upon the State for conduct related to The Contractor's performance under this Agreement. AHCCCS shall confer with The Contractor concerning defenses or objections to the imposition of such sanctions at all stages of the sanction process. In the event that the Federal government imposes sanctions upon the state, The Contractor shall reimburse AHCCCS upon demand any such sanction or disallowance amount or any amount determined by the Federal government to be unallowable, after exhaustion of the appeals process (if Federal regulations so permit) as long as the Federal government does not levy the sanctions until after the appeals process is completed. The Contractor shall bear the administrative cost of such an appeals process.

73. BUSINESS CONTINUITY AND RECOVERY PLAN

(REFER TO SECTION D)

74. TECHNOLOGICAL ADVANCEMENT

(REFER TO SECTION D)

75. PENDING LEGISLATIVE/OTHER ISSUES

(REFER TO SECTION D)

76. EXEMPT

77. ADMINISTRATIVE COORDINATION

Due to the nature of the services provided under the Attachment and extensive need for coordination with other AHCCCS services, the Contractor and AHCCCS shall meet periodically to review administrative and operational issues.

78. COLLABORATION

The Contractor shall collaborate with AHCCCS in identifying and applying best practices for the community planning process to improve integration of care to enhance the quality of care provided to recipients. The Contractor shall collaborate with AHCCCS at minimum, but not limited to, in identifying the scope and goals of this collaborative process.

79. CURRENT PERFORMANCE IMPROVEMENT PROJECT METHODOLOGIES

Electronic Health Information Performance Improvement Project For Members Receiving Children's Rehabilitative Services

Background

Children's Rehabilitative Services (CRS) is a unique health care program that provides services to children under age 21 with certain chronic and disabling health conditions. Eligibility requirements are based on medical conditions and many of the children require complex care and are medically fragile. For these children, health care involves multiple clinicians, covering the entire continuum of care. Within CRS, the physician who sees the child is not a primary care physician, but rather a subspecialist who has been managing care related to the child's CRS condition and coordinating with other specialty services, including specialty pharmacy, durable medical equipment, therapists, diagnostic services, and even telemedicine visits.

CRS care is driven by a multi-disciplinary team made up of other subspecialists and caregivers such as pulmonologists, cardiologists, nutritionists, psychologists, registered nurse coordinators, therapists, and social workers. The lead specialist is assigned to the child to act as the care coordinator. Over time, the child may transition to several lead specialists, as their treatment needs change. For instance, a child may start the program with a pediatric screening clinic, then move to a craniofacial/orofacial clinic, and then to a dental/orthodontia clinic. Because of the complexity of the needs of these children requiring multiple surgeries, hospitalization, and clinical care it is imperative that there be integrated health information for the member. Historically, this was accomplished by limiting the access to care points for the child so these records and the care could be more readily coordinated. Surgeries, hospitalizations, and clinics were only allowed to occur in a very limited number of locations and the majority of clinics relied upon on site pharmacies.

Arizona Physicians IPA (APIPA) subcontracts with four multi-specialty interdisciplinary clinics (MSICs): Yuma MSIC (Yuma Regional Medical Center), Phoenix MSIC (St. Joseph's Medical Center), Flagstaff MSIC (Flagstaff Medical Center), and Tucson MSIC (Tucson Children's Clinic). In the coming years, APIPA-CRS will work toward expanding the number of community clinics. Information related to patient care through an Electronic Health Records (eHR) system will help support this goal.

eHRs and Improved Outcomes

The eHR is vital to patient care coordination and accessing integrated health information. The eHR provides clinicians with timely access to patients' clinical history and facilitates with shared access to health information. Use of an eHR for the CRS population is expected to increase the clinician's ability to manage complex conditions efficiently and effectively.

There is a growing body of literature that suggests the use of eHRs can improve patient outcomes. Weber et al. (2008) found improvement in diabetes care in response to a multifaceted intervention featuring the use of an eHR-derived registry. There were significant increases in vaccinations for pneumococcal disease and influenza, as well as increases in the percent of patients with ideal glucose and blood pressure control.[1] Another study found that the implementation of an eHR system reduced the use of ambulatory care while maintaining quality and allowed doctors to replace some office visits with telephone contacts.[2]

An eHR also promotes reduction of redundant services and reduces medical errors and drug interactions. For example, electronically stored results of tests such as laboratory tests or an MRI or CT scan can be readily accessible to a wider range of providers, reducing the need for a repeated procedure. Integrating records with a pharmacy can tell a provider whether a patient hasn't filled a prescription.[3] There are many ways in which eHRs can minimize diagnostic errors. An eHR system filters, organizes, and provides access to information; serves as a place where clinicians can document evaluations and note unanswered questions; facilitates the documentation of evolving history, ongoing assessment, and follow-up; and ensures reliable communication and action in the areas of ordering tests and tracking results.[4]

Current Status

APIPA-CRS made substantial strides toward developing an electronic infrastructure with support from Title V resources made available through ADHS and substantial APIPA-CRS IT investments. Further development of an electronic infrastructure was enabled by a grant from United Health Care Foundation of Arizona provided at the request of APIPA-CRS to the four statewide MSICs.

A new system has been developed for statewide member enrollment to begin capturing some medical record information at the time of application along with an electronic Service Plan for new CRS members within 90 days of enrollment. APIPA-CRS has created a template for the electronic Service Plan to incorporate claims payment and authorization data. APIPA-CRS has also created a standard report format of this information to be included in the patient's chart at the time of scheduled appointments. Service Plans are electronically available to the four current MSICs by way of an MS-Access database that is posted to a secure website, which is used to exchange information between APIPA-CRS and the MSIC providers. CRS members for whom a Service Plan has been created may be searched and accessed by the member's name and CRS Member ID.

There are many limitations to the current Service Plan database including data consistency and access. Currently, the demographic information is limited to the quality of the data received at the time of enrollment and any requests for updates to this data received through Member Services. Data elements are not consistent and have not been validated. Sharing of the data is cumbersome and providers are not able to access the information in a timely manner.

This PIP will address these limitations by implementing a new application and providing timely access to health information by MSIC providers via a web-based registry that will serve as an electronic health record for each CRS recipient. The data in the current Service Plan database will be loaded into the new application. After an Initial Service Plan (ISP) is completed by MSIC staff at the time an AHCCCS member is determined eligible for CRS services, these data also will be loaded into the web application. More data will be incorporated into the eHR as newly enrolled recipients have their first CRS services, which as to occur within the timeframe specified in the ISP or within 90 days of eligibility determination. As capabilities are integrated, data will be validated with system checks and direct updates received at the time of registration and check-in at the clinics.

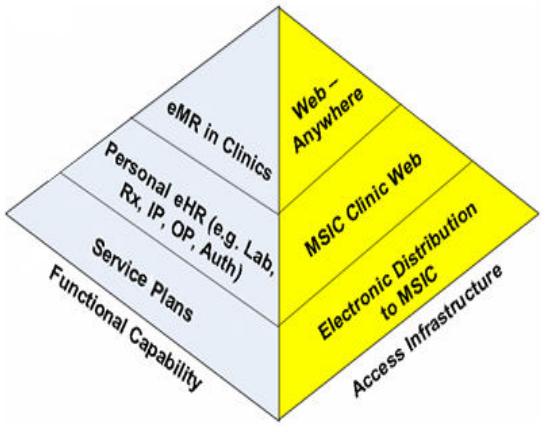
Once the eHR is implemented, all data sources will feed directly into the eHR application and information for approximately 21,000 CRS members will be accessible at the MSICs. Communication of this pending change has been provided to the four current MSICs.

Purpose

The purpose of this PIP is to advance the use of electronic records by CRS providers at contracted MSICs. As eMR capabilities evolve within the delivery network that provides services to Medicaid-eligible children with special health care needs, providers will progress in their abilities to meet meaningful use criteria for electronic health records, including incorporation of lab data into those records, under the 2009 American Recovery and Reinvestment Act.

There are two fundamental issues to be addressed in this PIP: functional capability and access. Functional capability includes capturing data related to the member's care such as procedures, medications, and lab tests. Once functional capability has been established, additional infrastructure development must be in place in order for providers to access this information. The bottom two tiers of Figure 1 illustrate the components of this PIP.

Figure 1



The PIP focuses on the development of system capability and its implementation, along two dimensions:

1) Capturing data elements and
2) Making them available electronically to CRS providers at the MSICs.

Measurement Periods

- Baseline Measurement: October 1, 2010, through September 30, 2011
- Intervention Year: October 1, 2011, through September 30, 2012
- Remeasurement I: October 1, 2012, through September 30, 2013 (Report completed by December 15, 2014)
- Remeasurement II: October 1, 2013 through September 30, 2014 (Report completed by December 15, 2015)

Study Question

What proportion of CRS recipients have clinical laboratory test results incorporated into the web-based eHR within 90 days of the ordering office visit?

Indicator Description

The eHR will include demographic, authorization, claims, laboratory, prescription, and social history data. Although the eHR system will include various types of data, the measurement of this PIP will focus on clinical laboratory tests. The indicator is defined as:

The number and percent of unique CRS recipients for whom clinical laboratory test results are incorporated into the eHR as structured data in a positive/negative or numeric format within 90 days of the ordering office visit.

Indicator Criteria

The indictor criteria will be met when:

- The eHR contains results of one or more laboratory tests conducted within 90 days of positive eligibility determination, and
- results are recorded as structured data in a positive/negative or numeric format.

Interventions

1. Provide eHR web application training to providers and staff at MSICs.
2. Monitor data completeness at regular intervals during the intervention period?
3. Provide feedback to MSICs regarding data completeness.
4. Provide additional training/technical assistance as needed.

Population

The population will consist of AHCCCS-enrolled members who also are receiving services through CRS. This includes more than 17,000 AHCCCS members younger than 21 years of age eligible under the Medicaid program (Title XIX of the Social Security Act) and approximately 1,000 members younger than 19 years of age who are enrolled in KidsCare (Title XXI).

Population Inclusion

The population will include members who have had a CRS provider order a minimum of one clinical lab or more in the measurement period.

Population Exclusions

- Members who do not have a minimum of one or more clinical labs ordered by a CRS provider within the measurement period will not be included.
- Members not enrolled under Title XIX or Title XXI will not be included.

Sample Frame

All members who qualify for inclusion in the population will be included; no sampling will be done.

Population Stratification

None

Denominator

The total number of unduplicated AHCCCS members who meet the population inclusion criteria during the measurement period

Numerator

The number of members in the denominator for whom clinical laboratory test results are incorporated into the eHR as structured data in a positive/negative or numeric format within 90 days of the ordering office visit.

Indicator Goals

The Centers for Medicare and Medicaid Services (CMS) has set an initial threshold for Medicare and Medicaid providers to meet in order to qualify for incentive payments for adoption and meaningful use of eHRs. The First Remeasurement goal for this PIP is based on that threshold.

Remeasurement I Goal = 40%
Remeasurement II Goal = 50%

Data Sources

The data source for both denominator and numerator data will consist of eHR data contained in the web-based registry application.

Data Collection

APIPA-CRS collect data from its eHR application. Data will be refreshed and updated over the course of the PIP.

Data Validation

- All professional claims and encounters (HCFA 1500s) from lab vendors will be unduplicated by member and date of service, and a match in the eHR will be conducted to look for results associated with each observation. APIPA-CRS staff will audit a random sample of eHR data annually for completeness and validity. These results will be included in annual reports to AHCCCS regarding the PIP's progress.

- AHCCCS may identify a statistically significant random sample of members who meet the numerator criteria and either request data and supporting documentation for validation purposes, or perform such validation through on site visits.

Analysis Plan

- The numerator will be divided by the denominator to determine the overall percentage for each measurement. Statistical analysis will be conducted to determine whether the overall rate for each remeasurement represents a statistically significant change from the previous measurement.
- Data also will be analyzed by MSIC and other stratifications as deemed appropriate (e.g., diagnosis category, type of test, etc.)

Comparative Analysis

- Analysis of rates for each measurement will be compared to goals.
- Rates by MSIC will be compared to each other and to previous results for each clinic, as well as any other stratifications deemed appropriate.

Confidentiality Plan

All data collection, analysis and reporting processes will protect member confidentiality in compliance with Health Insurance Portability and Accountability Act (HIPAA) guidelines.

- To prevent unauthorized access, data files are maintained on a secure, password-protected computer.
- Requested data are used only for the purpose of performing health care operations, oversight of the health care system, or research.
- All publicly reported information will be in aggregate form with no identifiers that could be associated with an individual member.
- Only APIPA-CRS and AHCCCS staff involved in collecting, analyzing and/or validating results will have access to member-specific study data.
- All personnel who have access to member-specific study data will have signed confidentiality agreements and completed training on HIPAA regulations.

References

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[END OF ATTACHMENT]