

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

1. AMENDMENT NO.:	2. CONTRACT NO.:  <b>YH12-0001</b>	3. EFFECTIVE DATE OF AMENDMENT:  <b>August 1, 2013</b>	4. PROGRAM:  <b>ALTCS EPD</b>
5. CONTRACTOR/PROVIDER NAME AND ADDRESS:			
6. PURPOSE: To amend Section D, Program Requirements, including Cost Settlement for Primary Care Payment Parity, and Section F, Attachments.			

7. THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

A. Section D, Program Requirements

Revisions include Paragraph 56, Compensation, Cost Settlement for Primary Care Payment Parity.

B. Section F, Attachments

Please refer to the individual contract sections for additional changes.

*Note: Please sign, date and return executed file by E-Mail to: Meggan Harley at meggan.harley@azahcccs.gov Contracts Manager, AHCCCS Contracts & Purchasing and Julie Ambur, Contracts and Policy Administrator, at julie.ambur@azahcccs.gov, Division of Health Care Management*

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT.	
IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.	
9. NAME OF CONTRACTOR:  <b>DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</b>	10. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  <b>DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</b>
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME:	TYPED NAME:  <b>MICHAEL VEIT</b>
TITLE:	TITLE:  <b>CONTRACTS AND PURCHASING ADMINISTRATOR</b>
DATE:	DATE:

**TABLE OF CONTENTS**

**SECTION A. OFFEROR ACCEPTANCE AND SIGNATURE PAGE ..... 1**

**SECTION B. CAPITATION RATES AND CONTRACTOR SPECIFIC INFORMATION..... 5**

**SECTION C. DEFINITIONS ..... 6**

**SECTION D. PROGRAM REQUIREMENTS ..... 16**

1. PURPOSE AND APPLICABILITY ..... 16

2. INTRODUCTION..... 16

AHCCCS’ Mission and Vision ..... 16

The ALTCS Program: ..... 16

ALTCS Guiding Principles ..... 16

ALTCS Eligibility: ..... 17

3. ENROLLMENT AND DISENROLLMENT ..... 17

4. OPEN/ANNUAL ENROLLMENT..... 18

5. ENROLLMENT HIERARCHY ..... 19

6. PLAN CHANGES..... 20

7. COUNTY OF FISCAL RESPONSIBILITY ..... 20

8. TRANSITION ACTIVITIES ..... 20

9. AHCCCS GUIDELINES, POLICIES AND MANUALS ..... 23

10. COVERED SERVICES ..... 23

ACUTE CARE SERVICES ..... 24

LONG TERM CARE SERVICES ..... 31

11. THERAPEUTIC LEAVE AND BED HOLD..... 35

12. BEHAVIORAL HEALTH ..... 35

13. CHILDREN’S REHABILITATIVE SERVICES ..... 37

14. OUT OF SERVICE AREA AND OUT-OF-STATE PLACEMENT..... 38

15. ALTCS TRANSITIONAL PROGRAM..... 39

16. CASE MANAGEMENT ..... 39

17. MEMBER HANDBOOK AND MEMBER COMMUNICATIONS..... 42

18. REPORTING CHANGES IN MEMBERS’ CIRCUMSTANCES ..... 44

19. PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR) ..... 44

20. QUALITY MANAGEMENT ..... 44

21. MEDICAL MANAGEMENT ..... 48

22. GRIEVANCE SYSTEM ..... 49

23. MATERNITY CARE PROVIDER STANDARDS..... 50

24. MEMBER COUNCILS..... 51

25. STAFF REQUIREMENTS AND SUPPORT SERVICES ..... 51

26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS ..... 56

27. MEDICAL DIRECTOR ..... 56

28. NETWORK DEVELOPMENT..... 57

29. NETWORK MANAGEMENT ..... 63

30. PROVIDER MANUAL ..... 64

31. PROVIDER REGISTRATION ..... 64

32. PROVIDER AFFILIATION TRANSMISSION ..... 65

33. SUBCONTRACTS ..... 65

34. ADVANCE DIRECTIVES ..... 68

35. SPECIALTY CONTRACTS..... 69

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT ..... 69

37. PRIMARY CARE PROVIDER STANDARDS..... 70

38. APPOINTMENT STANDARDS ..... 71

39. INCENTIVES/PAY FOR PERFORMANCE ..... 72

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS .....	74
41. MAINSTREAMING OF ALTCS MEMBERS .....	74
42. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs).....	75
43. RESERVED .....	76
44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM.....	76
45. MINIMUM CAPITALIZATION REQUIREMENTS .....	80
46. PERFORMANCE BOND OR BOND SUBSTITUTE .....	81
47. AMOUNT OF PERFORMANCE BOND .....	82
48. ACCUMULATED FUND DEFICIT.....	82
49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLANS.....	82
50. ADVANCES, DISTRIBUTIONS AND LOANS.....	83
51. RESERVED .....	83
52. FINANCIAL VIABILITY STANDARDS.....	83
53. SEPARATE INCORPORATION .....	84
54. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP .....	84
55. RESERVED .....	84
56. COMPENSATION .....	84
57. MEMBER BILLING AND LIABILITY FOR PAYMENT.....	87
58. REINSURANCE.....	88
59. CAPITATION ADJUSTMENTS.....	91
60. MEMBER SHARE OF COST.....	92
61. COPAYMENTS.....	93
62. PEDIATRIC IMMUNIZATIONS AND THE VACCINE FOR CHILDREN PROGRAM .....	93
63. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY .....	93
64. MEDICARE SERVICES AND COST SHARING .....	98
65. MARKETING.....	98
66. SURVEYS .....	99
67. PATIENT TRUST ACCOUNT MONITORING .....	99
68. RESERVED .....	99
69. CULTURAL COMPETENCY.....	99
70. CORPORATE COMPLIANCE .....	100
71. RECORDS RETENTION .....	103
72. RESERVED .....	103
73. DATA EXCHANGE REQUIREMENTS .....	103
74. ENCOUNTER DATA REPORTING.....	106
75. REPORTING REQUIREMENTS.....	107
76. REQUESTS FOR INFORMATION .....	107
77. DISSEMINATION OF INFORMATION .....	108
78. OPERATIONAL AND FINANCIAL READINESS REVIEWS .....	108
79. OPERATIONAL AND FINANCIAL REVIEWS.....	108
80. SANCTIONS .....	109
81. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSB) .....	110
82. PENDING LEGISLATION AND PROGRAM CHANGES .....	110
83. BUSINESS CONTINUITY AND RECOVERY PLAN.....	113
84. MEDICAL RECORDS .....	113
85. ENROLLMENT AND CAPITATION TRANSACTION UPDATES .....	114
86. SPECIAL HEALTH CARE NEEDS.....	115
87. TECHNOLOGICAL ADVANCEMENT.....	115
88. RESERVED .....	115
<b>SECTION E. CONTRACT TERMS AND CONDITIONS.....</b>	<b>116</b>
1. APPLICABLE LAW.....	116
2. AUTHORITY .....	116
3. ORDER OF PRECEDENCE.....	116
4. CONTRACT INTERPRETATION AND AMENDMENT.....	116
5. SEVERABILITY .....	116
6. RELATIONSHIP OF PARTIES .....	117
7. ASSIGNMENT AND DELEGATION .....	117
8. INDEMNIFICATION.....	117

9. INDEMNIFICATION -- PATENT AND COPYRIGHT .....	117
10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS .....	117
11. ADVERTISING AND PROMOTION OF CONTRACT .....	118
12. THIRD PARTY ANTITRUST VIOLATIONS .....	118
13. RIGHT TO ASSURANCE .....	118
14. TERMINATION FOR CONFLICT OF INTEREST .....	118
15. GRATUITIES .....	118
16. SUSPENSION OR DEBARMENT .....	118
17. TERMINATION FOR CONVENIENCE .....	119
18. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION .....	119
19. TERMINATION - AVAILABILITY OF FUNDS .....	121
20. RIGHT OF OFFSET .....	122
21. NON-EXCLUSIVE REMEDIES .....	122
22. NON-DISCRIMINATION .....	122
23. EFFECTIVE DATE .....	122
24. TERM OF CONTRACT AND OPTION TO RENEW .....	122
25. INSURANCE .....	123
26. DISPUTES .....	123
27. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS .....	124
28. CONTRACT .....	124
29. COVENANT AGAINST CONTINGENT FEES .....	124
30. CHANGES .....	124
31. TYPE OF CONTRACT .....	124
32. AMERICANS WITH DISABILITIES ACT .....	124
33. WARRANTY OF SERVICES .....	125
34. NO GUARANTEED QUANTITIES .....	125
35. CONFLICT OF INTEREST .....	125
36. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION .....	125
37. COOPERATION WITH OTHER CONTRACTORS .....	125
38. ASSIGNMENT OF CONTRACT AND BANKRUPTCY .....	126
39. OWNERSHIP OF INFORMATION AND DATA .....	126
40. AUDITS AND INSPECTIONS .....	126
41. LOBBYING .....	126
42. CHOICE OF FORUM .....	127
43. DATA CERTIFICATION .....	127
44. OFF-SHORE PERFORMANCE OF WORK PROHIBITED .....	127
45. FEDERAL IMMIGRATION AND NATIONALITY ACT .....	127
46. IRS W9 FORM .....	127
47. CONTINUATION OF PERFORMANCE THROUGH TERMINATION .....	127
48. E-VERIFYING REQUIREMENTS .....	127
49. SCRUTINIZED BUSINESSES .....	127
<b>SECTION F. ATTACHMENTS.....</b>	<b>129</b>
ATTACHMENT A. RESERVED.....	130
ATTACHMENT B(1). ENROLLEE GRIEVANCE SYSTEM .....	130
ATTACHMENT B(2). PROVIDER CLAIM DISPUTE SYSTEM STANDARDS AND POLICY .....	135
ATTACHMENT C: RESERVED.....	138
ATTACHMENT D. CONTRACTORS CHART OF DELIVERABLES.....	139

**SECTION B. CAPITATION RATES and CONTRACTOR SPECIFIC INFORMATION**

The Contractor shall provide services as described in this contract. In consideration for these services, the Contractor will be paid as shown below for the term of October 1, 2012 through September 30, 2013 (CYE 13) unless otherwise modified by contract amendment.

## SECTION C. DEFINITIONS

<b>A.A.C.</b>	Arizona Administrative Code. State regulations established pursuant to relevant statutes. Referred to in contract as “AHCCCS Rules”.
<b>ABUSE (OF MEMBER)</b>	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.
<b>ABUSE (BY PROVIDER)</b>	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
<b>ACOM</b>	AHCCCS Contractor Operations Manual available on the AHCCCS website at <a href="http://www.azahcccs.gov">www.azahcccs.gov</a>
<b>ADHS</b>	Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
<b>ADJUDICATED CLAIM</b>	Claims which have been received and processed by the Contractor which resulted in payment or denial of payment.
<b>ANNUAL ENROLLMENT CHOICE (AEC)</b>	The opportunity for a person to change contractors every 12 months, effective on their anniversary date.
<b>AGENT</b>	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
<b>AHCCCS</b>	Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person defined by A.R.S. § 36-2902, et seq.
<b>ALTCS</b>	The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by A.R.S. § 36-2932.
<b>AMBULATORY CARE</b>	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.
<b>AMERICAN INDIAN HEALTH PROGRAM (AIHP)</b>	AIHP is an acute care FFS program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Services (IHS), tribal health programs operated under PL 93-638 or other AHCCCS registered provider. AIHP is formerly known as the AHCCCS IHS FFS Program.
<b>AMPM</b>	AHCCCS Medical Policy Manual available on the AHCCCS website at <a href="http://www.azahcccs.gov">www.azahcccs.gov</a> .
<b>ANNIVERSARY DATE</b>	The anniversary date is 12 months from the date enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
<b>APPEAL RESOLUTION</b>	The written determination by the Contractor concerning an appeal.
<b>AT RISK</b>	Refers to the period of time that a member is enrolled with a Contractor during which

	time the Contractor is responsible to provide AHCCCS covered services under capitation.
<b>A.R.S.</b>	Arizona Revised Statutes.
<b>BIDDER'S LIBRARY</b>	A repository of manuals, statutes, Rules and other reference material located on the AHCCCS website at <a href="http://www.azahcccs.gov">www.azahcccs.gov</a> .
<b>BOARD CERTIFIED</b>	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
<b>BORDER COMMUNITIES</b>	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring counties, due to service availability or distance. (R9-22-201.F, R9-22-201.G, R9-22-101.B)
<b>CAPITATION</b>	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance for which the Contractor provides a full range of covered services as authorized under A.R.S. § 36-2931 and 36-2942.
<b>CATS</b>	Client Assessment and Tracking System, a component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from, the Contractor.
<b>CMS</b>	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services which administers the Medicare, Medicaid and State Children's Health Insurance Program.
<b>CLAIM DISPUTES</b>	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
<b>CLEAN CLAIM</b>	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
<b>CONTINUING OFFEROR</b>	An existing ALTCS Contractor serving the GSA that proposals are being solicited for, who submits a response to this solicitation?
<b>CYE</b>	Contract Year Ending, corresponds to Federal fiscal year (Oct. 1 through Sept. 30). For example, contract Year Ending 2002 is 10/1/01 – 9/30/02.
<b>CONTRACTOR</b>	A person, organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with stated contract requirements, AHCCCS statute and Rules and Federal laws and regulations as defined in A.R.S. § 36-2901.
<b>CONVICTED</b>	A judgment of conviction has been entered by a Federal, state or local court, regardless of whether an appeal from that judgment is pending.
<b>CO-PAYMENT</b>	A monetary amount specified by the Director that the member pays directly to a Contractor or provider at the time covered services are rendered as defined in 9 A.A.C. 22, Article 7.
<b>COST AVOIDANCE</b>	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the Contractor or before payment is made by the Contractor. (This assumes the Contractor can avoid costs by not paying until the first or third party

has paid what it covers first, or having the first or third party render the service so that the Contractor is only liable for coinsurance and/or deductibles.)



<b>COUNTY OF FISCAL RESPONSIBILITY</b>	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
<b>COVERED SERVICES</b>	The health and medical services to be delivered by the Contractor as defined in 9 A.A.C. 28, Article 2 and 9 A.A.C. 31, Article 2, the AMPM and Section D of this contract. [42 CFR 438.210(a)(4)]
<b>CRS (Children's Rehabilitative Services)</b>	A program administered by the AHCCCS CRS Contractor. The CRS Contractor provides services to Title XIX and Title XXI members who have completed the CRS application and have met the eligibility criteria to receive CRS covered services as specified in 9 A.A.C.7.
<b>CRS RECIPIENT</b>	An individual who has completed the CRS application process, and has met all applicable criteria to be eligible to receive CRS covered services.
<b>DAYS</b>	Calendar days unless otherwise specified as defined in the text, as defined in 9 A.A.C. 22, Article 1.
<b>DELEGATED AGREEMENT</b>	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.
<b>DES/DDD</b>	Department of Economic Security/Division of Developmental Disabilities.
<b>DIRECTOR</b>	The Director of AHCCCS.
<b>DISENROLLMENT</b>	The discontinuance of a member's ability to receive covered services through a Contractor.
<b>DME</b>	Durable medical equipment, is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury, as defined in 9 A.A.C. 22, Article 1.
<b>DUAL ELIGIBLE</b>	A member who is eligible for both Medicare and Medicaid.
<b>EMERGENCY MEDICAL CONDITION</b>	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]
<b>EMERGENCY MEDICAL SERVICE</b>	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. [42 CFR 438.114(a)]
<b>ENCOUNTER</b>	A record of a health care related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
<b>ENROLLEE</b>	A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR 438.10(a)]
<b>ENROLLMENT</b>	The process by which an eligible person becomes a member of a Contractor's plan, as defined in 9 A.A.C. 28, Article 4.

<b>EPD</b>	Elderly and Physically Disabled.
<b>EPSDT</b>	Early and Periodic Screening, Diagnostic and Treatment services for eligible persons or members less than 21 years of age as, defined in 9 A.A.C. 22, Article 2.
<b>EXHIBITS</b>	All items attached as part of the solicitation.
<b>FFS</b>	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
<b>FFP</b>	Federal Financial Participation (FFP) refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portion of AHCCCS as defined in 42 CFR 400.203.
<b>FFY</b>	Federal Fiscal Year, October 1 through September 30.
<b>FQHC</b>	Federally Qualified Health Center, an entity which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
<b>FQHC LOOK-ALIKE</b>	This is an organization that meets all of the eligibility requirements of an organization that receives a Public Health Service Section 330 Grant (FQHC), but does not receive grant funding. AHCCCS requires Contractors to credential providers employed by an FQHC Look-Alike through the temporary or provisional credentialing process.
<b>FIRST PARTY LIABILITY</b>	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by an AHCCCS, Contractor, or member.
<b>FRAUD</b>	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or Federal law, as defined in 42 CFR 455.2.
<b>FREEDOM TO WORK (TICKET TO WORK)</b>	Eligible individuals under the Title XIX expansion program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria; whose earned income, after allowable deduction, is at or below 250% of the FPL and who are not eligible for any other Medicaid program.
<b>GSA</b>	Geographic Service Area, an area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 28, Article 1.
<b>GRIEVANCE SYSTEM</b>	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
<b>HCBS</b>	Home and community-based services, as defined in A.R.S. § 36-2931 and 36-2939.
<b>HIPAA</b>	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996.

<b>HOME</b>	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a: health care institution defined in ARS § 36-401; residential care institution defined in ARS § 36-401; community residential facility defined in ARS § 36-551; or behavioral health service facility as defined in 9 A.A.C. 28, Article 11.
<b>IBNR</b>	Incurred But Not Reported, liabilities for services rendered for which claims have not been received.
<b>IHS</b>	Indian Health Service, authorized as a Federal agency pursuant to 25 U.S.C. 1661.
<b>LIABLE PARTY</b>	A person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
<b>LIEN</b>	A legal claim filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
<b>MANAGED CARE</b>	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality and medical management and the coordination of care.
<b>MANAGEMENT SERVICES AGREEMENT</b>	A type of subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.
<b>MANAGEMENT SERVICES SUBCONTRACTOR</b>	An entity to which the Contractor delegates comprehensive management and administrative services necessary for the operation of the Contractor.
<b>MANAGING EMPLOYEE</b>	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
<b>MATERIAL OMISSION</b>	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
<b>MAJOR UPGRADE</b>	Any upgrade or changes that may result in a disruption to the following: Loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
<b>MEDICAID</b>	A Federal/state program authorized by Title XIX of the Social Security Act, as amended.
<b>MEDICAL MANAGEMENT (MM)</b>	Is an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
<b>MEDICARE</b>	A Federal program authorized by Title XVIII of the Social Security Act, as amended.

<b>MEDICARE MANAGED CARE PLAN</b>	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
<b>MEMBER</b>	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. §§ 36-2931, 36-2901, 36-2901.01 and A.R.S. §36-2981.
<b>NPI</b>	National Provider Identifier assigned by the CMS contracted national enumerator.
<b>NON-CONTRACTING PROVIDER</b>	A person or entity who provides services as prescribed in A.R.S. § 36-2939 and A.R.S. § 36-2981 who does not have a subcontract with an AHCCCS Contractor.
<b>OFFEROR</b>	A person or other entity that submits a proposal to AHCCCS in response to a Request For Proposal, as defined in 9 A.A.C. 22, Article 1.
<b>PAS</b>	Pre-admission screening, is a process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28, Article 1.
<b>PAY AND CHASE</b>	Recovery method used by the Contractor to collect from legally liable first or third parties after the Contractor pays the member's medical bills. The service may be provided by a contracted or non-contracted provider. Regardless of who provides the service, pay and chase assumes that the Contractor will pay the provider, then seek reimbursement from the first or third party.
<b>PCP</b>	Primary Care Provider/Practitioner, an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's or eligible person's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
<b>PIP</b>	Performance Improvement Project (PIP), formerly referred to as Quality Improvement Projects (QIPs).
<b>PMMIS</b>	AHCCCS' Prepaid Medical Management Information System.
<b>POST STABILIZATION SERVICES</b>	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location. [42 CFR 438-114(a)]
<b>POTENTIAL ENROLLEE</b>	A Medicaid eligible recipient who is not enrolled with a Contractor [42 CFR 438.10(a)].
<b>PPC</b>	Prior Period Coverage, the period prior to the member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor.
<b>PIP</b>	Performance Improvement Project (PIP), formerly referred to as Quality Improvement Projects (QIPs).
<b>QMB</b>	Qualified Medicare Beneficiary, a person, eligible under A.R.S. §36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB, who is also

eligible for Medicaid, is commonly referred to as a QMB dual eligible.

<b>REINSURANCE</b>	A risk-sharing program provided by AHCCCS to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a monetary threshold, as defined in 9 A.A.C. 22, Article 1.
<b>RELATED PARTY</b>	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
<b>RFP</b>	Request For Proposals, a document prepared by AHCCCS that describes the services required and that instructs prospective Offerors how to prepare a response (proposal), as defined in 9 A.A.C. 22, Article 1.
<b>RBHA</b>	Regional Behavioral Health Authority, an organization under contract with ADHS to administer covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a tribal regional behavioral health authority (TRBHA) for the provision of behavioral health services to American Indian members.
<b>RBUC</b>	Reported But Unpaid Claims; Liability for services rendered for which claims have been received but not paid.
<b>RHC</b>	Rural Health Clinic, a clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of DHHS as medically underserved or having insufficient number of physicians, which meets the requirements under 42 CFR 491.
<b>ROOM AND BOARD (or ROOM)</b>	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Level 2) or an apartment like setting that may provide meals.
<b>SERVICE LEVEL AGREEMENT</b>	A type of agreement with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this contract.
<b>SFY</b>	State Fiscal Year, July 1 through June 30.
<b>SPECIAL HEALTH CARE NEEDS</b>	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that generally required by members.
<b>STATE</b>	The State of Arizona.
<b>STATE PLAN</b>	The written agreement between the State of Arizona and CMS which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program..

<b>SUBCONTRACT</b>	An agreement entered into by a Contractor with any of the following: a provider of health care services who agrees to furnish covered services to a member or with any other organization or person who agrees to perform any administrative function or service for a Contractor specifically related to fulfilling the Contractor’s obligations to AHCCCS under the terms of this contract, as defined in 9 A.A.C. 22, Article 1.
<b>SUBCONTRACTOR</b>	(1) A provider of health care who agrees to furnish covered services to members. (2) A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities. (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.
<b>SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS</b>	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have household income levels at or below 100% of the FPL.
<b>THIRD PARTY LIABILITY</b>	See Liable Party.
<b>TITLE XIX</b>	Means Medicaid as defined in 42 U.S.C. 7.19.
<b>TITLE XIX MEMBER</b>	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
<b>VENTILATOR DEPENDENT</b>	For the purposes of ALTCS eligibility, an individual who is medically dependent on a ventilator for life support at least six hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, ICF residing in their own home or a HCBS approved alternative residential setting for 30 consecutive days, as defined in 9 A.A.C. 28, Article 1.
<b>638 TRIBAL FACILITY</b>	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.

[END OF SECTION C]

## SECTION D. PROGRAM REQUIREMENTS

### 1. PURPOSE and APPLICABILITY

The purpose of the contract between AHCCCS and the Contractor is to implement and operate the Arizona Long Term Care System (ALTCS) for the elderly and physically disabled (E/PD) pursuant to A.R.S. § 36-2931 et seq. The terms of this contract apply to the Contractor, any provider participating in the Contractor's provider network, and any provider that furnishes items and services to an enrolled member upon the request or authorization of the Contractor.

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

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

### 2. INTRODUCTION

#### *AHCCCS' Mission and Vision*

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

AHCCCS supports a program that promotes the values of:

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

#### *The ALTCS Program:*

ALTCS services are provided in the 15 Arizona counties, either directly or indirectly, by Contractors under contract with AHCCCS. Contractors coordinate, manage and provide acute care, long term care, behavioral health and case management services to ALTCS members.

The ALTCS population has grown from approximately 10,000 in its first full year to 48,422 as of January, 2011. Of this population, 52.2% or 25,291 are members who are elderly and/or members with physical disabilities (EPD population) and, 47.8% or 23,131 are members with developmental disabilities (DD population). Approximately 3% of the EPD members are under 21 years of age.

#### *ALTCS Guiding Principles*

- ◆ *Member-centered case management*  
The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them.



Services are mutually selected to assist the member in attaining his/her goals(s) for achieving or maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

- ◆ *Consistency of services*  
Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and the Contractor.
- ◆ *Accessibility of network*  
Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed by the Contractor to meet member's needs which are not limited to normal business hours.
- ◆ *Most Integrated setting*  
Members are to be maintained in the most integrated setting. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.
- ◆ *Collaboration with stakeholders*  
The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

#### ***ALTCS Eligibility:***

##### *Financial eligibility*

Anyone may apply for ALTCS at any of the ALTCS eligibility offices located throughout the state. The applicant must be an Arizona resident as well as a U.S. citizen or qualified legal immigrant as defined in ARS § 36-2903.03. To qualify financially for the ALTCS program applicants must have countable income and resources below certain thresholds. The AHCCCS Eligibility Policy Manual provides a detailed discussion of all eligibility criteria. The Manual is on the AHCCCS website at:

<http://www.azahcccs.gov/shared/EligibilityManual/EligibilityManual.aspx?ID=applicants>.

##### *Medical eligibility*

In addition to financial eligibility an individual must meet the medical eligibility criteria as established by the Preadmission Screening tool (PAS). The PAS is conducted by an AHCCCS registered nurse or social worker with consultation by a physician, if necessary, to evaluate the person's medical status. The PAS is used to determine whether the person is at risk of placement in a nursing facility or an intermediate care facility for the mentally retarded. In most cases, AHCCCS will not re-evaluate the medical status of each ALTCS member annually. Thus, it is important for Contractors to notify AHCCCS of significant changes in conditions, which could result in a change in eligibility. Also see Paragraph 15, ALTCS Transitional Program and Paragraph 18, Reporting Changes in Members' Circumstances.

Additional information may be obtained by visiting the AHCCCS website: [www.azahcccs.gov](http://www.azahcccs.gov)

### **3. ENROLLMENT AND DISENROLLMENT**

AHCCCS has the exclusive authority to enroll and disenroll members. The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS. The Contractor may request AHCCCS to change the member's enrollment in accordance with the ACOM Policy 403. The Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's

utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. An AHCCCS member may request disenrollment from the Contractor for cause at any time. Please refer those requests due to situations defined in Section A (1) of the ACOM Policy 401 to the AHCCCS Division of Member Services via mail or at (602) 417-4000 or (800) 962-6690. For medical continuity requests, the Contractor shall follow the procedures outlined in the ACOM Policy 403 [42 CFR 438.56], before notifying AHCCCS.

AHCCCS will disenroll the member from the Contractor when:

- The member becomes ineligible for the AHCCCS program;
- In certain situations when they move out of the Contractor's service areas;
- The member changes Contractors during the member's open enrollment/annual enrollment choice period;
- The Contractor does not, because of moral or religious objections, cover the service the member seeks; or
- The member is approved for a Contractor change through the ACOM Policy 403.

***Prior Period Coverage:***

The Contractor is liable for costs for covered services provided during the prior period as described in the Eligibility Policy Manual located at

<http://www.azahcccs.gov/shared/EligibilityManual/EligibilityManual.aspx?ID=applicants>.

***Provider Refund Payments:***

Nursing facilities must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

Unless the Contractor's provider contracts state otherwise, all other providers, including in home and Alternative Residential Setting (ARS) providers, are not required to refund any payment received from a member (applicant) or family member (in excess of share of cost and/or room and board) for the period of time from the effective date of Medicaid eligibility until the Medicaid enrollment date.

***Disenrollment to Acute Care Program:***

When a member becomes ineligible for ALTCS but remains eligible for the acute care program, the member needs to choose an acute health plan. In such cases, the Contractor shall obtain the member's health plan choice and submit that choice to AHCCCS. When the reason for termination is due to a voluntary withdrawal obtained by the case manager or the member fails the PAS, obtaining the member's acute care health plan choice is part of transition planning.

***Member Identification Cards:***

Beginning October 1, 2011 the Contractor is responsible for the production, distribution and cost of member identification cards.

#### **4. OPEN/ANNUAL ENROLLMENT**

***Open Enrollment:***

Should AHCCCS add choice of Contractors to a Geographic Service Area (GSA) other than Maricopa County, all existing members in that GSA will be given the opportunity to choose the Contractor with whom they will be enrolled [42 CFR 438.56(c)(2)(ii)]. Information required by the Medicaid Managed Care Regulations will be provided to all members (enrollees). Existing members who do not indicate their desire to change

Contractors will remain with the Contractor they are currently enrolled with at the time multiple Contractors become available.

***Annual Enrollment Choice:***

AHCCCS conducts an Annual Enrollment Choice (AEC) in Geographic Service Areas (GSAs) with multiple Contractors for members. During AEC, members may change Contractors subject to the availability of other Contractors within their Geographic Service Area. Members are notified as required by the Medicaid Managed Care Regulations, 60 days prior to their AEC date. Members may choose a new Contractor by contacting AHCCCS to complete the enrollment process. If the member does not participate in the AEC, no change of Contractor will be made (except for approved changes under the ACOM Policy 403 during the new anniversary year). The Contractor shall comply with the ACOM Policy 402, ACOM Policy 403, and AMPM. [42 CFR 438.56(c)(2)(ii)]

For counties with more than one Contractor, AHCCCS may require a monthly submission of network information (PCPs, nursing facilities, Assisted Living Facilities etc.) to support initial enrollment, annual enrollment choice and open enrollment. Details will be provided at a later date.

## 5. ENROLLMENT HIERARCHY

When multiple Contractors are available in an ALTCS member's GSA, that member will have the opportunity to choose which Contractor they will be enrolled with to receive ALTCS services. The member and/or the member's authorized representative will be provided with informational material required by 42 CFR 438.10 from each available Contractor to assist them in making a choice. If the member or their authorized representative is unable or unwilling to make a choice, AHCCCS will use a decision tree based on the member's current place of residence or their current primary care provider to choose the most appropriate Contractor. If using the decision tree does not result in a choice of Contractors, an enrollment algorithm as described below will be used.

***Initial Choice – New Members:***

ALTCS members residing in a GSA with multiple Contractors are permitted to select a Contractor of their choice at the time of their initial enrollment into the program. When an ALTCS application is received in an ALTCS eligibility office, required materials in 42 CFR 438.10 for enrollment choice will be sent to the applicant's home with an appointment notice for an interview. During the application process, the ALTCS eligibility specialist will assist the applicant or their representative in selecting a Contractor by providing them with current provider network information. If the applicant is currently residing in a nursing facility or an alternative residential facility, the eligibility interviewer will identify which Contractors include that facility in their network. The eligibility interviewer will also search for the applicant's PCP in the provider network information.

***Decision Tree:***

If the applicant is unable or unwilling to make an enrollment choice and there is no representative without a conflict of interest, AHCCCS will make the enrollment choice for the applicant based on the philosophy that most applicants will want to remain living where they currently do, and will want to keep their current PCP. When neither or all Contractors contract with the facility, enrollment will then be determined if the applicant's PCP is contracted with any of the Contractors. If the PCP is contracted with only one of the Contractors, the applicant will be enrolled with that Contractor. When neither or all the Contractors contract with the PCP, the applicant's enrollment will be made utilizing an enrollment algorithm (auto-assignment).

***Auto-Assignment Algorithm:***

If the applicant does not exercise their enrollment choice and AHCCCS is not able to make an enrollment based on the policy referenced above in the *Initial Choice–New Member* section, an

auto-assignment algorithm will be utilized to systematically select a Contractor for the applicant. The algorithm is a mathematical formula used to distribute members to the various Contractors in a manner that is predictable and consistent with AHCCCS goals. When the algorithm applies it will be applied as follows:

- Maricopa County: 33% with Bridgeway, 33% with Mercy Care and 34% with Evercare Select
- Pima County: Evercare Select - 50%, Mercy Care Plan 50%

AHCCCS may favor Contractors new to a GSA in determining the algorithm.

AHCCCS may change the algorithm at any time during the term of this contract. AHCCCS is not obligated to adjust the algorithm for any financial impact this may have on a Contractor.

## 6. PLAN CHANGES

In Geographic Service Areas where the member has a choice of Contractors, the member may change Contractors in accordance with the ACOM Policy 403.

Members may submit Contractor change requests to the Contractor or AHCCCS. A denial of any Contractor change request must include a description of the member's right to appeal the denial.

## 7. COUNTY OF FISCAL RESPONSIBILITY

The Contractor continues to be responsible for members who are placed out of the service area in an acute care facility, a nursing facility or an alternative residential living facility. The Contractor is not responsible if a member moves to a county outside the Contractor's service area to receive home and community based services in their own home. The Contractor is responsible for emergency services only until the member is disenrolled with the current Contractor and enrolled with the Contractor responsible for the geographic service area where the member resides.

If a member is placed out of the current Contractor's service area, the current Contractor may request a Contractor change by submitting a Contractor Change Request Form (DE-621) to the Contractor responsible for the member's new county of residence and request that the new Contractor agree to accept the member. If the new Contractor agrees to accept the member, the DE-621 will be sent to AHCCCS for processing. If the new Contractor does not agree to accept the ALTCS member, the current Contractor may request AHCCCS to review the request. AHCCCS will make the final decision. The Contractor shall cooperate in all transition activities as required in ACOM Policy 402 and Policy 403. .

A Contractor Change Request (CCR) Form is not required when a member moves from the Contractor's service area to receive home and community based services in their home outside the current Contractor's service area, however, the Contractor shall report the change in address to the ALTCS local office within five days of becoming aware of the change in address. For more detailed information, refer to 9 A.A.C. 28, Article 7 and the ACOM Policy 403.

## 8. TRANSITION ACTIVITIES

### *Member Transition:*

The Contractor shall comply with the AMPM, ACOM Policy 402 and ACOM Policy 403 for member transitions between Contractors, to or from an AHCCCS Contractor, upon eligibility termination and upon termination or expiration of a contract. Also, see Paragraph 3, Enrollment and Disenrollment. The Contractor

shall develop and implement policies and procedures, which comply with AHCCCS policy to address transition of all ALTCS members. Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor. The exiting Contractor shall be responsible for performing all transition activities at no cost.

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

1. Home-based members with significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, and ventilators;
2. Members who are receiving ongoing services such as daily in home care, behavioral health, dialysis, home health, pharmacy prescriptions, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;
3. Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;
4. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;
5. Members who frequently contact AHCCCS, state and local officials, the Governor's Office and/or the media;
6. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

The Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. 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.

A new Contractor who receives members from another Contractor as a result of a contract award shall ensure a smooth transition for members by not discontinuing a member's service plan for 30 days after the member transition unless mutually agreed to by the member or responsible party.

Members who transition from one Contractor to another are considered newly enrolled with the receiving Contractor. Initial contact and on-site visit timeframes as specified in AMPM Chapter 1600, shall apply.

When relinquishing members, the 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 to coordinate 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 on how to obtain services.

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

***Contract Termination:***

In the event 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 other Contractors, and shall abide by standards and protocols set forth above. 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. AHCCCS may discontinue enrollment of members with the Contractor three months prior to the contract termination date. The Contractor shall make provisions for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. The Contractor shall submit, upon request, to AHCCCS for approval a detailed plan for the transition of its 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 15<sup>th</sup> 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 reconciliation 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 20, Quality Management, and 21, 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 investigation and reporting based on the date of service.
- h. Participating in and closing out Performance Measures and Performance Improvement Projects as requested by ACCCS.
- 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 records for a period of five years from the date of the 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, Paragraph 27, Disputes.

### **9. AHCCCS GUIDELINES, POLICIES and MANUALS**

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS website located at [www.azahcccs.gov](http://www.azahcccs.gov). The Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS Rules, Statutes and other resources are also available to all interested parties through the AHCCCS website. Upon adoption by AHCCCS, updates will be made available to Contractors. The Contractor shall be responsible for implementing and maintaining current copies of updates.

### **10. COVERED SERVICES**

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

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

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

The Contractor must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service. Notification must be submitted prior to entering into a contract with AHCCCS or prior to adopting the policy during the term of the contract [42 CFR 438.102(a)(2) and (b)(1)]. Members must be notified on how to access the services. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to members during their initial appointment, and must be provided to members at least 30 days prior to the effective date of the policy. AHCCCS will disenroll from the Contractor members who are seeking these services and assign the members to another Contractor [42 CFR 438.56].

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

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

*Notice of Action:* The Contractor must notify the requesting provider, and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, or for any action as defined in Attachment B(1). [42 CFR 438.400(b)] The notice must meet the requirements of 42 CFR.438.404, AHCCCS Rules and ACOM Policy 414. The notice to the provider must also be in writing as specified in Attachment B (1). [42 CFR 438.210(c)] The Contractor must comply with all decision timelines outlined in ACOM Policy 414.

### **ACUTE CARE SERVICES**

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

*American Indian Health Program (AIHP):* AHCCCS Division of Fee for Service Management (DFSM) will reimburse claims for acute care services that are medically necessary, eligible for 100% Federal reimbursement, and are provided to Title XIX members enrolled with the Contractor by an IHS or a 638 tribal facility and when the member is eligible to receive services at the HIS or tribally operated 638 program. Encounters for Title XIX services billed by an IHS or tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

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

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

*Behavioral Health:* The Contractor shall provide behavioral health services to all members, including Acute Care Only members, as described in Section D, Paragraph 12, Behavioral Health Services. Services are described in detail in the AMPM and the AHCCCS Behavioral Health Services Guide available on the AHCCCS website at:

<http://www.azahcccs.gov/commercial/shared/BehavioralHealthServicesGuide.aspx?ID=contractormanuals>

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

*Chiropractic Services:* The Contractor shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. Medicare approved chiropractic services for any member shall be covered, subject to limitations specified in 42 CFR 410.22, for Qualified Medicare beneficiaries, regardless of age, if prescribed by the member's PCP and approved by the Contractor.

*Dialysis:* The Contractor shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified end stage



renal disease (ESRD) providers. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services.

**Early and Periodic Screening, Diagnostic and Treatment (EPSDT):** The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings for members under age 21. The Contractor shall ensure that these members receive required health screenings, including developmental and behavioral health screenings, in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule (Exhibit 430-1 in the AMPM).

**Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention:** The Contractor shall provide health care services through screening, diagnosis and medically necessary treatment for members 21 years of age and older. These services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis and HIV/AIDS; breast cancer, cervical cancer and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the over and under nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in Arizona Administrative Code Section R9-22-205. AHCCCS does not cover well exams (i.e., physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination) for adult members.

**Emergency services:** The Contractor shall provide emergency services per the AHCCCS AMPM Policy and the following:

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

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

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

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

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

Additionally, the Contractor may not:

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

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

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

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

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

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

**Foot and Ankle Services -Adults:** The Contractor shall provide foot and ankle services to include wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional person as described in the AMPM. Services are not covered for members 21 years of age and older, when provided by a podiatrist or podiatric surgeon.

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

staff to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability. Refer to the AHCCCS Medical Policy Manual for limitations on hospital stays.

**Immunizations:** The Contractor shall provide medically necessary immunizations for adults (21 years of age and older). Human Pappiloma virus (HPV) is covered only for EPSDT aged male and female members (through age 20). (Please refer to the AMPM for current immunization requirements.) (See also Section D Paragraph 62 Pediatric Immunizations and the Vaccine for Children Program).

**Incontinence Supplies/Diapers:** The Contractor shall cover incontinence supplies as specified in AHCCCS Rule A.A.C.R9-22-212 and the AMPM.

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

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

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

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

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary HIV/AIDS testing and the availability of medical counseling if the test is positive. The Contractor shall provide information in the Member Handbook to encourage pregnant women to be tested and instructions on where to be tested. The Contractor shall report to AHCCCS, Division of Health Care Management, the number of pregnant women

who have been identified as HIV/AIDS positive for each quarter during the contract year. This report is due no later than 30 days after the end of the quarter.

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

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

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

**Oral Health:** Members under the age of 21: The Contractor shall provide all members under the age of 21 with all medically necessary dental services including emergency dental services, dental screening, preventive services in accordance with the AHCCCS Dental Periodicity Schedule, as well as therapeutic dental services, therapeutic services and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 20, Performance Standards. The Contractor shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second notice must be sent. Members under the age of 21 may request dental services without referral and may choose a dental provider from the Contractor's provider network.

Pursuant to A.A.C. R9-22-207, for members who are 21 years of age and older, the Contractor shall cover medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist. These services would be considered physician services if furnished by a physician. Limited dental services are covered for pre-transplant candidates and for members with cancer of the jaw, neck or head. Refer to the AMPM for specific details.

**Orthotics:** These services are covered for members under the age of 21 when prescribed by the member's PCP, attending physician, practitioner, or by a dentist as described in the AMPM. Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item.

Reasonable repairs or adjustments of purchased equipment are covered for all members over and under the age of 21 to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

The component will be replaced if at the time authorization is sought documentation is provided to establish that the component is not operating effectively.

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

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

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

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

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

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

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

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

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

Medicare Part D: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS. This applies to members that are enrolled in Medicare Part D or are eligible for Medicare Part D. (See AMPM Chapter 300, Section 310-V)

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

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

**Rehabilitation Therapy:** The Contractor shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation. Outpatient Physical Therapy for members 21 years of age or older are subject to a 15 visit limit per contract year as described in the AMPM.

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

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

**Transportation:** These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services using the appropriate mode based on the needs of the member. The Contractor shall ensure that members have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

**Triage/ Screening and Evaluation:** These are covered services when provided by acute care hospitals, IHS facilities, a PL 93-638 tribal facility and after-hours settings to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine services necessary to alleviate or stabilize the emergent condition. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

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

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

### ***LONG TERM CARE SERVICES***

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

***Adult Day Health Care:*** A program that provides planned care and supervision, recreation and socialization, personal living skills training, group meals, health monitoring and various preventive, therapeutic and restorative health care services.

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

Self-Directed Attendant Care (SDAC): A service option within Attendant Care. As of February 1, 2011 members selecting SDAC may direct their SDAC Attendant to provide certain skilled services. See AMPM Chapters 1200, 1300 and 1600 for requirements pertaining to SDAC.

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

Agency with Choice: A service option within attendant care. As of January 1, 2013 members selecting Agency with Choice may enter into a co-employment relationship in which the agency/provider maintains the authority to hire and fire paid caregivers and provide standardized training to the caregiver. Under this service option, the member or authorized representative may elect to recruit, select, dismiss, determine duties, schedule, specify training to meet the unique needs of the member, and supervise the paid caregivers on a day-to-day basis.

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

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

***Group Respite:*** This service is similar to Adult Day Health and is provided as a substitute when Adult Day Health services are not available.

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

**Home Delivered Meals:** A service that provides a nutritious meal containing at least one-third of the Federal recommended daily allowance for the member, delivered to the member's own home.

**Home Health Service:** Part-time or intermittent care for members who do not require hospital care; this service is provided under the direction of a physician to prevent re-hospitalization or institutionalization and may include skilled nursing, therapies, supplies and home health aide services.

**Homemaker:** Assistance in the performance of routine household activities such as shopping, cooking, running errands, etc. (see ACOM Policy 429 and AMPM Chapter 1200 for Attendant Care, Homemaker and Personal Care training requirements)

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

**Hospice:** A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with the Contractor. Contractors are required to pay nursing facilities 100% of the class specific contracted rate when a member elects the hospice benefit. The hospice agency is responsible for providing covered services to meet the needs of the member related to the member's hospice-qualifying condition. ALTCS services which are duplicative of the services included in the hospice benefit should not be provided. If, however, the hospice agency is unable to provide or cover medically necessary services the Contractor must provide the services. Attendant care services are not considered duplicative.

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

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

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

## LONG TERM CARE - INSTITUTIONAL SETTINGS

**Level I Psychiatric Acute Hospital:** A behavioral health facility licensed by ADHS, as defined in 9 A.A.C. 20, to provide continuous treatment to an individual who is experiencing a behavioral health issue that causes the individual to be a danger to self, a danger to others, or gravely disabled; or to suffer severe and abnormal judgment, reason, behavior, or the capacity to recognize reality. Some Level I facilities are IMDs.



***Institution for Mental Disease (IMD):*** A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Office of Behavioral Health Licensure licensed Level I facilities with more than 16 beds are considered IMDs. Reimbursement for services provided in an IMD to Title XIX persons age 21 through 64 years is not available. For Title XIX members under age 21 and 65 years of age or over, there is no benefit limitation. A Title XIX member who is receiving services in an IMD who turns 21 may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. AHCCCS provider types B6 and 71 are IMDs.

***Level 1 Residential Treatment Center 1 (Available to Title XIX members under 21 years of age):*** Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A Title XIX member who is receiving services in an inpatient psychiatric facility considered to be an IMD who turns age 21, may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. Some Level 1 Residential Treatment Centers are IMDs.

***Level 1 Sub-Acute Facility:*** A behavioral health facility licensed by ADHS as defined by 9 A.A.C. 20, to provide continuous treatment to a person who is experiencing acute and severe behavioral health and/or substance abuse symptoms. Some Level 1 Sub-Acute Facilities are IMDs.

***Nursing facility, including Religious Nonmedical Health Care Institutions:*** The Contractor shall provide nursing facility services for members. The nursing facility must be licensed and Medicare/Medicaid certified by ADHS in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. (Religious Nonmedical Health Care Institutions are exempt from state licensing requirements.)

#### **LONG TERM CARE - HCBS ALTERNATIVE RESIDENTIAL SETTINGS**

Under the Home and Community Based Services program, members may receive certain services while they are living in their own homes. (See Section C for a definition of “home”) In addition, there are other alternative HCBS settings as defined in 9 A.A.C. 28 Article 1 available for members. Every effort to advance a person-centered approach by promoting non-institutional, home-like settings that allows members to age in-place should be encouraged.

Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting. For the alternative residential settings described below, when room and board are included in the setting, members residing in these settings are responsible for the room and board payment.

Alternative residential settings include the following:

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

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

Adult – Home Care Training to Home Care Client services can only be provided for no more than three adults in an Adult Therapeutic Foster Care Home (R9-20-1501) licensed by ADHS/OBHL or a home licensed by federally recognized tribes that attest to CMS via AHCCCS that they meet equivalent requirements..

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

**Assisted Living Facilities:** Residential care institutions that provide supervisory care services, personal care services or directed care services on a continuing basis. All ALTCS approved residential settings in this category are required to meet ADHS licensing criteria as defined in 9 A.A.C. 10, Article 7. Of these facilities, ALTCS has approved three as covered settings.

- a. *Adult Foster Care:* An ALTCS HCBS approved alternative residential setting that provides supervision and coordination of necessary services within a family type environment for up to four adult residents.
- b. *Assisted Living Home:* An ALTCS approved alternative residential setting that provides supervision and coordination of necessary services to 10 or fewer residents.
- c. *Assisted Living Center:* An ALTCS approved alternative residential setting as defined in, A.R.S. §36-401, that provides supervision and coordination of necessary services to more than 10 residents. Under A.R.S. §36-2939 members residing in Assisted Living Centers must be offered the choice of single occupancy.

**Level II Behavioral Health Residential Agency:** A behavioral health service agency licensed by ADHS, as defined in 9 A.A.C. 20, to provide a structured residential setting with 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level I behavioral health facility.

**Level III Behavioral Health Residential Agency:** A behavioral health service agency licensed by ADHS, as defined in A.A.C. 20, to provide a residential setting with 24-hour supervision and intermittent treatment in a group setting to persons who are determined to be capable of independent functioning but still need some protective oversight.

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

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

**Rural Substance Abuse Transitional Agency:** An agency that provides behavioral health services to an individual who is intoxicated or has a substance abuse problem and is located in a county with a population of fewer than 500,000 individuals as defined in 9 A.A.C. 20, Article 14.

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

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

## 11. THERAPEUTIC LEAVE AND BED HOLD

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

## 12. BEHAVIORAL HEALTH

The Contractor shall provide medically necessary Title XIX (Medicaid) behavioral health services to all members in accordance with AHCCCS policies and 9 A.A.C. 28, Article 11. Covered services include:

- a. Behavior Management (personal care, family support/home care training, peer support)
- b. Behavioral Health Case Management Services (with limitations)
- c. Behavioral Health Nursing Services
- d. Emergency Behavioral Health Care
- e. Emergency and Non-Emergency Transportation
- f. Evaluation and Assessment
- g. Individual, Group and Family Therapy and Counseling
- h. Inpatient Hospital Services - (Contractors may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings.
- i. Non-Hospital Inpatient Psychiatric Facilities Services (Level I Residential Treatment Centers and Sub-Acute Facilities)
- j. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- k. Opioid Agonist Treatment
- l. Partial Care (Supervised day program, therapeutic day program and medical day program)
- m. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
- n. Psychotropic Medication
- o. Psychotropic Medication Adjustment and Monitoring
- p. Respite Care (with limitations)
- q. Rural Substance Abuse Transitional Agency Services
- r. Screening
- s. Home Care Training to Home Care Client

Behavioral health needs shall be assessed and services provided in collaboration with the member, the member's family and all others involved in the member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and their family shall determine the types and intensity of services. Services should be provided in a manner that respects the member and family's cultural heritage and appropriately utilizes natural supports in the member's community.

### **Training:**

The Contractor is responsible for training case managers and providers to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services, how to access them, including the petitioning process, how to involve the member and their family in

decision-making and service planning, and information regarding initial and quarterly behavioral health consultation requirements. Training for case managers and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. Training must be provided in sufficient detail and frequency to ensure that case managers and providers appropriately identify and refer members with behavioral health needs. The Contractor shall maintain documentation of the behavioral health trainings.

The Contractor shall ensure that training and education are available to PCPs regarding behavioral health referral and consultation procedures. The Contractor shall establish policies and procedures for referral and consultation and shall describe them in its provider manual. Policies for referral must include, at a minimum, criteria, processes, responsible parties and minimum requirements no less stringent than those specified in this contract for the forwarding of member medical information.

***Referrals:***

The Contractor shall develop, monitor and continually evaluate its processes for timely referral, evaluation and treatment planning for behavioral health services. Requests for behavioral health services made by the family, guardian, or the member shall be assessed by the Contractor for appropriateness within three business days of the request. If it is determined that services are needed, a referral for evaluation shall be made within one business day. A direct referral for a behavioral health evaluation may be made by the member. A direct referral for a behavioral health evaluation may be made by any health care professional in coordination with the case manager and PCP assigned to the member. Psychiatrists, psychologists, physician assistants, certified psychiatric nurse practitioners, licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and licensed independent substance abuse counselors may bill independently. Other behavioral health professionals must be employed by or contracted with and bill through an AHCCCS registered behavioral health provider. The Contractor shall ensure that all behavioral health services provided are medically necessary as determined by a qualified behavioral health professional.

***EPSDT:***

The Contractor shall ensure that PCPs screen for behavioral health needs at each EPSDT visit, and when appropriate, initiate a behavioral health referral. The Contractor must develop a process to ensure that a referral is made when a behavioral health need is identified, and that the member is referred for appropriate medically necessary behavioral health services.

***Coordination of Care:***

There shall be procedures in place for ensuring that members' behavioral health services are appropriately provided, are documented in the member's record and are tracked by the case manager. The Contractor shall also have procedures in place for ensuring communication occurs between the case manager, the PCP and behavioral health providers and that care is coordinated with other agencies and involved parties. For members transferring to the ALTCS program who have previous enrollment with a Regional Behavioral Health Authority, the Contractor shall ensure the members receive uninterrupted behavioral health services and supports and shall coordinate with the Regional Behavioral Health Authority to ensure the member is appropriately transitioned.

The Contractor is responsible for ensuring that a medical record is established by the PCP when behavioral health information is received from the provider about an assigned member even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established. The Contractor shall require the PCP to respond to provider information requests pertaining to behavioral health recipient members within 10 business days of receiving the request. The response should include all pertinent information, including but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations. The Contractor shall require the PCP to document or initial

signifying review of member behavioral health information received from a behavioral health provider who is also treating the member.

The Contractor shall have a policy and process in place to timely involve a behavioral health professional to assess, develop a care plan and preserve the current placement if possible when a member in a non-behavioral health setting presents with difficult to manage behaviors (new or existing). For further guidance in addressing the needs of members with multi system involvement and complex behavior health and co-occurring conditions, refer to the AMPM Chapter 500, Policy 570, effective March 2012. When attempting to place a member in a NF or HCBS setting, the Contractor shall also disclose all information that pertains to the member's behaviors. To address members residing in a non-behavioral health unit who present with behaviors that may be a danger to self or danger to others, in order to promote early intervention and avoid placement at an alternative setting, see AMPM Chapter 1600 and Appendix H.

Quality management processes for behavioral health services must be included in the Contractor's Quality Management Plan and shall meet the quality management requirements of AHCCCS as specified in the AMPM Chapter 900. The Contractor must monitor to ensure that primary care physicians receive behavioral health information as established in AMPM Chapter 500, Policy 510, and AMPM Chapter 900, Policy 940.

The Contractor shall ensure that its quality management program incorporates monitoring of the PCP's referral to, coordination of care with, and transfer of care to behavioral health providers as required under this contract.

**Co-Morbidities:**

The Contractor must ensure that members with diabetes who are being discharged from the Arizona State Hospital (AzSH) are issued the same brand and model of both glucometer and supplies they were trained to use while in the facility. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

For enrolled members who are inpatient at the Arizona State Hospital, the Contractor is required to follow ACOM Policy 422 regarding medical care coordination for these members.

**Crisis Services:**

The Contractor shall develop policies that outline the Contractor's role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must address:

- a. Involuntary evaluation/petitioning
- b. Court ordered process including tracking the status of court orders
- c. Execution of court order, and
- d. Judicial review

Reimbursement for court ordered screening and evaluation services is not the responsibility of the Contractor and instead falls to the county pursuant to A.R.S. 36-545.

For more information, refer to the AHCCCS Behavioral Health Services Guide that is available on the AHCCCS website at:

<http://www.azahcccs.gov/commercial/shared/BehavioralHealthServicesGuide.aspx?ID=contractormanuals>

**13. CHILDREN'S REHABILITATIVE SERVICES**

Children's Rehabilitative Services (CRS) is a program for children with special health care needs. The CRS program is administered by AHCCCS utilizing a CRS Contractor for children who meet CRS eligibility

criteria. The Contractor shall refer children to CRS who are potentially eligible for services related to CRS covered conditions, as specified in R9-22, Article 2 and A.R.S. Title 36, Chapter 2, Article 3. In addition, the Contractor shall notify the member when a referral to CRS has been made. The Contractor is responsible for care of members until those members are determined eligible by the CRS Contractor. In addition, the Contractor is responsible for covered services for CRS eligible members unless and until the Contractor has received written confirmation from the CRS Contractor that the CRS Contractor will provide the medically necessary, CRS covered service. The Contractor shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Contractor. For detailed information regarding eligibility criteria, referral practices and Contractor CRS coordination issues, refer to the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractors' Operations Manual (ACOM) located on the AHCCCS website at [www.azahcccs.gov](http://www.azahcccs.gov).

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

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

A member with private insurance is not required to utilize CRS. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. If the member uses a private insurance network for a CRS covered condition, the Contractor is responsible for all applicable deductibles and copayments. If the member is on Medicare ACOM Policy 201 shall apply. When private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to the CRS covered conditions, the Contractor shall refer the member to CRS for determination of eligibility. If the member with private insurance or Medicare chooses to enroll with CRS, CRS becomes the secondary payer responsible for all applicable deductibles and copayments. The Contractor is not responsible to provide services in instances when a member with a CRS covered condition who has no primary insurance or Medicare, refuses to participate in the CRS application process, or refuses to receive CRS covered services through the CRS program. The member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

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

ALTCS members who are temporarily out of the Contractor's service area may be provided long term care services while out of the service area, including HCB services. Contractors are not expected to set up special contractual arrangements to provide long term care services out of the service area but, should consider

authorization when member-specific providers, such as family Attendant Care, are available during the temporary absence. ALTCS members temporarily absent from Arizona without authorization from the Contractor are eligible for acute emergency services only. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Contractor shall report absences of more than 30 days from the state to the ALTCS eligibility office for a determination of continued eligibility as specified in the AHCCCS Eligibility Policy Manual.

The Contractor shall submit a written request to AHCCCS Division of Health Care Management, ALTCS Unit, Case Manager Administrator before placing a member in a residential facility outside the state to facilitate a coordinated review with the Division of Member Services for any potential eligibility impact.

### **15. ALTCS TRANSITIONAL PROGRAM**

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

ALTCS Transitional members are entitled to all ALTCS covered services except for institutional custodial care. When institutional custodial care is determined to be medically necessary, the period of institutionalization may not exceed 90 consecutive days. If institutional care is expected to exceed 90 consecutive days, the Contractor shall request a medical eligibility reassessment (PAS) at least 30 days prior to the 90th consecutive day. ALTCS Transitional members determined by the PAS to be at risk of institutionalization will be transferred from the ALTCS Transitional Program to the regular ALTCS program effective the PAS reassessment disposition date.

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

### **16. CASE MANAGEMENT**

Case management is the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.

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

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

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

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

- a. Respect the member's rights;
- b. Provide adequate information and training to assist the member/family in making informed decisions and choices;
- c. Provide a continuum of service options that support the expectations and agreements established through the care plan process;
- d. Facilitate access to non-ALTCS services available throughout the community;
- e. Educate the member/family on how to timely report unavailability or other problems with service delivery to the Contractor or AHCCCS in order that unmet needs can be addressed as quickly as possible;
- f. Advocate for the member and/or family/significant others as the need occurs;
- g. Allow the member/family to identify their role in interacting with the service system;
- h. Provide members with flexible and creative service delivery options;
- i. Educate members on their option to choose their spouse as their paid attendant caregiver and the need to consider how that choice may impact eligibility for other publicly funded programs;
- j. Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services;
- k. Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member;
- l. Assist members to identify their independent living goals and provide them with information about local resources that may help them transition to greater self-sufficiency in areas of housing, education and employment.

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

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

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

The case manager shall be responsible for assessing the member's overall functional and medical status at each review. This information must be incorporated into the service plan development, and for HCBS members as outlined in policy, the contingency plan process in order to ensure the member's needs are being met. The case



manager shall maintain a cost-effective individualized service plan while assisting to resolve problems in the delivery of needed services.

For members who have HCB services in place prior to enrollment (during the Prior Period Coverage (PPC) enrollment) a documented retrospective assessment must be conducted to determine whether those services are medically necessary, cost effective and if they were provided by a registered AHCCCS provider. If so, a care service plan must be developed to indicate that services will be retroactively authorized and reimbursed by the Contractor.

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

Client Assessment and Tracking System (CATS): The Contractor shall ensure complete, correct and timely entry of data related to placement history and cost effectiveness studies into the CATS. "Timely" shall mean within 14 days of the event which gave rise to the transaction (e.g., service approval by the case manager, placement change). Unless the Contractor is currently transmitting data to CATS electronically, all data entry shall be entered on-line. If the Contractor is not currently on-line, it must have a systems interface in place so it can update the case management information no less than twice per month with an error rate of 5% or less. Contractors are not required to enter service authorizations into the CATS. The Contractor is, however, expected to maintain a uniform tracking system in each member chart documenting the begin and end date of services inclusive of renewal of services and the number of units authorized for services as required by the AMPM Chapter 1600.

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

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

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

Each case manager's caseload may not exceed a weighted value of 96. Contractors may assign a weighted value lower than those outlined below however, Contractors must obtain authorization from the Division of Health Care Management prior to implementing caseloads whose values exceed these AHCCCS standards. The following formula represents the standard maximum allowable per case manager.

- For institutionalized members, a weighted value of **0.8** is assigned. Case managers may have up to 120 institutionalized members (120 x 0.8=96)
- For HCBS (own home), a weighted value of **2.0** is assigned. Case managers may have up to 48 HCBS members (48 x 2.0=96)
- For Assisted Living Facility (ALF) members, a weighted value of **1.6** is assigned. Case managers may have up to 60 ALF members (60 x 1.6 = 96).
- For Acute Care Only members, a weighted value of **1.0** is assigned. Case manager may have up to 96 Acute Care Only members (96 x 1.0 = 96).
- If a mixed caseload is assigned, there can be no more than a weighted value of 96. The following formula is to be used in determining a case manager's mixed caseload:

$$\begin{aligned}
 & (\# \text{ of HCBS members} \times 2.0) \\
 & (\# \text{ of ALF members} \times 1.6) \\
 & (\# \text{ of ACO members} \times 1.0) \\
 & + \underline{(\# \text{ of NF members} \times 0.8)} \\
 & = 96 \text{ or less}
 \end{aligned}$$

The Contractor shall ensure that a staff person(s) is designated as the expert(s) on housing, education and employment issues and resources within the Contractor's service area. This individual must be available to assist case managers with up to date information designed to aid members in making informed decisions about their independent living options.

#### **17. MEMBER HANDBOOK and MEMBER COMMUNICATIONS**

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

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

All vital materials shall be translated when the Contractor is aware that a language is spoken by 1,000 or 5%, whichever is less, of the Contractor's members, who also have LEP. Vital materials must include, at a minimum, Notices of Actions, vital information from the member handbooks and consent forms.

All written notices informing members of their right to interpretation and translation services in a language shall be translated when the Contractor is aware that 1,000 or 5%, whichever is less, of the Contractor's members speak that language and have LEP [42 CFR 438.10(c)(3)].

Oral interpretation services must be available and free of charge to all members regardless of the prevalence of the language. The Contractor must notify all members of their right to access oral interpretation services and how to access them. Refer to the ACOM Policy 404 [42 CFR 438.10(c)(4) and (5)].

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM Policy 404. Regardless of the format chosen by the Contractor, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment [42 CFR

438.10(b)(1) and (b)(3)]. The Contractor must notify its members that alternative formats are available and how to access them [42 CFR 438.10(d)].

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

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

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

The Contractor shall review and update the Member Handbook at least once a year. The handbook must be submitted to AHCCCS, Division of Health Care Management for approval within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution.

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

II. A description of the Contractor's provider network, which at a minimum, includes those items listed in the ACOM Policy 404.

The Contractor must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider. Affected members must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4) and (5)]. The Contractor shall have information available for potential enrollees as described in the ACOM Policy 404.

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

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

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

- a. An updated member handbook at no cost to the member
- b. The network description as described in the ACOM Policy 404

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

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

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

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

#### **18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES**

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

#### **19. PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)**

The Contractor shall ensure members have the Preadmission Screening and Resident Review (PASRR) Level I and, if needed, Level II screenings prior to admission to a nursing facility. Level I is the identification of members who are suspected of having mental illness or intellectual disability. Level II determines whether nursing facility or specialized services are needed. Failure to have the proper PASRR screening prior to placement of members in a nursing facility may result in Federal financial participation (FFP) being withheld from AHCCCS. Should withholding of FFP occur, AHCCCS will recoup the withheld amount from a Contractor's subsequent capitation payment. The Contractor may, at its option, recoup the withholding from the nursing facility which admitted the member without the proper PASRR.

#### **20. QUALITY MANAGEMENT**

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, evaluate, and as mandated report, quality management and performance improvement activities, as specified in the AMPM, [42 CFR 438.240(a)(1) and (e)(2) and CFR 42 447.26].

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

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

A. Quality Management Program:

The Contractor shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPM Chapter 900 and the following:

1. A written Quality Assessment and Performance Improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and Quality Management Quarterly reports that address its strategies for performance improvement and conducting the quality management activities.
2. QM/PI Program monitoring and evaluation activities that include Peer Review and Quality Management Committees chaired by the Contractor's Chief Medical Officer.
3. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
4. Member rights and responsibilities.
5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's Medical Director [42 CFR 438.214]. The Contractor should refer to the AMPM and Attachment D, Chart of Deliverables, for reporting requirements. The process:
  - a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the Contractor;
  - b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
  - c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
  - a. Acknowledgement letter to the originator of the concern;
  - b. Documentation of all steps utilized during the investigation and resolution process;
  - c. Follow-up with the member to assist in ensuring immediate health care needs are met;
  - d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;
  - e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
  - f. Analysis of the effectiveness of the interventions taken.
7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
9. Performance improvement programs including performance measures and performance improvement projects.

#### B. Performance Improvement

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

1. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS;

2. Submit to the State data specified by the State, that enables the State to measure the Contractor's performance; or
3. Perform a combination of the activities.

***I. Performance Measures:***

The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. AHCCCS has identified three of the Healthcare Effectiveness Data and Information Set (HEDIS) diabetes indicators for performance measurement: Hb A1c testing, lipid (LDL-C) screening, and eye exams. Measurements of these indicators are based on the National Committee for Quality Assurance (NCQA) HEDIS methodology. AHCCCS bases the measurement of EPSDT Participation on the methodology established in CMS "Form 416," which can be found on the AHCCCS website (<http://www.azahcccs.gov/reporting/quality/performanceasures.aspx>). The methodology for Initiation of Home and Community Based Services was developed by AHCCCS. Complete descriptions of these measures can be found in the most recently published reports of ALTCS E/PD performance measures located on the AHCCCS website. Methodologies for the measures of Influenza Vaccination and Pressure Ulcers have been developed by AHCCCS based on comparable methodologies available from other sources. Methodologies for these measures are available on the AHCCCS website.

Contractors must comply with national performance measures and levels that may be identified and developed by CMS in consultation with AHCCCS and/or other relevant stakeholders. CMS has been working in partnership with states in developing core performance measures for Medicaid programs. The current AHCCCS established performance measures may be subject to change when these core measures are finalized and implemented.

The Contractor must have a process in place for internal monitoring of performance measures rates, using the standard methodology established or adopted by AHCCCS, for each required performance measure. The Contractor's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration. It also will report this performance measure data to AHCCCS in conjunction with its Quarterly EPSDT Improvement and Adult Monitoring Report.

The Contractor must meet AHCCCS stated Minimum Performance Standards for each population for which AHCCCS reports results. However, it is equally important that the Contractor continually improve performance measure outcomes from year to year. The Contractors shall strive to meet the goal established by AHCCCS.

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

***Goal*** – If the Contractor has already met or exceeded the AHCCCS Minimum Performance Standard for any measure, the Contractor must strive to meet the established Goal for the measure. However, it is equally important that the Contractor continually improve performance measure outcomes from year to year.

A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on Contractors that do not show statistically significant improvement in a measure rate and 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 and may sanction any Contractor that shows a statistically significant decrease in its rate, even if it meets or exceeds the Minimum Performance Standard.

An evidence-based corrective action plan must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up on-site reviews to verify compliance with a corrective action plan.

### Performance Measures

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

AHCCCS has established standards for the measures listed below:

Performance Measure	CYE 2012 Minimum Performance Standard (1)	AHCCCS Goal (1)
Diabetes Care		
Hb A1c Testing	80%	89%
Lipid Profiles	72%	91%
Retinal Exams	60%	68%
Initiation of HCB Services	92%	98%
Influenza Vaccination		
Nursing Facility	75%	90%
HCBS	50%	90%
Prevalence of Pressure Ulcers		
High-risk residents	12%	10%
Low-risk residents	3%	2%
EPSDT Participation	60%	80%
EPSDT Dental Participation – Medicaid (2)	46%	54%

Notes:

(1) Minimum Performance Standards are based on the most recent statewide average for a measure or other appropriate benchmarks (such as the most recent HEDIS Medicaid mean). Goals are based on Healthy People 2010 objectives or other appropriate national goals or benchmarks.

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

In addition to improving adult measures, the Contractor must take affirmative steps to increase member participation in the EPSDT program. The EPSDT participation rate is the number of children younger than 21 years receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility.

### II. Performance Improvement Program:

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

1. Measurement of performance using objective quality indicators;
2. Implementation of system interventions to achieve improvement in quality;
3. Evaluation of the effectiveness of the interventions;

#### 4. Planning and initiation of activities for increasing or sustaining improvement.

PIPs are mandated by AHCCCS, but Contractors may self-select additional projects based on opportunities for improvement identified by internal data and information. The Contractor shall report the status and results of each project to AHCCCS as requested using the AHCCCS PIP Reporting Template included in the AMPM. Each 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)].

#### **III. Data Collection Procedures:**

When requested, the Contractor must submit data for standardized Performance Measures and/or Performance Improvement Projects as required by AHCCCS within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor is responsible for collecting valid and reliable data and using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or Performance Improvement Projects must be returned by the Contractor in the format and according to instructions from AHCCCS, by the due date specified. Any extension for additional time to collect and report data must be made in writing in advance of the initial due date. Failure to follow the data collection and reporting instructions that accompany the data request may result in sanctions imposed on the Contractor.

### **21. MEDICAL MANAGEMENT**

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

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee, which is chaired by the Contractor's Chief Medical Officer;
2. Prior authorization and Referral Management; for the processing of requests for initial and continuing authorizations of services the Contractor shall:
  - a. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;
  - b. Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)];
  - c. Monitor and ensure that all enrollees with special health care needs have direct access to care.
  - d. Review all prior authorization requirements for services, items or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for those changes must be included in the annual MM/UM Plan and Evaluation submission; and
  - e. Comply with all decision timelines as outlined in the ACOM and the AMPM
3. Development and/or Adoption of Practice Guidelines [42 CFR 438.235(b), that:
  - a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
  - b. Consider the needs of the Contractor's members;
  - c. Are adopted in consultation with contracting health care professionals;
  - d. Are reviewed and updated periodically as appropriate;
  - e. Are disseminated by Contractors to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
  - f. Provide a basis for consistent decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply [42 CFR 438.236(d)].



4. Concurrent review;
  - a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services and other areas to which the guidelines apply;
  - b. Contractors must have policies and procedures in place that govern the process for proactive discharge planning when members have been admitted into acute care facilities. The intent of the discharge planning policy and procedure would be to increase the utilization management of inpatient admissions and decrease readmissions within 30 days of discharge.
  - c. In addition, 42 CFR 447.26 prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider –Preventable Condition (OPPC) (refer to AMPM Chapter 1000 requirements). If an HCAC or OPPC is identified, the Contractor must report the occurrence to AHCCCS and conduct a quality of care investigation.
5. Continuity and coordination of care;
  - a. Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
  - b. Establish a process for timely and confidential communication of clinical information among providers; and
  - c. Must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes, but is not limited to, members who do not meet the Contractor's criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.
6. Monitoring and evaluation of over- and/or under- utilization of services [42 CFR 438.240(b)(3)];
7. Evaluation of new medical technologies, and new uses of existing technologies; and
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee.

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

The Contractor shall maintain a written MM plan and workplan that addresses monitoring of MM activities (AMPM Chapter 1000). The plan and workplan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in Attachment D.

## **22. GRIEVANCE SYSTEM**

The Contractor shall have in place a written grievance system process for subcontractors, enrollees and non-contracted providers, which defines their rights regarding disputed matters with the Contractor. The Contractor's grievance system for enrollees includes a grievance process (the procedures for addressing enrollee grievances), an appeals process and access to the state's fair hearing process. The Contractor shall provide the appropriate personnel to establish, implement and maintain the necessary functions related to the grievance systems process. Refer to Attachments B (1) and B (2) for Enrollee Grievance System and Provider Grievance System Standards and Policy, respectively.

The Contractor may delegate the grievance system process to subcontractors, however, the Contractor must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the grievance system requirements. This information

must include a description of: the right to a state fair hearing, the method for obtaining a state fair hearing, the Rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or state fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent. Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 17, Member Handbook and Member Communications, and Section D, Paragraph 69, Cultural Competency.

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

The Contractor will provide reports on the Grievance System as required in the Grievance System Reporting Guide available on the AHCCCS website at <http://www.azahcccs.gov/>.

### **23. MATERNITY CARE PROVIDER STANDARDS**

The Contractor shall ensure that a maternity care provider is designated for each pregnant member for the duration of her pregnancy and postpartum care and that those maternity services are provided in accordance with the AMPM. The Contractor may include in its provider network the following maternity care providers:

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

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

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

## 24. MEMBER COUNCILS

To promote a collaborative effort to enhance the service delivery system in local communities while maintaining a **member focus**, the Contractor shall establish a Member Council that will participate in providing input on policy and programs. The council is to be chaired by the Contractor's Administrator/CEO or designee and will meet at least quarterly. Every effort shall be made to include a cross representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. Members/families/significant others and member advocacy groups shall make up at least 50% of the membership. The Contractor shall provide an orientation and ongoing training for council members so they have sufficient information and understanding to fulfill their responsibilities. On an annual basis, the Contractor shall submit a plan to AHCCCS, Division of Health Care Management, outlining the schedule of meetings and the draft goals for the council. The DHCM will consider alternative proposals to these Member Council requirements. An alternative to these requirements should be submitted in writing annually by December 15<sup>th</sup>. AHCCCS, Division of Health Care Management shall be included on all correspondence to the Council, including agenda and Council minutes. Other reporting requirements pertaining to the Member Council are defined in Attachment D.

The Member Council should not be the only venue for the Contractor to communicate and participate in the issues affecting the local long-term care communities and members. Contractors should also actively participate with other long-term care and other related organizations so that there can be a better understanding of the long-term care issues in the local community and their impact on members.

## 25. STAFF REQUIREMENTS and SUPPORT SERVICES

The Contractor shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

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

The Contractor shall have local staff available 24 hours a day, seven days a week to work with AHCCCS and/or other State agencies (for example ADHS Licensure) on urgent issue resolutions, such as in the case of an Immediate Jeopardy (IJ), fires, or other public emergency situations. These staff person(s) shall have access to information necessary to identify members who may be at risk, their current health/service status, ability to initiate new placements/services, and to be available to perform status checks at affected facilities and potentially ongoing monitoring, if necessary. The Contractor shall supply AHCCCS CQM with the contact information for these staff persons, such as a telephone number, to call in these urgent situations.

The Contractor must obtain approval from AHCCCS prior to moving functions outside the State of Arizona. Such a request for approval must be submitted to the Division of Health Care Management at least 60 days prior to the proposed changes in operations and must include a description of the processes in place that assure rapid responsiveness to effect changes for contract compliance.

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

An individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below unless prior approval is obtained by AHCCCS, Division of Health Care Management. The Contractor shall inform the Division of Health Care Management, in writing within seven days, when an employee leaves one of the **Key Staff** positions listed below (this requirement does not apply to Additional Required Staff, also listed below). The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place along with a revised Organization Chart. Each year on October 15<sup>th</sup>, the Contractor must provide the name, Social Security Number and date of birth of the staff members performing the duties of the Key Staff listed as a, b and c below to the Office of the Inspector General (OIG). AHCCCS will compare this information against Federal databases to confirm that those individuals have not been banned or debarred from participating in Federal programs [42 CFR 455.104].

At a minimum, the following staff is required:

***Key Staff Positions:***

- a. **Administrator/CEO/COO** or their 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 and QM and MM components of the Contractor. The Medical Director shall devote sufficient time to the Contractor's operations to ensure timely medical decisions, including after-hours consultation as needed (see Paragraph 27).
- c. **Chief Financial Officer/CFO** to oversee the budget, accounting systems and financial reporting implemented by the Contractor.
- d. **Pharmacy Coordinator/Director** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or Contractor of the Plan.
- e. **Dental Director/Coordinator** that is responsible for coordinating dental activities of the Contractor and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or Contractor of the plan and must be a licensed dentist in Arizona if they are required to review or deny dental services.
- f. **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 designated and recognized authority to access records and make independent referrals to AHCCCS, Office of the Inspector General. See paragraph 70, Corporate Compliance for more information.
- g. **Dispute and Appeal Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for hearing and provider claim disputes.
- h. **Business Continuity Planning and Recovery Coordinator** as noted in the ACOM Policy 104.
- i. **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

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

- j. **Quality Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care 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
- k. **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
- l. **Maternal Health/EPSTD (child health) Coordinator** who is an Arizona licensed nurse, physician, or physician's assistant; or have a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM. Staffing under this position should be sufficient to meet quality and performance measure goals. The primary functions of the MCH/EPSTD Coordinator are:
- Ensuring receipt of EPSTD services
  - Ensuring receipt of maternal and postpartum care
  - Promoting family planning services
  - Promoting preventive health strategies
  - Identification and coordination assistance for identified member needs
  - Interface with community partners
- m. **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 degree in health services, health care administration, or business administration if not required to make medical necessity determination, 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 is conducted
  - Develop, implement and monitor the provision of care coordination, disease management and case management functions
  - Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
  - Monitor prior authorization functions and assure that decisions are made in a consistent manner based on clinical criteria and meet timeliness standards
- n. **Behavioral Health Coordinator** who shall be a behavioral health professional as described in Health Services Rule, 9 A.A.C. 20. The Behavioral Health Coordinator shall devote sufficient time to assure the Contractor's Behavioral Health Program is implemented per AHCCCS requirements. The primary functions of the Behavioral Health Coordinator are:

- Coordinate member behavioral care needs with behavioral health providers
  - Develop processes to coordinate behavioral health care between PCPs and behavioral health providers
  - Participate in the identification of best practices for behavioral health in a primary care setting
  - Coordinate behavioral care with medically necessary services
- o. **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 inquiries and appropriate education about participation in the AHCCCS program and maintain a sufficient provider network.
- p. **Claims Administrator** to develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and Federal requirements. The primary functions of the Claims Administrator are:
- Develop and implement claims processing systems capable of paying claims in accordance with state and Federal requirements
  - Develop processes for cost avoidance
  - Ensure minimization of claims recoupments
  - Meet claims processing timelines
  - Meet AHCCCS encounter reporting requirements
- q. **Provider Claims Educator** (full-time equivalent employee for a Contractor with over 100,000 members) The position is fully integrated with the Contractor's grievance, claims processing, and provider relations systems and facilitates the exchange of information between these systems and providers. The primary functions of the Provider Claims Educator are:
- Educate contracted and non-contracted providers (i.e., professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc.
  - Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls
  - Identify trends and guide the development and implementation of strategies to improve provider satisfaction
  - Frequently communicate (i.e., telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- r. **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of five years of management/supervisory experience in the health care field.

***Additional Required Staff:***

- s. **Prior Authorization staff** to authorize health care 24 hours per day, seven days per week. This staff shall 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.
- t. **Concurrent Review staff** to conduct inpatient concurrent review. This 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.
- u. **Clerical and support staff** to ensure proper functioning of the Contractor's operation.
- v. **Provider Services staff** to enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management, for more information).
- w. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
- x. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.

- y. **Case Management Supervisor(s)** to oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16 and a minimum of three years of management/supervisory experience in the health care field or a minimum of three years of case management experience.
- z. **Case Managers** in sufficient numbers and who meet the qualifications defined in Section D, Paragraph 16 to perform assessment and care planning services for all enrolled members.

The Contractor must submit to the Division of Health Care Management the following items annually by October 15:

1. An organization chart complete with the “**key staff**” positions. The chart must include the person’s name, title and telephone number and portion of time allocated to each Medicaid contract and other lines of business.
2. A functional organization chart of the key program areas, responsibilities and the areas which report to that position.
3. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

The Contractor is responsible for maintaining a significant local (within the State of Arizona) presence. This presence includes staff listed below.

***In State Positions:***

- Administrator/CEO/COO
- Medical Director/CMO
- Compliance Officer
- Dispute and Appeal Manager
- Contract Compliance Officer
- Quality Management Coordinator
- Maternal Health/EPSTD (child health) Coordinator
- Medical Management Coordinator
- Behavioral Health Coordinator
- Provider Services Manager
- Provider Claims Educator
- Concurrent Review Staff
- Clerical and Support Staff
- Provider Services Staff
- Case Management Administrator/Manager
- Case Management Supervisors
- Case Managers

***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. AHCCCS may require additional staffing for a Contractor that has substantially failed to maintain compliance with any provision of this contract and/or AHCCCS policies.

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

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

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

**26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS**

The Contractor shall develop and maintain written policies, procedures and job descriptions for each functional area, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least bi-annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's appropriate manager, coordinator, director or administrator. Minutes reflecting the review and approval of the policies by an appropriate committee are also acceptable documentation. All medical and quality management policies must be approved and signed by the Contractor's Medical Director. Job descriptions shall be reviewed at least bi-annually to ensure that current duties performed by the employee reflect written requirements.

Based on provider or member feedback, if AHCCCS deems a Contractor policy or process to be inefficient and/or place an unnecessary burden on the members or providers, the Contractor will be required to work with AHCCCS to change the policy or procedure within a time period specified by AHCCCS.

**27. MEDICAL DIRECTOR**

The Contractor shall have on staff a Medical Director who is currently actively licensed as a physician in Arizona through the Arizona Medical Board or the Arizona Osteopathic Board. The Medical Director must have at least three years of training and/or experience appropriate to the needs of the population being served. For example, if the program is mainly focused on the medical needs of members, then training/experience should be in a medical specialty. If the program is mainly focused on the behavioral health needs of members, then the training/experience should be in a psychiatric specialty. For those programs with a significant overlap in need (behavioral and medical), then the Medical Director should have sufficient training/experience to be able to comfortably and competently deal with issues in both areas. If not, then the Contractor must clearly identify a physician who will be available and accountable for these areas in which the Medical Director's training/experience may be lacking. The Medical Director shall be responsible for:

- a. The development, implementation and medical interpretation of medical policies and procedures to guide and support the provision of medical care to members. This includes, among others, policies pertaining to



- prior authorization, concurrent review, claims review, discharge planning, credentialing and referral management, as well as for medical review in the grievance, appeal and fair hearing processes.
- b. Oversight and involvement in provider recruitment activities.
  - c. As appropriate, reviewing all providers' applications and submitting recommendations to those with contracting authority regarding credentialing and reappointment of all professional providers who fall under the Contractor's scope of authority for credentialing (i.e., physicians, dentists, nurse practitioners, midwives, podiatrists and other licensed independent practitioners) prior to the physician's contracting (or renewal of contract) with the Contractor.
  - d. Oversight and involvement in provider profiling, provisional, initial, and organizational credentialing, and recredentialing.
  - e. Administration of all medical management activities of the Contractor.
  - f. Continuous assessment and improvement of the quality of care provided to members (e.g. oversight of quality of care issues, AHCCCS performance measures, Performance Improvement Projects, periodic medical study/audit).
  - g. The development and implementation of the quality management/medical management plan and serving as Chairperson of Quality Management, Credentialing Committee, Medical Management, and Peer Review Committees.
  - h. Oversight and involvement in provider education, in-service training and orientation.
  - i. Assuring that adequate staff and resources are available for the provision of proper medical care to members.
  - j. Attending AHCCCS Medical Directors' meetings.
  - k. Oversight of the Medical/Utilization Management Committee and/or data reporting.

During periods when the Medical Director is not available, the Contractor shall have physician staff to provide competent medical direction.

## 28. NETWORK DEVELOPMENT

The Elderly and Physically Disabled (EPD) population is expected to increase significantly in the coming years. As a result, the number of people needing long term care services and support will dramatically increase. It is critical for Contractors to develop provider networks that are diverse and flexible to meet a variety of member issues both in the immediate as well as long range basis. A priority should be placed on allowing members, when appropriate, to reside or return to their own home versus having to reside in an institutional or alternative residential setting. Some critical issues to consider in the development of an effective network are the following:

- Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles of (as defined in Section D, paragraph 2):
  - *Member-Centered Case Management*
  - *Consistency of Services*
  - *Available and Accessible Services*
  - *Most Integrated Setting*
  - *Collaboration with Stakeholders*
- Ensuring support of the member's informal support system (e.g., family caregivers).
- Developing HCB services and settings to meet the needs of members who have cognitive impairments, behavioral health needs, and other special medical needs.

- Providing not only linguistic services but also developing services that are able to address, as needed, the culture, race, ethnic and religious facets in the process of meeting the needs of members as described in the ACOM Policy 405 and Paragraph 69, Cultural Competency.

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

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of AHCCCS' culturally and linguistically diverse member population. The Contractor shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, and hospitalization for preventable medical problems.

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

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

The Contractor shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The requirements for the Network Development and Management Plan are found in the ACOM, Policy 415. The Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS within 45 days from the start of the contract year. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

In conjunction with ACOM Policy 415 IV. Procedure, bullet point #17, the Network Management and Development Plan must include specific pro-active strategies/actions the Contractor will take to reduce the percentage of HCBS members in Alternative Residential Settings once 20% or more of its HCBS membership resides in Alternative Residential Settings. The Contractor will not be required to reduce the Alternative Residential Setting placement percentage but will be expected to demonstrate the implementation of its strategies/actions. The strategies/actions that are developed shall not lead to or incentivize an increase in the percentage of members residing in nursing facilities.

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

In accordance with the ALTCS Network Standards specified in ACOM Policy and the members' needs, the proposed network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix or Tucson do not have to travel more than five miles to visit a PCP or pharmacy. A member residing outside the metropolitan boundary area, but within Maricopa or Pima County, must not have to travel more than 10 miles to see such providers if a provider resides within 10 miles and is willing to contract with the ALTCS Contractor. Any exceptions to the Network Standards must be prior approved by AHCCCS, Division of Health Care Management.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the Contractor must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs and quality consistent with its responsibilities under this contract nor does it preclude the Contractor from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If the Contractor declines to include individuals or groups of providers in its network, it must give the affected providers timely written notice of the reason for its decision [42 CFR 438.12(a)(1)]. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

***Other:***

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

***Ball v Betlach:***

In compliance with Orders by the District Court in Ball v Betlach the Contractor is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. The

Contractor shall resolve gaps in critical services within two hours of a gap being reported. The Contractor shall have back-up caregivers available on-call to substitute for those times when an unforeseeable gap in critical service occurs.

The term "critical services" is inclusive of tasks such as bathing, toileting, dressing, feeding, transferring to or from bed or wheelchair, and assistance with similar daily activities. A "gap in critical services" is defined as the difference between the number of hours of home care worker critical service scheduled in each member's HCBS care plan and the hours of the scheduled type of critical service that are actually delivered to the member. Also see AMPM Chapter 1600, Policy 1620 for an explanation of "critical services".

The Contractor shall implement policies and procedures to identify, correct, and track gaps in service. See ACOM Policy 413, and AMPM Chapter 1600. These policies shall, at a minimum, cover the following areas:

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

On a semi-annual basis, (November 15, May 15), the Contractor shall submit a report to AHCCCS outlining trends and corrective actions regarding gaps in services, grievances related to service gaps, and other reports as deemed necessary to fulfill the settlement agreement in the Ball v. Betlach case. See also Section D, ¶16, Case Management.

### ***Medicare Requirement to Coordinate Care for Dual Eligible ALTCS Individuals***

#### ***Background Information:***

ALTCS members who are also enrolled in Medicare are considered dual eligible. In an effort to improve care coordination for dual eligible members, AHCCCS requires the Contractor to be an organization that manages and provides Medicare benefits to ALTCS dual eligible members in its Geographic Service Area(s).

AHCCCS is currently working with CMS to implement a three-year Demonstration beginning January 1, 2014 which would integrate Medicare and Medicaid for dual eligible AHCCCS beneficiaries. AHCCCS submitted a Demonstration proposal to CMS on May 31, 2012 and this document can be found at:

<http://www.azahcccs.gov/commercial/Downloads/ContractAmendments/AcuteCare/YH08-0049/CYE12CMDPCContractRenewal.pdf>.

The integration of the Medicare and Medicaid program benefits is a new opportunity to improve quality through care coordination and reduce costs for dual eligible members in Arizona. Under the CMS Capitated Financial Alignment Model, a three way contract is entered into by CMS, AHCCCS, and the Contractor. The Contractor receives payments from both AHCCCS and CMS to provide comprehensive, coordinated care for the integrated Medicare and Medicaid benefits. AHCCCS intends to work with CMS to develop actuarially sound rates ensuring sufficient reimbursement for the Demonstration. The State is pursuing automatic enrollment of all dual eligible members into their ALTCS plan for Medicare benefits on January 1, 2014.

Under the Demonstration, individuals will have the ongoing option to opt-out of the plan for Medicare benefits.

It is important to note this Demonstration is pending Federal approval. The State continues to work with CMS and will involve Contractors whenever possible to develop the terms for a finalized contract or Memorandum of Understanding (MOU). The MOU will outline State-specific details associated with the terms and conditions of the Demonstration, including, but not limited to: Program Authority, Contracting Process, Readiness Review, Enrollment, Beneficiary Protections, Administration and Reporting, Quality Management, Financing and Payment, Evaluation, and Oversight Responsibilities. The contract/MOU may also change some or all of the clinical and non-clinical performance measures, performance improvement project and quality management requirements that are specified in contract. The Contract may be amended to include these requirements. Additional information and MOU templates can be found in the July 8 State Medicaid Director Letter Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees. The Demonstration approach is subject to change until the MOU is finalized and approved by CMS.

July 8 State Medicaid Director Letter:

[http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial\\_Models\\_Supporting\\_Integrated\\_Care\\_SMD.pdf](http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf).

AHCCCS Dual Demonstration Website: <http://www.azahcccs.gov/reporting/legislation/Integration/Duals.aspx>.

#### ***Participation in the Demonstration***

In addition to all requirements in this Contract, Contractors must meet all Medicare Demonstration participation requirements as dictated by CMS and AHCCCS. This may include, but is not limited to, approval of a Medicare Demonstration specific application, approval of a formulary consistent with Part D requirements, approval of a medication therapy management program (MTMP), and approval of a unified model of care March 29 CMS Memo found here:

[http://www.azahcccs.gov/reporting/Downloads/Integration/Duals\\_CMSMemo\\_MarchGuidanceDocumentforFinancialAlignmentDemonstrationPlans032912.pdf](http://www.azahcccs.gov/reporting/Downloads/Integration/Duals_CMSMemo_MarchGuidanceDocumentforFinancialAlignmentDemonstrationPlans032912.pdf)

Specific to the Demonstration and coordination of Medicare and Medicaid benefits for dual eligible members, the Contractor will be rigorously evaluated by CMS and AHCCCS as to the ability to improve quality and reduce costs for dual eligible individuals. After evaluation of the Contractor to become a Medicare Demonstration plan, a contract would be signed between CMS, the State, and the Contractor. This contract would outline the health plan responsibilities for dual eligible members enrolled in the Demonstration plan for Medicare in addition to Medicaid. Finally, the Contractor must pass a Readiness Review process that will be completed prior to enrollment of any beneficiary for Medicare. The Contractor will be subject to a Readiness Review by CMS and the State across all areas including but not limited to network adequacy, stakeholder involvement, and consumer protections.

All Contractors must submit a Notice of Intent to Apply with CMS as a Medicare-Medicaid Demonstration plan by November 9, 2012. This is a non-binding submission, but is required for the Contractor to participate as a Demonstration plan.

The Contractor will be responsible for working with the State and CMS to meet CMS Demonstration timelines and submission requirements.

#### ***Demonstration Requirements***

If the Contractor is either an outlier in CMS' past performance analysis for CY 2013 or has a "consistently low performing" icon on the Medicare Plan Finder website it may qualify to participate as a Demonstration plan,

after meeting other requirements, but will not be eligible to receive any new passive enrollments. If Contractor does not meet all CMS Demonstration requirements and become approved by CMS and the State to participate as a Demonstration plan or is not eligible to receive new passive enrollments, the State reserves the right to take whatever action it deems is in the best interest of the State, which may include termination of the Contract.

***Rates under the Medicare-Medicaid Demonstration***

If the State and CMS successfully reach an agreement to implement the Demonstration, capitation rates shall be adjusted for dual members participating in the Demonstration. The rates will be replaced with capitation rates computed by AHCCCS and CMS for the Medicaid and Medicare expenses, respectively, of the dual members projected under the Demonstration. AHCCCS intends to work with CMS to develop actuarially sound rates ensuring sufficient reimbursement for the Demonstration. AHCCCS proposes to use its current rate-setting methods for the Medicaid component of the Demonstration, including the potential for reconciliation of excess profits or losses.

***Participation as a Medicare Advantage Special Needs Plan***

If AHCCCS and CMS are unable to reach an agreement to implement the Demonstration, the Contractor will be required to provide Medicare benefits to dual eligible members as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP). The Contractor will be required to implement Medicare coverage on January 1, 2014. The Special Instructions for this procurement require the submission of a non-binding Notice of Intent to Apply as D-SNPs to CMS. This submission is **in addition** to the above Demonstration Notice of Intent to Apply, must submit a Notice of Intent to Apply as a D-SNP to CMS no later than November 9, 2012. Contractors would then be required to meet all additional requirements to become a D-SNP.

Additional information on D-SNPs can be found at: <http://www.cms.gov/SpecialNeedsPlans/>.

**29. NETWORK MANAGEMENT**

The Contractor shall have policies on how the Contractor will [AMPM; 42 CFR 438.214(a)]: Communicate and negotiate with the network regarding contractual and/or program changes and requirements;

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

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

***Material Change to Operations and/or Provider Network:***

***Operations:*** A material change to operations is defined as any change in overall business operations (i.e., policy, process, protocol such as prior authorization or retrospective review) which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this contract. It also includes any change that would impact more than 5% of total membership and/or provider network in a specific GSA.

The Contractor must submit the request for approval of a material change to operations, including draft notification to affected members and providers, 60 days prior to the expected implementation of the change. The request should contain, at a minimum, information regarding the nature of the operational change; the reason for the change; methods of communication to be used; and the anticipated effective date. If AHCCCS does not respond to the Contractor within 30 days; the request and the notices are deemed approved. A material change in Contractor operations requires 30 days advance written notice to affected providers and members. The requirements regarding material changes to operations do not extend to contract negotiations between the Contractor and a provider.

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

**Provider Network:** All material changes in the Contractor's provider network must be approved in advance by AHCCCS, Division of Health Care Management. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and network standards as described in this contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. The Contractor must submit the request for approval of a material change in their provider network, including draft notification to affected members, 60 days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If AHCCCS does not respond within 30 days the request and the notice are deemed approved. A material change in the Contractor's provider network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

The Contractor shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network [42 CFR 438.207(c)]. 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 quality of member care, if the provider network change is likely to affect the delivery of covered services.

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

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

### **30. PROVIDER MANUAL**

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

### **31. PROVIDER REGISTRATION**

The Contractor shall ensure that all its subcontractors register with AHCCCS as an approved service provider. For specific requirements on Provider Registration refer to the AHCCCS website at <http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx>

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



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

### **32. PROVIDER AFFILIATION TRANSMISSION**

The Contractor must submit information quarterly regarding its provider network. This information must be submitted in the format described in the Provider Affiliation Transmission (PAT) User Manual on October 15, January 15, April 15, and July 15 of each contract year. The PAT User Manual may be found on the AHCCCS website.

### **33. SUBCONTRACTS**

The Contractor shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c)]. No subcontract shall terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by the Contractor pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(l)]. See the ACOM Policy 203.

All subcontracts entered into by the Contractor are subject to prior review and written approval by AHCCCS, Division of Health Care Management, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to the AHCCCS Division of Health Care Management for prior approval at least 60 days prior to the beginning date of the subcontract.

#### ***Administrative Services Subcontracts:***

- a. Delegated agreements that subcontract:
  1. Any function related to the management of the contract with AHCCCS. Examples include member services, provider relations, quality management, medical management (e.g., prior authorization, concurrent review, issuance of denials or limited authorizations, member appeals, medical claims review, member record review)
  2. Claims processing, including pharmacy claims
  3. Credentialing including those for only primary source verification (CVO)
- b. All Management Service Agreements
- c. All service level agreements with any Division or Subsidiary of a corporate parent owner

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

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

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor

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

A merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS.

The Contractor must submit the Administrative Services Annual Subcontractor Assignment and Evaluation Report (within 90 days from the start of the contract year) detailing any Contractor duties and responsibilities that have been subcontracted as described under Administrative Services Subcontracts previously listed in this section.. The Administrative Services Annual Subcontractor Assignment and Evaluation Report will include the following:

- Subcontractor's name
- Delegated duties and responsibilities
- Most recent review date of the duties, responsibilities and financial position of the subcontractor
- A comprehensive summary of the evaluation of the performance (operational and financial) of the subcontractor. The full report shall be made available upon request from AHCCCS.
- Next scheduled review date
- Identified areas of deficiency
- Corrective action plans as necessary

The Contractor shall inform AHCCCS, Division of Health Care Management, within 30 days if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract. The Contractor will submit this in writing and provide the Corrective Action Plan and any measures taken by the Contractor to bring the subcontractor into compliance.

***Provider Agreements:***

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

The Contractor shall require any ADHS licensed or certified provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. The Contractor shall monitor contracted providers for compliance with quality assurance measures such as supervisory visits conducted by a Registered Nurse when a home health aide is providing services.

The Contractor must enter into a written agreement with any provider the Contractor reasonably anticipates will be providing services at the request of the Contractor more than 25 times during the contract year. Exceptions to this requirement include the following:

- a. If a provider who provides services more than 25 times during the contract year refuses to enter into a written agreement with the Contractor, the Contractor shall submit documentation of such refusal to

- AHCCCS Division of Health Care Management within seven days of its final attempt to gain such agreement.
- b. If a provider performs emergency services such as an emergency room physician or an ambulance company, a written agreement is not required.
  - c. Individual providers as detailed in the AMPM.
  - d. Hospitals, as discussed in Section D, Paragraph 36, Hospital Subcontracting and Reimbursement.
  - e. If a provider primarily performs services in an inpatient setting.
  - f. If upon the Medical Director's review, it is determined that the Contractor or members would not benefit by adding the provider to the contracted network.

Any other exceptions to this requirement must be approved by AHCCCS Division of Health Care Management. If AHCCCS does not respond within 30 days the requested exception is deemed approved. The Contractor may request an expedited review and approval.

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

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

All subcontracts must reference the provisions of Attachment A, Minimum Subcontract Provisions located on the AHCCCS website at <http://www.azahcccs.gov/commercial/default.aspx>. In addition, each subcontract must contain the following:

- a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
- b. Identification of the name and address of the subcontractor.
- c. Identification of the population, to include patient capacity, to be covered by the subcontractor.
- d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
- e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation.
- f. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability.
- g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to the Contractor.
- h. A description of the subcontractor's patient medical, dental and cost record keeping system.
- i. Specification that the subcontractor shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.
- j. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of the Contractor shall require a contract amendment and prior approval of AHCCCS.
- k. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population.
- l. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.

- m. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members.
- n. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
- o. Provision(s) that allow the Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.
- p. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor.
- q. For Nursing Facility subcontracts, a provision that the subcontractor must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e) 3 and (g) 2. The provision must also require the subcontractor to ensure these registry personnel are fingerprinted as required by ARS §36-411.
- r. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee (42 CFR 438.210(e)).

If a Contractor has a contract for specialty services with a nursing facility or assisted living facility, these contracts must include Work Statements that outline the special services being purchased, including admission criteria, discharge criteria, staffing ratios (if different from non-specialty units), staff training requirements, program description and other non-clinical services such as increased activities.

#### 34. ADVANCE DIRECTIVES

The Contractor shall maintain policies and procedures addressing directives for adult members that specify [42 CFR 422.128]:

- a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care must comply with Federal and state law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:
  - (1) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)
  - (2) Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].
  - (3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
  - (4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
  - (5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- b. Contractors shall require subcontracted PCPs which have agreements with the entities described in paragraph a. above, to comply with the requirements of subparagraph a. (1) through (5) above. Contractors shall also encourage health care providers specified in subparagraph a to provide a copy

of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

- c. The Contractor shall provide written information to adult members that describe the following:
  - (1) A member's rights under State law, including a description of the applicable State law
  - (2) The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience
  - (3) The member's right to file complaints directly with AHCCCS
  - (4) Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)]

### 35. SPECIALTY CONTRACTS

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

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

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

### 36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

***Maricopa and Pima counties only:*** The Inpatient Hospital Reimbursement Program is defined in the Arizona Revised Statutes (A.R.S.) 36-2905.01, and requires hospital subcontracts to be negotiated between Contractors in Maricopa and Pima counties to establish reimbursement levels, terms and conditions. Subcontracts shall be negotiated by the Contractor and hospitals to cover operational concerns, such as timeliness of claims submission and payment, payment of discounts or penalties, and legal resolution, which may, as an option, include establishing arbitration procedures. These negotiated subcontracts shall remain under close scrutiny by AHCCCS to insure availability of quality services within specific service districts, equity of related party interests, and reasonableness of rates. The general provisions of this program encompass acute care hospital services and outpatient hospital services that result in an admission. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and any amendments. For non-emergency patient-days, the Contractor shall ensure that at least 65% of its members use contracted hospitals. AHCCCS reserves the right to subsequently adjust the 65% standard. Further, if in AHCCCS' judgment the number of non-emergency inpatient days at a particular non-contracted hospital becomes significant, AHCCCS may require a subcontract at that hospital. In accordance with R9-22-718, unless otherwise negotiated by both parties, the reimbursement for inpatient services, including outliers, provided at a non-contracted hospital shall be based on the rates as defined in A.R.S. § 36-2903.01, multiplied by 95%.

***All counties EXCEPT Maricopa and Pima:***

The Contractor shall reimburse hospitals for member care in accordance with AHCCCS Rule 9 A.A.C. 22, Article 7. The Contractor is encouraged to obtain subcontracts with hospitals in all GSA's. The Contractor, upon request, shall make available to AHCCCS, all hospital subcontracts and amendments.

***For Out-of-State Hospitals:***

The Contractor shall reimburse out-of-state hospitals in accordance with AHCCCS Rule 9 A.A.C. 28, Article 7. A Contractor serving border communities (excluding Mexico) is strongly encouraged to establish contractual agreements with bordering out-of-state hospitals.

***Hospital Recoupments:***

The Contractor may conduct pre-payment and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Contractor fails to identify lack of medical necessity through concurrent review and/or pre-payment medical review, lack of medical necessity identified during post-payment medical review shall not constitute a basis for recoupment by the Contractor. See also Section D, Paragraph 44, Claims Payment/Health Information System. For a more complete description of the guidelines for hospital reimbursement, please consult the applicable statutes and Rules.

***Outpatient Hospital Services:***

In the absence of a contract, the default payment rate for outpatient hospital services billed on a UB-04 will be based on the AHCCCS outpatient hospital fee schedule, rather than a hospital-specific cost-to-charge ratio (pursuant to ARS 36-2904).

### **37. PRIMARY CARE PROVIDER STANDARDS**

The Contractor shall include in its provider network a sufficient number of PCPs to meet the requirements of this contract. Health care providers designated by the Contractor as PCPs shall be licensed in Arizona as allopathic or osteopathic physicians who generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; certified nurse practitioners or certified nurse midwives; or physician's assistants [42 CFR 438.206(b)(2)].

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. The Contractor should also consider the PCP's total panel size (e.g. AHCCCS and non-AHCCCS patients) when making this determination. The Contractor will adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards.

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

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

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with 42 CFR 438.6(m) and 438.52(d) and this contract. The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall

inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Contractor's receipt of notification of assignment by AHCCCS. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the ACOM Policy 404. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

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

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

### 38. APPOINTMENT STANDARDS

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

The Contractor shall have monitoring procedures in place that ensure:

For **PCP appointments**, the Contractor shall be able to provide:

- a. Emergency appointments the same day or within 24 hours of the member's phone call or other notification, or as medically appropriate
- b. Urgent care appointments within 2 days of request
- c. Routine care appointments within 21 days of request

For **specialty referrals**, the Contractor shall be able to provide:

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

For **behavioral health services**, the Contractor shall be able to provide:

- a. Emergency appointments within 24 hours of referral
- b. Routine appointments within 30 days of referral

For **dental appointments**, the Contractor shall be able to provide:

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

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

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

The Contractor shall actively monitor provider compliance with Appointment Standards through methods such as “mystery shopping” and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits [42 CFR 438.206(c)(1)(i)].

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

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

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

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

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

### **39. INCENTIVES/PAY FOR PERFORMANCE**

#### ***Physician Incentives:***

The reporting requirements under 42 CFR 417.479 have been suspended. No reporting to CMS is required until the suspension is lifted.



The Contractor must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479. These regulations prohibit physician incentive plans that directly or indirectly make payments to a doctor or a group as an inducement to limit or refuse medically necessary services to a member. The Contractor is required to disclose all physician incentive agreements to AHCCCS and to AHCCCS members who request them.

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

- a. A complete copy of the contract;
- b. A plan for the member satisfaction survey;
- c. Details of the stop-loss protection provided;
- d. A summary of the compensation arrangement that meets the substantial financial risk definition.

The Contractor shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(i) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS.

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

***Nursing Facility/HCBS Shared Savings Demonstration Model***

The Contractor shall work collaboratively with a minimum of five nursing facilities and three home and community based service providers to develop a shared savings demonstration model(s), aimed at improving the quality of care and outcomes for dual eligible members enrolled with the Contractor for both Medicaid and Medicare, while also enhancing operational and financial efficiencies. AHCCCS prefers that all models recognize both Medicare and Medicaid expenses and savings, and requires that a portion of these combined savings realized as a result of the model(s) be distributed back to participating providers. It is AHCCCS' intent that Contractors be permitted to keep a share of the Medicaid savings generated by these efforts, if any. Further, AHCCCS intends to raise this issue with CMS for consideration with Medicare rate setting for the duals demonstration. The Contractor shall submit an outline and work plan, detailing the proposed model(s), including identified measures that seek to align performance and financial incentives, to AHCCCS on or before January 1, 2013, for an anticipated implementation date of January 1, 2014.

***Transparency:***

AHCCCS programs will be in compliance with Federal and State transparency initiatives. AHCCCS may publicly report or make available any data, reports, analysis or outcomes related to Contractor activities, operations and/or performance. Public reporting may include, but is not limited to, the following components:

- a. Use of evidence-based guidelines
- b. Identification and publication of top performing Contractors
- c. Identification and publication of top performing providers
- d. Program pay for performance payouts
- e. Mandated publication of guidelines
- f. Mandated publication of outcomes
- g. Identification of Centers of Excellence for specific conditions, procedures or member populations
- h. Establishment of Return on Investment goals

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

#### **40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS**

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

- a. Use of referral forms clearly identifying the Contractor;
- b. Process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services;
- c. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services;
- d. Referral to Medicare Managed Care Plan;
- e. PCP referral shall be required for specialty physician services, except that women shall have direct access to in-network GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice [42 CFR 438.206(b)(2)]. In addition, for members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
- f. Allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].
- g. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.

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

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

#### **41. MAINSTREAMING OF ALTCS MEMBERS**

To ensure mainstreaming of ALTCS members, the Contractor shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic

information or physical or intellectual disability. Contractors must take into account a member's literacy and culture, when addressing members and their concerns, and must take reasonable steps to ensure subcontractors to do the same. The Contractor must also make interpreters, including assistance for the visual or hearing impaired, available to members at no cost to ensure appropriate delivery of covered services.

Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 CFR 438.6(f):

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

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

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

#### **42. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINICS (RHCs)**

The Contractor is encouraged to use FQHCs/RHCs and FQHC Look-Alikes in Arizona to provide covered services. AHCCCS requires the Contractors to negotiate rates of payment with FQHCs/RHCs/FQHC Look-Alikes for non-pharmacy services that are comparable to the rates paid to providers that provide similar services. AHCCCS reserves the right to review a Contractor's negotiated rates with an FQHC/RHC/FQHC Look-Alikes for reasonableness and to require adjustments when negotiated rates are found to be substantially less than those being paid to other, non-FQHC/RHC/FQHC Look-Alikes providers for comparable services.

For FQHC and FQHC Look-Alike pharmacies, all drugs identified in the 340B Drug Pricing Program are required to be billed at the lesser of: 1) the actual acquisition cost of the drug or 2) the 340B ceiling price. These drugs shall be reimbursed at the lesser of the two amounts above plus a dispensing fee. See AHCCCS Rule R9-22-710 (C) for further details.

The Contractor is required to submit member month information for Title XIX members for each FQHC/RHC/FQHC Look-Alikes on a quarterly basis to AHCCCS Division of Health Care Management. AHCCCS may perform periodic audits of the member information submitted. Contractors should refer to the AHCCCS Reporting Guide for ALTCS Contractors for further guidance. The FQHCs/RHCs registered with AHCCCS are listed on the AHCCCS website: [www.azahcccs.gov](http://www.azahcccs.gov).

**43. RESERVED****44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM**

The Contractor shall develop and maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, service utilization and claim disputes and appeals [42 CFR 438.242(a)].

***System Requirements:***

The Contractor must have a health information system that integrates member demographic data, case management information, provider information, service provision, claims submission and reimbursement. This system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with ARS 36-2903, 2904 and AHCCCS Rules R9-28 Article 7. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements as needed.

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

- Medicaid Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services;
- Multiple Surgical Reductions;
- Global Day E & M Bundling.

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

- Benefit Package Variations;
- Timeliness Standards;
- Data Accuracy;
- Adherence to AHCCCS Policy;
- Provider Qualifications;
- Member Eligibility and Enrollment;
- Over-Utilization Standards.

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

- An adequate description of all denials and adjustments;
- The reasons for such denials and adjustments;
- The amount billed;
- The amount paid;
- Application of COB and SOC; and
- Provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). The remittance advice sent related to an EFT must be sent to the provider, no later than the date of the EFT.

**General Claims Processing Requirements:**

AHCCCS will require the Contractor to participate in an AHCCCS workgroup to develop uniform guidelines for standardizing hospital outpatient and outpatient provider claim requirements, including billing Rules and documentation requirements. The workgroup may be facilitated by an AHCCCS selected consultant. The Contractor will be held responsible for the cost of this project based on its share of AHCCCS enrollment.

Standardized claims for services must be submitted per R9-22-710, therefore,

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

A claim for an authorized service submitted by a licensed skilled nursing facility, alternative residential setting or other home and community based provider (see Section D, ¶10, Subsection Long Term Care Services) shall be adjudicated within 30 days after receipt by the Contractor. Any clean claim for an authorized service provided to a member that is not paid within 30 days after the claim is received accrues interest at the rate of 1% per month from the date the claim is submitted. The interest is prorated on a daily basis and must be paid by the Contractor at the time the clean claim is paid. (A.R.S. 36-2943.D)

Unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than six months after the date of service or pay a clean claim submitted more than 12 months after the date of service except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claims mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date or the effective date of eligibility posting, whichever is later as stated in A.R.S. 36-2904H.

In accordance with the Deficit Reduction Act of 2005, Section 6085, the Contractor is required to reimburse non-contracted emergency services providers at no more than the AHCCCS FFS rate. This applies to in-state as well as out-of-state providers.

In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, the Contractor is required to reimburse non-contracted non-emergent in state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at 95% of the AHCCCS fee for service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered services.

For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. 2903.01. Effective for all non-hospital clean claims (excluding licensed skilled nursing facilities, alternative residential settings and home and community based claims) in the absence of a contract specifying other late payment terms, Contractors are required to pay interest on late payments. Late claims payments are those that are paid after 45 days of receipt of the clean claim (as defined in this contract). In grievance or claim dispute situations, interest shall accrue from the day following 45 days after receipt of the clean claim through the date of payment resulting from the grievance/claim dispute decision. Interest shall be at the rate of 10% per annum, unless a different rate is stated in a written contract. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after the contracted clean claim payment date. When slow payment penalties or interest is paid, the Contractor must report penalty or interest as directed in the AHCCCS Encounter Manual.

Unless a subcontract specifies otherwise, Contractors shall ensure that 90% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

***Electronic Transactions:***

Contractors are required to accept and generate required HIPAA compliant electronic transactions from/to any provider interested in and capable of electronic submission or electronic remittance receipt; and, must be able to make claims payments via electronic funds transfer. In addition, Contractors shall implement and meet the following milestones in order to make claims processing and payment more efficient and timely:

- Urban GSAs: Receive and pay 60% of all claims electronically based on volume of actual claims processed excluding claims processed by Pharmacy Benefit Managers (PBMs). A Contractor who is in both urban and rural GSAs must meet the urban GSA benchmark.
- Rural GSAs: a. Receive claims electronically based on volume of actual claims processed excluding claims processed by Pharmacy Benefit Managers (PBMs). Benchmarks as follows:
- |           |     |
|-----------|-----|
| 2011-2012 | 30% |
| 2012-2013 | 40% |
| 2013-2014 | 50% |
| 2014-2015 | 60% |
| 2015-2016 | 60% |
- b. Pay 60% of all claims electronically based on volume of paid claims excluding claims processed by Pharmacy Benefit Managers (PBMs).

***Recoupments:***

The Contractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of \$50,000 per provider within a contract year must be approved in advance by AHCCCS, Division of Health Care Management. AHCCCS will respond within 30 days of the recoupment request. AHCCCS must be notified of any cumulative recoupment greater than \$50,000 per provider Tax Identification Number per contract year. A Contractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim without prior approval of AHCCCS as further described in the ACOM Policy 412.

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

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

The Contractor must void encounters that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. AHCCCS will validate the submission of applicable voids and replacement encounters upon completion of any approved recoupment that meets the qualifications of this section. All replaced or voided encounters must reach adjudicated status within 120 days of the approval of the recoupment. The Contractor should refer to the ACOM Policy 412 and the AHCCCS Encounter Manual for further guidance.

***Appeals:***

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

***System Related Reporting:***

The Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Dashboard Reporting Guide.

AHCCCS may in the future require Contractors to review claim requirements, including billing Rules and documentation requirements, and submit a report to AHCCCS that will include the rationale for the requirements. AHCCCS shall determine and provide a format for the report.

***System Changes and Upgrades:***

The Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least six months before the anticipated implementation date, the Contractor shall provide the system change plan to AHCCCS for review and comment.

***System Audits:***

The Contractor shall develop and implement an internal claims audit function that will include the following:

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

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

Additionally, AHCCCS may require the Contractor to have an independent audit of the Claims Payment/Health Information System. The Division of Health Care Management will monitor the scope of this audit, to include no less than a verification of contract information management (contract loading and auditing), claims processing and encounter submission processes. The Contractor may be required in future contract years to initiate an additional independent Claim System/Health Information System audit at the direction of the AHCCCS Administration. In the event of a system change or upgrade, the Contractor may be required to initiate an independent Claim System/Health Information System audit.

**45. MINIMUM CAPITALIZATION REQUIREMENTS**

In order to be considered for contract award, the Offeror must meet a minimum capitalization requirement for each GSA bid. The capitalization requirement for both new and continuing Offerors must be met within 30 days after contract award [42 CFR 438.116(a)(1) and (b)(1)].



Minimum capitalization requirements by GSA are as follows:

Geographic Service Area (GSA)	# Members as of (January 1, 2011)	Awards	Proposed Capitalization Requirement Per Contractor
Maricopa (52)	15,296	3	\$5,000,000
Mohave/Coconino/Apache/Navajo (44)	1,492	1	\$1,500,000
La Paz/Yuma (42)	810	1	\$ 800,000
Pima/Santa Cruz (50)	4,337	1	\$4,300,000
Cochise/Graham/Greenlee (46)	871	1	\$ 900,000
Pinal/Gila (40)	1,498	1	\$1,500,000
Yavapai (48)	987	1	\$1,000,000

***New Offerors:***

To be considered for a contract award in a given GSA or group of GSAs, a new Offeror must meet the minimum capitalization requirements listed above. The capitalization requirement is subject to a \$5,000,000 ceiling regardless of the number of GSAs awarded. This requirement is in addition to the Performance Bond requirements defined in Paragraphs 46 and 47 below and must be met with cash with no encumbrances, such as a loan subject to repayment. The capitalization requirements may be applied toward meeting the equity per member requirement (see Section D, Paragraph 52. Financial Viability Criteria) and is intended for use in operations of the Contractor.

***Continuing Offerors:***

Continuing Offerors that are bidding a county or GSA that they are currently servicing must meet the equity per member standard (see Section D, Paragraph 52. Financial Viability Criteria) for their current membership. Continuing Offerors that do not meet the equity standard must fund through capital contribution the necessary amount to meet this requirement. Continuing Offerors that are bidding a new GSA must provide the additional capitalization for the new GSA they are bidding. (See the table of requirements by GSA above). Continuing Offerors will not be required to provide additional capitalization if they currently meet the equity per member standard with their existing membership and their excess equity is sufficient to cover the proposed additional members, or they have at least \$5,000,000 in equity.

**46. PERFORMANCE BOND OR BOND SUBSTITUTE**

In addition to the minimum capitalization requirements, the Contractor shall be required to establish and maintain a performance bond, in accordance with the ACOM Policy 306 to AHCCCS for 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, to guarantee: (1) payment of the Contractor's obligations to providers, and (2) performance by the Contractor of its obligations under this contract [42 CFR 438.116]. The performance bond shall be in a form acceptable to AHCCCS as described in the ACOM Policy 306.

In the event of a default by the Contractor, AHCCCS shall, in addition to any other remedies it may have under this contract, obtain payment under the performance bond or substitute security for the purposes of the following:

- a. Paying any damages sustained by providers, contracted or otherwise, because of a breach of the Contractor's obligations under this contract;
- b. Reimbursing AHCCCS for any payments made by AHCCCS on behalf of the Contractor; and

- c. Reimbursing AHCCCS for any extraordinary administrative expenses incurred by reason of a breach of the Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the state by AHCCCS.

In the event AHCCCS agrees to accept substitute security in lieu of the security types outlined in the ACOM Policy 306, the Contractor agrees to execute any and all documents and perform any and all acts necessary to secure and enforce AHCCCS' security interest in such substitute security including, but not limited to, security agreements and necessary UCC filings pursuant to the Arizona Uniform Commercial Code. The Contractor must request acceptance from AHCCCS when a substitute security in lieu of the security types outlined in the ACOM Policy 306 is established. In the event such substitute security is agreed to and accepted by AHCCCS, the Contractor acknowledges that it has granted AHCCCS a security interest in such substitute security to secure performance of its obligations under this contract. The Contractor is solely responsible for establishing the credit-worthiness of all forms of substitute security. AHCCCS may, after written notice to the Contractor, withdraw its permission for substitute security, in which case the Contractor shall provide AHCCCS with a form of security described in the ACOM Policy 306. The Contractor may not change the amount, duration or scope of the performance bond without prior approval from AHCCCS, Division of Health Care Management.

The Contractor shall not leverage the bond for another loan or create other creditors using the bond as security.

#### **47. AMOUNT OF PERFORMANCE BOND**

The initial amount of the performance bond shall be equal to 80% of the total capitation payment (full long term care and acute care only) expected to be paid to the Contractor in the first month of the contract year, or as determined by AHCCCS. This requirement must be satisfied by the Contractor no later than 30 days after notification by AHCCCS of the amount required. Thereafter, AHCCCS shall evaluate the capitation amounts of the Contractor on a monthly basis to determine if the performance bond must be increased. The Contractor shall have 30 days following notification by AHCCCS to increase the amount of the performance bond. The Performance Bond amount that must be maintained after the contract term shall be sufficient to cover all outstanding liabilities and will be determined by AHCCCS. The Contractor may not change the amount of the Performance Bond without prior written approval from AHCCCS, Division of Health Care Management. Refer to the ACOM Policy 305 for more details.

#### **48. ACCUMULATED FUND DEFICIT**

The Contractor and its owners must review for accumulated fund deficits on a quarterly and annual basis. In the event the Contractor has a fund deficit, the Contractor and its owners shall fund the deficit through capital contributions in a form acceptable to AHCCCS. The capital contributions must be for the period in which the deficit is reported and shall occur within 30 days of the financial statement due date to AHCCCS. AHCCCS at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. AHCCCS may, at its option, impose enrollment caps in any or all GSA's as a result of an accumulated deficit, even if unaudited.

#### **49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLANS**

If the Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS upon request. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership

occur. AHCCCS will not permit two Contractors to utilize the same management service company in the same GSA.

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

#### **50. ADVANCES, DISTRIBUTIONS AND LOANS**

The Contractor shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line business within its organization. The Contractor shall not, without prior approval of AHCCCS, make loans or advances to providers in excess of \$50,000. All requests for prior approval are to be submitted to the AHCCCS Division of Health Care Management. Refer to the ACOM Policy 418 for further information.

#### **51. RESERVED**

#### **52. FINANCIAL VIABILITY STANDARDS**

The Contractor must comply with the AHCCCS established financial viability standards. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: 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 a critical combination of the Financial Viability Standards are not met, 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 may include 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 at the end of the period) Additional information regarding the Equity per Member requirement may be found in the ACOM Policy 306 and Policy 305.

Standard: At least \$2,000

**Medical Expense Ratio**

Standard: At least 85%

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

**Total Administrative Cost Percentage**

Standard: No greater than 8%

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

The Contractor shall comply with all financial reporting requirements contained in Attachment D, Chart of Deliverables and the ALTCS Financial Reporting Guide; 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 D, Chart of Deliverables.

**53. SEPARATE INCORPORATION**

Within 60 days of contract award, a non-governmental Contractor shall have established a separate corporation for the purposes of this contract, whose sole activity is the performance of the requirements of this contract.

**54. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP**

A proposed merger, reorganization or change in ownership of the Contractor shall require prior approval of AHCCCS and may require a contract amendment. AHCCCS may terminate this contract pursuant to Section E, CONTRACT TERMS AND CONDITIONS, Paragraph 19, Temporary Management/Operation of a Contractor and Termination. If the Contractor does not obtain prior approval or AHCCCS determines that the change in ownership is not in the best interest of the State, AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA.

The Contractor must submit a detailed merger, reorganization and/or transition plan to AHCCCS, Division of Health Care Management, for review at least 60 days prior to the effective date of the proposed change. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to perform the contract requirements, ensure that services to members are not diminished and that major components of the organization and AHCCCS programs are not adversely affected by such merger, reorganization or change in ownership.

**55. RESERVED****56. COMPENSATION**

The forms of compensation under this contract will be Prior Period Coverage (PPC) capitation, prospective capitation, reinsurance and payments from liable first and third parties, as described and defined within this contract and appropriate laws, regulations or policies.

Subject to the availability of funds, AHCCCS shall make payments to the Contractor in accordance with the terms of this contract provided that the Contractor's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of ARS Title 36. AHCCCS reserves the option to make payments to the Contractor by wire or National Automated Clearing House Association (NACHA) transfer and will provide the Contractor at least 30 days notice prior to the effective date of any such change.

Where payments are made by electronic funds transfer, AHCCCS shall not be liable for any error or delay in transfer, nor indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor.

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

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

No payment due the Contractor by AHCCCS may be assigned or pledged by the Contractor. This section shall not prohibit AHCCCS at its sole option from making payment to a fiscal agent hired by the Contractor.

Capitation is not available for amounts expended for providers excluded by Medicare, Medicaid, or S-CHIP, except for emergency services.

Actuaries establish the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purpose of setting and rebasing and/or updating the capitation rates:

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

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The following are examples of risk factors that may be included:

- a. Reinsurance (as described in Paragraph 58)
- b. Medicare enrollment
- c. HCBS member mix
- d. Member share of cost amounts

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.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary. A Contractor may cover services that are not covered under the State Plan; however, those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)].

***Prospective Capitation:***

The Contractor will be paid capitation for all prospective member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during the prospective period.

The Contractor may receive two types of prospective capitation: full long term care capitation and acute care only capitation. Full long term care capitation is paid for those members who are receiving long term care services and reside in a nursing facility, a certified home and community based setting or in their own home. At a minimum, the member must receive long term care services at least once every 30 days.

Acute care only capitation is paid for those members who are: residing in an uncertified facility, refusing long term care services, awaiting disenrollment from the ALTCS program, or have not received long term care services for more than 30 days. Chapter 1600 of the AMPM and, Chapter 1600 of the ALTCS Eligibility Manual describe the Contractor's reporting responsibility regarding ALTCS members who meet this criteria.

***Prior Period Coverage (PPC) Capitation:***

The Contractor will be paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during prior period coverage. The PPC capitation rates will be set by AHCCCS and will be paid to the Contractor along with the prospective capitation described above.

***Reconciliation of PPC Costs to Reimbursement:***

AHCCCS will offer a reconciliation process for Contractors whose total PPC medical experience (excluding administrative and non-operating expenses and premium tax) is more than 5% higher than the reimbursement associated with PPC (PPC capitation excluding administrative add-on and premium tax). AHCCCS will reimburse 100% of the amount in excess of 5% of a Contractor's reasonable costs. AHCCCS may also require Contractors to provide documentation to support an audit of the PPC medical expenses and reconciliation to audited medical expenses. AHCCCS may recoup from any Contractor, profit amounts in excess of a 5% limit.

***HCBS Assumed Mix and Recoupment:***

The Contractor's capitation rate is based in part on the assumed ratio ("mix") of HCBS member months to the total number of member months (i.e. HCBS + institutional). After the end of the contract year, AHCCCS will compare the *actual* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. Member months for those members who received acute care services only are not included in this reconciliation. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage. This reconciliation will be made in accordance with the following schedule and ACOM Policy 303:

Percent <i>over/under</i> assumed percentage:	Amount to be recouped/reimbursed:
0 – 1%	0% of capitation over/underpayment
>1%	50% of capitation over/underpayment

***Share of Cost Reconciliation:***

After the end of the contract year, AHCCCS will compare actual Share of Cost assignment to the Share of Cost assignment assumed in the calculation of the capitation rate. Assumed Share of Cost will be fully reconciled to actual Share of Cost Assignment, and AHCCCS will either recoup or refund the total difference, as applicable. This share of cost reconciliation may, at AHCCCS' sole discretion, be performed more frequently than once per year.

***NF Enhanced Payment Reconciliation:***

After the end of the contract year, AHCCCS will compare actual NF Enhanced Payment funds to the NF Enhanced Payment allotment assumed in the calculation of the capitation rate. Assumed NF Enhanced Payment will be fully reconciled to actual NF Enhanced Payment funds, and AHCCCS will either recoup or refund the total difference, as applicable. This NF Enhanced Payment reconciliation may, at AHCCCS' sole discretion, be performed more frequently than once per year.

***Cost Settlement for Primary Care Payment Parity:***

The Patient Protection and Affordable Care Act (ACA) requires that the Contractor pay qualified primary care providers (and other providers specified in ACA) fees that are no less than the Medicare fee schedule in effect for 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare conversion factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes. AHCCCS has developed an enhanced fee schedule containing the qualifying codes using the 2009 Medicare conversion factor in compliance with the greater-of requirement. The enhanced payments apply only to services provided on and after January 1, 2013 by qualified providers, who self-attest to AHCCCS as defined in the federal regulations.

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

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

AHCCCS will make quarterly cost-settlement payments to the Contractor based upon adjudicated/approved encounter data. The Contractor will be required to refund payments to AHCCCS for any reduced claim payments in the event that a provider is subsequently "decertified" for enhanced payments due to audit or other reasons.

Refer to ACOM Draft Policy for further details.

***Provider Rate Requirements:***

Contractors shall ensure that individual Nursing Facility rates are at least equal to the Fee-for-Service rates. AHCCCS may verify that these reimbursement requirements for nursing facility providers have been met.

The Contractors should provide AHCCCS with documentation to support rate adjustments that need to be considered when building the capitation rates. AHCCCS expects provider contracts to be finalized by the start of the contract year. All negotiations on rates are to be done in good faith.

## **57. MEMBER BILLING AND LIABILITY FOR PAYMENT**

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

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

- The Contractor's or any subcontractor's debts in the event of the Contractor's or the subcontractor's insolvency;
- Covered services provided to the member except as permitted under R9-28-702; or
- Payments to the Contractor or any subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if the Contractor or any subcontractor provided the services directly.

## 58. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services as described in this paragraph and incurred for a member beyond an annual deductible. AHCCCS is self-insured for the reinsurance program and is characterized by an initial deductible level and a subsequent coinsurance percentage (see table below). The coinsurance percent is the rate at which AHCCCS will reimburse the Contractor for covered services incurred above the deductible. The deductible is the responsibility of the Contractor. Deductible levels are subject to change by AHCCCS during the term of this contract. Any change would have a corresponding impact on capitation rates.

The deductible level is based on the Contractor's statewide ALTCS enrollment as of October 1st of each contract year. The following table represents current deductible and coinsurance levels:

### *Prospective Reinsurance*

<i>Statewide Plan Enrollment</i>	<i>Deductible With Medicare Part A</i>	<i>Deductible Without Medicare Part A</i>	<i>Coinsurance</i>
<b>0-1,999</b>	<b>\$10,000</b>	<b>\$20,000</b>	<b>75%</b>
<b>2,000 +</b>	<b>\$20,000</b>	<b>\$30,000</b>	<b>75%</b>

Annual deductible levels apply to all members. AHCCCS may increase each of the deductible levels above by \$5,000 annually on October 1.

### **Reinsurance Case Types**

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

### ***Regular Reinsurance:***

Regular reinsurance coverage applies to prospective enrollment periods and is only available for members who have had an inpatient stay during the contract year. Once an inpatient stay has occurred, all reinsurance covered services for the entire contract year may be applied to meet the deductible. Regular reinsurance covered services only include medically necessary acute care services, including outpatient and inpatient hospitalizations. See the AHCCCS Reinsurance Processing Manual for further detail.

### ***Prior Period Coverage Reinsurance:***

PPC expenses are not covered for any members under the reinsurance program unless they qualify under catastrophic or transplant reinsurance.

### ***Catastrophic Reinsurance:***

The Catastrophic Reinsurance program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with hemophilia and non-DDAVP responding Von Willebrand's Disease, Gaucher's Disease and those considered by AHCCCS to be high cost behavioral health who are reinsurance eligible. For additional detail and restrictions refer below and to the AHCCCS Reinsurance Processing



Manual and the AMPM. There are no deductibles for catastrophic reinsurance cases. For members receiving Biotech drugs outside of specific conditions mentioned in this paragraph, AHCCCS will reimburse at 85% of the cost of the drug only. For those members diagnosed with hemophilia, Von Willebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, whichever is lower, depending on the subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower. All catastrophic claims are subject to medical review by AHCCCS.

AHCCCS holds a specialty contract for anti-hemophilic agents and related services for hemophilia. The Contractor may access anti-hemophilic agents and related pharmaceutical services for hemophilia or Von Willebrand's under the terms and conditions of the specialty contract for members enrolled in their plans. In that instance, the Contractor is the authorizing payor. As such, the Contractor will provide prior authorization, care coordination, and reimbursement for all components covered under the contract for their members. A Contractor utilizing the contract will comply with the terms and conditions of the contract. A Contractor may use the AHCCCS contract or contract with a provider of their choice.

The Contractor must notify AHCCCS, Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage within 30 days of initial diagnosis and/or enrollment with the Contractor, and annually 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.

*Hemophilia:* Catastrophic reinsurance coverage is available for all members diagnosed with Hemophilia (ICD9 codes 286.0, 286.1, 286.2).

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

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

*High Cost Behavioral Health:* Effective October 1, 2007 high cost behavioral health was discontinued under catastrophic reinsurance unless the case was approved prior to October 1, 2007 and was active on September 30, 2007.

Members considered by AHCCCS Division of Health Care Management to be high-cost behavioral health will be covered under catastrophic reinsurance using separate guidelines. In order to qualify for reinsurance reimbursement these members must have been approved by AHCCCS prior to October 1, 2007 and active on September 30, 2007. Behavioral health reinsurance will cover the institutional or HCBS setting only. Acute care services and all other ALTCS services are not covered by catastrophic behavioral health reinsurance but are covered under regular reinsurance as described above, subject to applicable deductible levels and coinsurance percentages. The Contractor will be reimbursed at 75% of allowable payments with no deductible. High cost behavioral health services are further defined in the AMPM.

***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 unless the member is CRS enrolled, the medications are related to the management of a CRS covered condition, and CRS

is providing coverage. Catastrophic reinsurance will cover the drug cost only. Refer to the AHCCCS Reinsurance Processing Manual. 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 or its generic equivalent for reinsurance purposes.

***Transplant Reinsurance:***

This program covers members who are eligible to receive covered major organ and tissue transplantation. Refer to AMPM and the AHCCCS Reinsurance Processing Manual for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of the Contractor's paid amount. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. The Contractor must notify AHCCCS Division of Health Care Management, Medical Management Unit when a member is referred to a transplant facility for evaluation for an AHCCCS covered organ transplant. In order to qualify for reinsurance benefits, the notification must be received by AHCCCS Medical Management Unit within 30 days of referral to the transplant facility for evaluation.

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

***Other Reinsurance:***

For all reinsurance case types other than transplants, Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case reaches \$650,000. It is the responsibility of the Contractor to notify AHCCCS, Division of Health Care Management, Reinsurance Supervisor, once a reinsurance case reaches \$650,000. 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 of service will disqualify the related encounters for 100% reimbursement consideration.

***Encounter Submission and Payments for Reinsurance:***

- a. ***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.

**Disputed Matters:** For encounters which are the subject of a member appeal, provider claim dispute, or other legal action, including an informal resolution originating from a request for a formal claim dispute or member appeal, the Contractor has the longer of: 1) 90 days from the date of the final decision in that proceeding/action or 2) 15 months from the end date of service/date of eligibility posting to file the reinsurance claim AND for the reinsurance claim to reach clean claim status. Therefore, reinsurance claims for disputed matters will be considered timely if the Contractor files such claims in clean claim status no later than 90 days from the date of the final decision in that proceeding/action even though the 15 month deadline has expired.

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

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

- b. ***Payment of Regular and Catastrophic Reinsurance Cases:*** AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level and 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.

When a member with an annual enrollment choice changes Contractors within a contract year, for reinsurance purposes, no costs incurred for that member follow the member to the receiving Contractor. Encounters from the Contractor the member is leaving (for dates of service within the current contract year) will not be applied toward the receiving Contractor's deductible level. For further details regarding this policy and other reinsurance policies refer to the AHCCCS Reinsurance Processing Manual.

- c. ***Payment of Transplant Reinsurance Cases:*** Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the Contractor's paid amount, subject to coinsurance percentages. Contractors are required to submit all supporting encounters for transplant services. Reinsurance payments are linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and Contractor paid amounts for adjudicated encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage. Please refer to the AHCCCS Reinsurance Processing Manual for the appropriate billing of transplant services.

***Reinsurance Audits:***

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

## **59. CAPITATION ADJUSTMENTS**

***Rate Adjustments:***

Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review the effect of program changes, legislative requirements, Contractor experience, actuarial assumptions, and/or Contractor specific capitation factors (e.g., Nursing Facility/HCBS mix adjustments) 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 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.

***Change in Member Status:***

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

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

Upon becoming aware that a member may be an inmate of a public institution, the Contractor must notify AHCCCS for an eligibility determination. Notifications must be sent via email to one of the following two email addresses as applicable:

For children under age 18: [DMSJUVENILEIncarceration@azahcccs.gov](mailto:DMSJUVENILEIncarceration@azahcccs.gov)

For adults age 18 and older: [DMSADULTIncarceration@azahcccs.gov](mailto:DMSADULTIncarceration@azahcccs.gov)

Notifications must include:

- AHCCCS ID
- Name
- Date of Birth (DOB)
- When incarcerated
- Where incarcerated

Contractors do **not** need to report members incarcerated with the Arizona Department of Corrections.

Several Counties are submitting a daily file of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration. Contractors will see the "IE" code for ineligible associated with the disenrollment. Upon release from jail, the member will be re-enrolled with their previous Contractor. A member is eligible for covered services until the effective date of the member's "no-pay" status.

**60. MEMBER SHARE OF COST**

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

The Contractor receives monthly capitation payments which incorporate an assumed deduction for the share of cost which members contribute to the cost of care. Refer to Section D, Paragraph 56, Compensation, for details on the share of cost reconciliation. The Contractor or its subcontractors has sole responsibility for collecting

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

### **61. COPAYMENTS**

The Contractor is required to apply copayments as per ACOM and other direction by AHCCCS. There are currently no copayments for ALTCS members for ALTCS covered services. [42 CFR 438.108].

### **62. PEDIATRIC IMMUNIZATIONS AND THE VACCINE FOR CHILDREN PROGRAM**

Through the Vaccine for Children Program (VFC) Federal and State governments' purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. Therefore, the Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Contractor shall contact AHCCCS, Division of Health Care Management, Clinical Quality Management Unit for guidance. Any provider licensed by the State to administer immunizations may register with ADHS as a "VFC provider" and receive free vaccines. The Contractor shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS found in the AHCCCS fee schedule. The Contractor shall comply with all VFC requirements and monitor its providers to ensure that, a physician when acting as primary care physician (PCP) to members under the age of 19, is registered with ADHS/VFC.

In some GSAs, providers may choose not to provide vaccinations due to low numbers of children in their panels, etc. The Contractor must develop processes to ensure that vaccinations are available through a VFC enrolled provider or through the county Health Department. In all instances, the antigens are to be provided through the VFC program. The Contractor must develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

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

### **63. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY**

Pursuant to Federal and State law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

The two methods used in the coordination of benefits are cost avoidance and post-payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et. seq. and Federal and State law. (See also Section D, Paragraph 64, Medicare Services and Cost Sharing).

**Cost Avoidance:**

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

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

If a third-party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, the Contractor is responsible for making these payments under the method described below, even if the services are provided outside of the Contractor network.

A. If the provider is **CONTRACTED** with the Contractor:

The Contractor shall pay the **lesser** of the **difference** between:

1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance

OR

2) The Primary Insurance Paid amount and the Contractor's Contracted Rate

The lesser of methodology applies unless the Contractor's contract with the provider requires a different payment scheme.

B. If the provider is **NOT CONTRACTED** with the Contractor:

The Contractor shall pay the **lesser** of the **difference** between:

1) The Primary Insurance Paid amount and the Primary Insurance Rate, i.e., the member's copayment required under the Primary Insurance

OR

2) The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate

**Examples**

<p><b>Scenario 1</b></p> <p>AHCCCS FFS Rate \$50</p> <p>Contractor Rate \$55</p> <p>Primary Insurance Rate \$45</p> <p>Primary Paid \$30</p>
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Contractor Payment to Contracted Provider in this example	\$15 (this is calculated from the lesser of: \$45-\$30 vs. \$55 - \$30)
Contractor Payment to Non-Contracted Provider in this example	\$15 (this is calculated from the lesser of: \$45-30 vs. \$50-30)

<b>Scenario 2</b>	
AHCCCS FFS Rate \$50 Contractor Rate \$55 Primary Insurance Rate \$60 Primary Paid \$40	
Contractor Payment to Contracted Provider in this example	\$15 (this is calculated from the lesser of: \$60 - \$40 vs. \$55-\$40)
Contractor Payment to Non-Contracted Provider in this example	\$10 (this is calculated from the lesser of: \$60-\$40 vs. \$50-\$40)
<b>Scenario 3</b>	
AHCCCS FFS Rate \$50 Contractor Rate \$55 Primary Insurance Rate \$70 Primary Paid \$60	
Contractor Payment to Contracted Provider in this example	\$0 (this is calculated from the lesser of: \$70 - \$60 vs. \$55-\$60)
Contractor Payment to Non-Contracted Provider in this example	\$0 (this is calculated from the lesser of: \$70-\$60 vs. \$50-\$60)

If the Contractor refers the member for services to a third-party insurer, other than Medicare, and the insurer requires payment in advance of all co-payments, coinsurance and deductibles, the Contractor must make such payments in advance.

Members with CRS condition:

See Section D, Paragraph 13 for CRS related information.

**Post-payment Recoveries:**

Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable party at the time services were rendered or paid for, or was unable to cost-avoid. The following sections set forth requirements for Contractor recovery actions including recoupment activities, other recoveries and total plan case requirements.

Recoupments: The Contractor must follow the protocols established in the ACOM Policy 412. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in an adjusted claim value, the Contractor must submit replacement encounters.

Other Recoveries: The Contractor shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 through 999.9 (excluding code 994.6) external causes of injury codes E000 through E999 and other procedures. The Contractor shall not pursue recovery in the

following circumstances unless the case has been referred to the Contractor by AHCCCS or AHCCCS' authorized representative:

Uninsured/underinsured motorist insurance	Restitution Recovery
First-and third-party liability insurance	Worker's Compensation
Tortfeasors, including casualty	Estate Recovery
Special Treatment Trust Recovery	

Upon identification of any of the above situations, the Contractor shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or fee-for-service payments are involved. By contract, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Contractor shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

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

*Total Plan Case Requirements:* In "total plan" cases, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. 36-2915 and A.R.S. 36-2916. The Contractor shall use the AHCCCS approved casualty recovery correspondence when filing liens and when corresponding to others in regard to casualty recovery.

The Contractor may retain up to 100% of its third-party collections if all of the following conditions exist:

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

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS to ensure that there is no reinsurance or fee for service payments that have been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

For total Contractor cases, the Contractor shall report settlement information to AHCCCS utilizing the AHCCCS approved casualty recovery Notification of Settlement form within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.



***Other Reporting Requirements:***

If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. Notification by the Contractor must occur electronically either through the website provided by the TPL Contractor or by using the Third Party Leads submission file. Refer to the <http://www.azahcccs.gov/commercial/ContractorResources/manuals/TIG/Default.aspx> . In addition, the Contractor shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the Technical Interface Guidelines. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

Upon AHCCCS' request, the Contractor shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCS TPL Section shall provide the format and reporting schedule for this information to the Contractor. AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the Technical Interface Guidelines.

***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.

***Contract Termination:***

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

**64. MEDICARE SERVICES AND COST SHARING**

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligibles". Generally, Contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. Unless prior approval is obtained from AHCCCS, the Contractor must limit their cost sharing responsibility according to ACOM Policy 201fd. Contractors shall have no cost sharing obligation if the Medicare payment exceeds what the Contractor would have paid for the same service for a non-Medicare member. Please refer to Section D, Paragraph 10, Covered Services, for information regarding prescription medication for Medicare Part D.

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

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay co-payments for their Medicare covered prescription medications for the remainder of the calendar year regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

- a. Members who have Medicare part "B" only;
- b. Members who have used their Medicare part "A" life time inpatient benefit;
- c. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.

To ensure appropriate information is communicated for these members to the Center for Medicare and Medicaid Services (CMS) the following processes will be utilized:

1. Contractors must ensure that member placement information on the CA 161 screen is timely and as accurate as possible. Information regarding members placed in medical institutions funded by Medicaid for a full calendar month will be submitted to CMS.
2. Contractors will complete the ALTCS Medical Institution Notification form for Dual Eligible members who are placed in the medical institutions listed below to the AHCCCS Member Database Management Administration, via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month:
  - a. Acute hospital
  - b. Psychiatric Hospital – Non IMD
  - c. Psychiatric Hospital – IMD

**65. MARKETING**

The Contractor shall submit all proposed marketing and outreach materials and events that will involve the general public to the AHCCCS Marketing Committee for prior approval in accordance with AHCCCS Rules and the ACOM Policy 101, a copy of which is available on the AHCCCS Website [www.azahcccs.gov](http://www.azahcccs.gov) [42 CFR 438.104]. The Contractor must have signed contracts with hospitals, PCPs, specialists, pharmacies, nursing facilities and residential placement options (i.e., adult foster home, assisted living homes and centers,

Alzheimer's Treatment Assisted Living Facilities) in order for them to be included in marketing materials. Marketing materials that have received prior approval must be resubmitted to the Division of Health Care Management every two years for re-approval.

## **66. SURVEYS**

The Contractor may be required to perform its own annual general or focused member survey. All such Contractor surveys, along with a timeline for the project, must be approved in advance by AHCCCS. The results, analysis and improvement strategies shall be communicated to the AHCCCS Division of Health Care Management, DHCM Operations Unit within 45 days of completion and to the Contractor's Member Council. AHCCCS may require inclusion of certain questions. Contractors are required to include questions related to case manager performance, appointment waiting time, transportation wait times and culturally competent treatment on member surveys and to use personnel other than the case managers to administer the survey.

For non AHCCCS required surveys, the Contractor shall provide AHCCCS notification 15 days prior to conducting any Contractor initiated member or provider survey. The notification must include a project scope statement, project timeline and a copy of the survey. The results and the analysis of the results of any Contractor initiated surveys shall be submitted to the DHCM Operations Unit within 45 days of the completion of the project.

AHCCCS may periodically conduct surveys of a representative sample of the Contractor's membership and providers. AHCCCS will consider suggestions from the Contractor for questions to be included in this survey. The draft reports from the surveys will be shared with the Contractor prior to finalization. The results of these surveys will become public information and available to all interested parties on the AHCCCS website. The Contractor will be responsible for reimbursing AHCCCS for the cost of the survey based on its share of AHCCCS enrollment.

At least quarterly, the Contractor is required to survey a sample of its membership that have received services to verify that services the Contractor paid for were delivered as outlined in the ACOM Policy 424 [42 CFR 455.20].

## **67. PATIENT TRUST ACCOUNT MONITORING**

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

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

## **68. RESERVED**

## **69. CULTURAL COMPETENCY**

The Contractor shall have a Cultural Competency Plan which meets the requirements of the ACOM Policy 405. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, DHCM Operations Unit, no later than 45 days after the

start of each contract year. The Plan should address all services and settings, i.e., attendant care, assisted living facilities, etc. [42 CFR 438.206(c)(2)]

The Contractor shall ensure compliance with the cultural competency plan and all requirements pertaining to Limited English Proficiency.

## 70. CORPORATE COMPLIANCE

In accordance with A.R.S. §36-2918.01, and the ACOM, Chapter 100, Contractors and their subcontractors and providers are required to immediately notify the AHCCCS, Office of the Inspector General (OIG) regarding any suspected fraud or abuse [42 CFR 455.17]. The Contractor agrees to immediately (within 10 business days of discovery) inform the OIG in writing of instances of suspected fraud or abuse [42 CFR 455.1(a)(1)] by completing the confidential AHCCCS Referral for Preliminary Investigation form. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, contractors or sub-contractors.

As stated in A.R.S. §13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises, or material omissions is guilty of a Class 2 felony.

The Contractor agrees to permit and cooperate with any onsite review. A review by the OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to representatives of the OIG upon request. The OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the OIG request.

The Contractor shall be in compliance with 42 CFR 438.608. The Contractor must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. The Contractor shall have written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected member fraud, provider fraud and member abuse cases to the OIG or other duly authorized enforcement agencies.

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

1. Written policies, procedures, and standards of conduct that articulates the organization's commitment to and processes for complying with all applicable Federal and State standards.
2. The written designation of a compliance committee who are accountable to the Contractor's top management.
3. The Compliance Officer must be an onsite management official who reports directly to the Contractor's top management. Any exceptions must be approved by AHCCCS.
4. Effective training and education.
5. Effective lines of communication between the compliance officer and the organization's employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Provision for internal monitoring and auditing.
8. Provision for prompt response to problems detected.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The

- Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), Contractors, as a condition for receiving payments shall establish written policies for employees detailing:
    - a. The Federal False Claims Act provisions;
    - b. The administrative remedies for false claims and statements;
    - c. Any state laws relating to civil or criminal penalties for false claims and statements;
    - d. The whistleblower protections under such laws.
  11. The Contractor must establish a process for training existing staff and new hires on the compliance program and on the items in 10 above. All training must be conducted in such a manner that can be verified by AHCCCS.
  12. The Contractor must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions:
    - a. The administrative remedies for false claims and statements;
    - b. Any state laws relating to civil or criminal penalties for false claims and statements;
    - c. The whistleblower protections under such laws.
  13. The Contractor must notify AHCCCS of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.

Once the Contractor has referred a suspected case of fraud or abuse to AHCCCS, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments until AHCCCS provides written notice to the Contractor that the fraud or abuse case has been closed or otherwise dispositioned. At that time, and after conducting a cost benefit analysis to determine if such action is warranted, the Contractor should attempt to recover any overpayments identified. The OIG shall be advised of the final disposition of the research and advised of actions, if any, taken by the Contractor. . In addition the Contractor must furnish to AHCCCS or CMS within 35 days of receiving the request, full and complete information, pertaining to business transactions (42 CFR 455.105):

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

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

***Disclosure of Ownership and Control [42 CFR 455.104] (SMDL09-001)***

- A. The Contractor must provide the following information to AHCCCS:
- 1.(a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
  - (b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the Contractor;
  - (c) The Tax Identification Number of any corporation with an ownership or control interest in the Contractor;

2. Whether the person (individual or corporation) with an ownership or control interest in the Contractor is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the Contractor has a 5% or more interest is related to another person with ownership or control interest in the Contractor as a spouse, parent, child, or sibling;
3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the Contractor has an ownership or control interest;
4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the Contractor as defined in 42 CFR 455.101.

The Contractor shall provide the above-listed information to AHCCCS at any of the following times:

1. Upon the Contractor submitting the proposal in accordance with the State's procurement process;
  2. Upon the Contractor executing the contract with the State;
  3. Upon renewal or extension of the contract;
  4. Within 35 days after any change in ownership of the Contractor.
- B. The Contractor shall also, with regard to its fiscal agents, obtain the following information regarding ownership and control:
- 1.(a) The Name and Address of any person (individual or corporation) with an ownership or control interest in the fiscal Agent. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address;
  - (b) The Date of Birth and Social Security Numbers of any person with an ownership or control interest in the fiscal agent;
  - (c) The Tax Identification Number of any corporation with an ownership or control interest in the fiscal agent;
  2. Whether the person (individual or corporation) with an ownership or control interest in the fiscal agent is related to another person with ownership or control interest in the fiscal agent as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor of the fiscal agent has a 5% or more interest is related to another person with ownership or control interest in the fiscal agent as a spouse, parent, child, or sibling;
  3. The name of any other disclosing entity as defined in 42 CFR 455.101 in which an owner of the fiscal agent has an ownership or control interest;
  4. The Name, Address, Date of Birth and Social Security Number of any managing employee of the fiscal agent as defined in 42 CFR 455.101.

***Disclosure of Information on Persons Convicted of Crimes*** (42 CFR 455.101; 106; 436)(SMDL09-001)

The Contractor must identify all persons associated with the Contractor and its fiscal agents which have an ownership or control interest or managing employee interest and determine if they have been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title

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

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

The Contractor must immediately notify AHCCCS of any person who has been excluded through these checks.

The results of the *Disclosure of Ownership and Control* and the *Disclosure of Information on Persons Convicted of Crimes* shall be held by the Contractor. The Contractor shall submit an annual attestation that the above-listed information has been requested and obtained. Refer to Attachment F, Chart of Deliverables for further information. Upon request, the Contractor shall provide AHCCCS with the above-listed information.

### **71. RECORDS RETENTION**

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

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

The Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract.

Records covered under HIPAA must be preserved and made available for six years per 45 CFR 164.530(j)(2).

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

### **72. RESERVED**

### **73. DATA EXCHANGE REQUIREMENTS**

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

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

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

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

The Contractor shall accept from AHCCCS original evidence of eligibility and enrollment in a form appropriate for electronic data exchange. Upon request by AHCCCS, the Contractor shall provide to AHCCCS updated date-sensitive PCP assignments in a form appropriate for electronic data exchange.

The Contractor shall be provided with a Contractor-specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by the Contractor shall include the Contractor's security code. The Contractor agrees that by use of its security code, it certifies that any data transmitted is accurate and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606]. The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCS from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the Contractor in the submitted input data. Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's AHCCCS services providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

***Health Insurance Portability and Accountability Act (HIPAA):***

The Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of the Contractor by the dates required by the implementing Federal regulations as well as all subsequent requirements and regulations as published.

***HIPAA Privacy and Security:***

The Contractor is required to have a HIPAA security audit performed by an independent third party. The initial audit must be conducted at contract award (prior to the first exchange of AHCCCS data) and annually thereafter, and must include a review of Contractor compliance with all security and privacy requirements. The annual audit report must be submitted to AHCCCS within 90 days of the start of the contract year.

The audit must include a review of Contractor policies and procedures to verify that appropriate security and privacy requirements have been adequately incorporated into the Contractors business practices, and the use of automated and/or manual scans of the production processing systems to validate compliance.



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

## 74. ENCOUNTER DATA REPORTING

### *Encounter Submissions:*

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

A Contractor shall prepare, review, verify, certify, and submit encounters for consideration to AHCCCS. Upon submission, the Contractor certifies that the services listed were actually rendered. The encounters must be submitted in the format prescribed by AHCCCS.

Encounter data must be provided to AHCCCS as outlined in the X12 and NCPDP Transaction Companion Guides & Trading Partner Agreements and the AHCCCS Encounter Manual and should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Requirements for encounter data are described in the AHCCCS Encounter Manual and the AHCCCS Encounter Companion Guides.

To support Federal Drug Rebate processing, pharmacy related encounter data must be provided to AHCCCS no later than 30 days after the end of the quarter in which the pharmaceutical item was dispensed. For the purposes of this requirement, pharmacy encounter data is defined as retail pharmacy encounters until such time AHCCCS expands Federal Drug Rebate processing to include all other pharmaceuticals reported on professional and outpatient facility encounters.

The Contractor will be assessed sanctions for noncompliance with encounter submission requirements.

### *Encounter Reporting:*

The Contractor must produce reports for the purposes of tracking, trending, reporting process improvement and monitoring submissions of encounters and encounter revisions. The Contractor will submit these reports to AHCCCS as required per the AHCCCS Encounter Manual.

At least twice each month AHCCCS provides the Contractor with full replacement files containing provider and medical coding information. These files should be used by the Contractor to ensure accurate Encounter Reporting. Refer to the AHCCCS Encounter Manual for further information.

### *Encounter Corrections:*

Contractors are required to monitor and resolve pended encounters, encounters denied by AHCCCS, and encounters voided and voided/replaced. AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. In addition to adjudicated approved encounters, pended, denied and voided encounters affect completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

Contractors are required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced

claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. For those recoupments requiring approval from AHCCCS, replacement encounters must be submitted within 120 days of the recoupment approval from AHCCCS. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected encounters.

***Encounter Validation Studies:***

Per the CMS requirement, AHCCCS will conduct encounter validation studies of the Contractor's encounter submissions, and may sanction the Contractor and/or require a correction action plan for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the Contractor's submitted encounter data. Any and all covered services may be validated as part of these studies. The criteria use in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS Data Validation Technical Document for further information.

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

## **75. REPORTING REQUIREMENTS**

AHCCCS, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 80, Sanctions and Attachment D, Chart of Deliverables. Standards applied for determining adequacy of required reports are as follows:

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

The Contractor shall comply with all reporting requirements contained in this contract. AHCCCS requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the term of the contract. The Contractor shall comply with all changes specified by AHCCCS.

The Contractor shall be responsible for continued reporting beyond the term of the contract.

## **76. REQUESTS FOR INFORMATION**

AHCCCS may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such requests for information, the Contractor shall provide complete information to AHCCCS as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself.

If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed statement to AHCCCS, within the timeframe designated by AHCCCS,

setting forth the reasons why the information is confidential and describing the specific harm or injury that would result from disclosure. In the event that AHCCCS withholds information from a third party as a result of the Contractor's statement, the Contractor shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

#### **77. DISSEMINATION OF INFORMATION**

Upon request, the Contractor shall assist AHCCCS in the dissemination of information prepared by AHCCCS, or the Federal government, to its members. The cost of such dissemination shall be borne by the Contractor. All advertisements, publications and printed materials which are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCS.

#### **78. OPERATIONAL AND FINANCIAL READINESS REVIEWS**

AHCCCS may conduct Operational and Financial Readiness Reviews on the Contractors and will, subject to the availability of resources, provide technical assistance as appropriate. The Readiness Reviews will be conducted prior to the start of business. The purpose of Readiness Reviews is to assess a Contractors' readiness and ability to provide covered services to members at the start of the contract year. The Contractor will be permitted to commence operations only if the Readiness Review factors are met to AHCCCS' satisfaction.

#### **79. OPERATIONAL AND FINANCIAL REVIEWS**

In accordance with CMS requirements and AHCCCS Rule 9 A.A.C. 28, Article 5, AHCCCS, or an independent agent, will conduct periodic operational and financial reviews for the purpose of (but not limited to) identifying best practices and ensuring program compliance [42 CFR 438.204]. The type and duration of the review will be solely at the discretion of AHCCCS. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor the Contractor's progress towards implementing mandated programs and provide the Contractor with technical assistance if necessary.

Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give the Contractor at least three weeks advance notice of the date of the scheduled Operational and Financial Review. AHCCCS reserves the right to conduct reviews without notice. AHCCCS may conduct a review without notice in the event the Contractor undergoes a merger, reorganization, changes ownership or makes changes in three or more key staff positions within a 12 month period, or to investigate complaints received by AHCCCS. The Contractor shall comply with all other medical audit provisions as required by AHCCCS.

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

In preparation for the reviews, the Contractor shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, records, logs and other material that AHCCCS may request. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. Contractor personnel as identified in advance shall be available to the Review Team at all times during AHCCCS review activities. Should the review be conducted on-site, the Contractor shall provide the Review Team with appropriate workspace, access to a telephone, electrical outlets, internet access and privacy for conferences.

The Contractor will be furnished a copy of the draft Operational and Financial Review report and given the opportunity to comment on any review findings prior to AHCCCS issuing the final report. Recommendations

made by the Review Team to bring the Contractor into compliance with Federal, State, AHCCCS, and/or contract requirements, must be implemented by the Contractor. Modifications to the corrective action plan must be approved in advance by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial Operational and Financial Review to determine the Contractor's progress in implementing recommendations and achieving compliance. Review findings may be used in the scoring of subsequent bid proposals submitted by the Contractor.

The Contractor shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report nor final report to other AHCCCS Contractors.

In addition to the annual Operational and Financial Review AHCCCS may conduct unannounced site visits to monitor contractual requirements and performance as needed.

## 80. SANCTIONS

In accordance with applicable Federal and State laws and regulations, AHCCCS Rules R9-22-606 and R9-28-608, ACOM Policy 408 and the terms of this contract, AHCCCS may impose sanctions, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; and suspension, refusal to renew, or termination of the contract, or any related subcontracts. [42 CFR 422.208; 42 CFR 438.700, 702, and 704, 45 CFR 92.36(i)(1); 45 CFR 74.48]. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. R9-34-401 et seq.

Intermediate sanctions may be imposed for actions including, but are not limited to:

- a. Substantial failure to provide medically necessary services that the Contractor is required to provide under the terms of this contract to its enrolled members.
- b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
- c. Discrimination of members on the basis of their health status or need for health care services.
- d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
- e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider.
- f. Failure to comply with the requirement for physician incentive plan as delineated in Paragraph 39, Physician Incentive/Pay for Performance.
- g. Distribution directly, or indirectly through any agent or independent Contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
- h. Failure to meet AHCCCS Financial Viability Standards.
- i. Material deficiencies in the Contractor's provider network.
- j. Failure to meet quality of care and quality management requirements.
- k. Failure to meet AHCCCS encounter standards.
- l. Violation of other applicable State or Federal laws or regulations.
- m. Failure to fund accumulated deficit in a timely manner.
- n. Failure to increase the Performance Bond in a timely manner.
- o. Failure to comply with any provisions contained in this contract.
- p. Failure to report third party liability cases as described in paragraph 63 Coordination of Benefits/Third Party Liability.
- q. Submitting late, incomplete or inaccurate deliverables.

AHCCCS may impose the following types of intermediate sanctions:

- a. Civil monetary penalties.

- b. Appointment of temporary management for a Contractor as provided in 42 CFR 438.706 and A.R.S. §36-2903 and §36-2932.
- c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll [42 CFR 438.702(a)(3)].
- d. Suspension of all new enrollment, including auto assignments after the effective date of the sanction.
- e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

***Cure Notice Process:***

Prior to the imposition of a sanction for non-compliance, AHCCCS may provide a written cure notice to the Contractor regarding the details of the non-compliance. If a notice to cure is provided to the Contractor, the cure notice will specify the period of time in which the Contractor must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the Contractor has complied with the cure notice requirements, AHCCCS will not impose a sanction. If, however, the Contractor has not complied with the cure notice requirements, AHCCCS may proceed with the imposition of sanctions.

Refer to the ACOM Policy 408 for details.

**81. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSB)**

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

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

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

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

**82. PENDING LEGISLATION AND PROGRAM CHANGES**

The following constitute pending items that may be resolved after the initial issuance of the contract amendment. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract.

Final capitation rates may also be adjusted to reflect the financial impact of program changes. The items in this paragraph are subject to change and should not be considered all-inclusive.

***Children's Rehabilitative Services:***

Service to Individuals With a Qualifying Medical Conditions Under Arizona Administrative Code, R9-7-202 – Beginning on October 1, 2013, individuals enrolled with an ALTCS E/PD Contractor who would also qualify for Children's Rehabilitative Services (CRS), as a result being diagnosed with a qualifying medical condition under Arizona Administrative Code R9-7-202, will no longer be deemed eligible to receive services through the AHCCCS Health Plan contracted to provide services to CRS-eligible individuals. Alternatively, ALTCS EP/D Contractors will be required to provide comprehensive health care coverage to these individuals, including acute care, long term care and behavioral health services as well as services needed to treat the qualifying medical condition. ALTCS E/PD Contractors will only be held to those regulations, contractual requirements and policies specific to the provision of health care services for individuals enrolled with an ALTCS E/PD Contractor when providing services to individuals with a qualifying medical condition.

***Federal and State Legislation:***

AHCCCS and its Contractors are subject to legislative mandates that may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

***Health Information Technology for Economic and Clinical Health Act (HITECH):***

In February 2009, as part of the Federal stimulus package, Congress enacted the Health Information Technology for Economic and Clinical Health Act (HITECH). The legislation included a number of provisions designed to encourage the adoption and use of health information technology including electronic health records (EHRs) and the development of a health information exchange (HIE) infrastructure. The underlying rationale for the Act is the belief that the adoption on a nationwide basis would reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors.

The Health Information Technology for Economic and Clinical Health Act (HITECH) includes provisions designed to encourage the adoption and use of health information technology including electronic health records (EHRs), e-prescribing and the development of a health information exchange (HIE) infrastructure. AHCCCS and its Contractors support these new evolving technologies, designed to create efficiencies and improve effectiveness of care resulting in improved patient satisfaction with the health care experience, the provision of optimal care outcomes and cost efficiencies.

To further the integration of technology based solutions and the meaningful use of electronic health records within provider offices, AHCCCS anticipates increasing opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. Contractors will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that Contractors review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates expanding utilization of health information technology as it relates to health care management and Contractor deliverables in the following, but not limited to, areas:

- Access to care
- Care coordination



- Pharmacy, including but not limited to polypharmacy
- Evidence based care
- Disease management
- EPSDT services
- Coordination with community services
- Referral management
- Discharge planning
- Performance measures
- Performance improvement projects
- Medical record review
- Quality of care review processes
- Quality improvement
- Claims review
- Prior authorization
- Claims

***Patient Protection and Affordable Care Act:***

The Contractor shall comply with the applicable sections of the Patient Protection and Affordable Care Act (PPACA) including, but not limited to, the Health Insurer Fee effective January 1, 2014, and including those provisions as adopted by AHCCCS in the Arizona State Plan. The Contractor shall provide services to Medicaid eligible individuals who will be covered by the Medicaid restoration and expansion starting January 1, 2014.

### **83. BUSINESS CONTINUITY AND RECOVERY PLAN**

The Contractor shall develop a Business Continuity and Recovery Plan, as detailed in the ACOM Policy 104, to deal with unexpected events that may affect its ability to adequately serve members. This plan shall, at a minimum, include planning and training for:

- Electronic/telephonic failure at the Contractor's main place of ALTCS business
- Complete loss of use of the main site and satellite offices out of state
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCS in the event of a business disruption
- Periodic testing

The Business Continuity and Recovery Plan shall be updated annually. The Contractor shall submit a summary of the Plan to AHCCCS 15 days after the start of the contract year. All staff shall be trained and familiar with the Plan.

### **84. MEDICAL RECORDS**

The member's medical record is the property of the provider who generates the record. Medical records include those maintained by PCPs or other providers as well as but not limited to those kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers. Each member is entitled to one copy of his or her medical record free of charge annually. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

The Contractor is responsible for ensuring that a medical record is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an

appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

The Contractor shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The Contractor shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with the AMPM.

The Contractor shall have written plans for providing training and evaluating providers' compliance with the Contractor's medical records standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other agency. The Contractor may obtain a copy of a member's medical records without written approval of the member, if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or paper within 20 business days of receipt of request.

Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed [A.R.S. §36-664(I)].

### **85. ENROLLMENT AND CAPITATION TRANSACTION UPDATES**

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data, which the Contractor shall use to update its member records. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction will be produced to provide Contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will record the results of the

reconciliation, which will be made available upon request, and will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation into the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS, Information Services Division.

Refer to Section D, Paragraph 73, Data Exchange Requirements, for further information.

#### **86. SPECIAL HEALTH CARE NEEDS**

AHCCCS has specified in its Quality Strategy certain populations with special health care needs including members enrolled in DDD, CRS and those receiving behavioral health services. The Contractor must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring [42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals [42 CFR 438.240(c)(2)] [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3) and (c)(3)]. Members enrolled in the ALTCS Program who are elderly, physically disabled, or developmentally disabled are automatically identified as having special health care needs.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. [42 CFR 208(c)(4)]

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

#### **87. TECHNOLOGICAL ADVANCEMENT**

The Contractor must have a website with links to the information as described in ACOM Policy 404 and Policy 416.

#### **88. RESERVED**

[END OF SECTION D]

**SECTION E. CONTRACT TERMS AND CONDITIONS****1. APPLICABLE LAW**

*Arizona Law* - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

*Implied Contract Terms* - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

**2. AUTHORITY**

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this contract based on those changes.

**3. ORDER OF PRECEDENCE**

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State Rules; the terms of this contract which consists of the RFP, the proposal of the successful Offeror, and Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

**4. CONTRACT INTERPRETATION AND AMENDMENT**

*No Parol Evidence* - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

*No Waiver* - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

*Written Contract Amendments* - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State and signed by a duly authorized representative of the Contractor.

**5. SEVERABILITY**

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

## 6. RELATIONSHIP OF PARTIES

The Contractor under this contract is an independent Contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

## 7. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this contract. Delegation of less than all of the duties of this contract must conform to the requirements of Section D, Paragraph 33, Subcontracts.

## 8. INDEMNIFICATION

### Contractor/Vendor Indemnification (Not Public Agency)

The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Contractor for the vicarious liability of the State as a result of entering into this contract. The Contractor agrees to indemnify, defend, and hold harmless the State from and against any and all claims, losses, liability, costs, and expenses, including attorney's fees and costs, arising out of litigation against AHCCCS including, but not limited to, class action lawsuits challenging actions by the Contractor. The requirement for indemnification applies irrespective of whether or not the Contractor is a party to the lawsuit. Each Contractor shall indemnify the State, on a pro rata basis based on population, attorney's fees and costs awarded against the State as well as the attorney's fees and costs incurred by the State in defending the lawsuit. The Contractor shall also indemnify AHCCCS, on a pro rata basis based on population, the administrative expenses incurred by AHCCCS to address Contractor deficiencies arising out of the litigation. The parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence and/or willful misconduct. Each party to this contract is responsible for its own negligence and/or willful misconduct.

### Contractor/Vendor Indemnification (Public Agency)

Each party ("as indemnitor") agrees to indemnify, defend, and hold harmless the other party ("as indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnitee, are caused by the act, omission, negligence, misconduct, or other fault of the indemnitor, its officers, officials, agents, employees, or volunteers.

## 9. INDEMNIFICATION -- PATENT AND COPYRIGHT

To the extent permitted by applicable law the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph.

## 10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback

Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. The Contractor shall maintain all applicable licenses and permits.

#### **11. ADVERTISING AND PROMOTION OF CONTRACT**

The Contractor shall not advertise or publish information for commercial marketing benefit concerning this contract without the prior written approval of the Contracting Officer.

#### **12. THIRD PARTY ANTITRUST VIOLATIONS**

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this contract.

#### **13. RIGHT TO ASSURANCE**

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or continue to perform under this contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

#### **14. TERMINATION FOR CONFLICT OF INTEREST**

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R. S. 38-511.

#### **15. GRATUITIES**

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

#### **16. SUSPENSION OR DEBARMENT**

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610(a) and (b)] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise

excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website by the names of any individuals. The database can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

The Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this contract if it determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

#### **17. TERMINATION FOR CONVENIENCE**

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

#### **18. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION**

***Temporary Management/Operation by AHCCCS:*** Pursuant to Medicaid Managed Care Regulations, 42 CFR 438.700 et seq. and State Law ARS §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law ARS §36-2903 authorizes AHCCCS to operate a Contractor as specified in this contract. In addition to the bases specified in 42 CFR 438.700 et seq., AHCCCS may directly operate the Contractor if, in the judgment of AHCCCS, the Contractor's performance is in material breach of the contract or the Contractor is insolvent. Under these circumstances, AHCCCS may directly operate the Contractor to assure delivery of care to members enrolled with the Contractor until cure by the Contractor of its breach, by demonstrated financial solvency or until the successful transition of those members to other Contractors. Prior to operation of the Contractor by AHCCCS pursuant to state statute, the Contractor shall have the opportunity for a hearing. If

AHCCCS determines that emergency action is required, operation of the Contractor may take place prior to hearing. Operation by AHCCCS shall occur only as long as it is necessary to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other contractors, or until the Contractor reorganizes or otherwise corrects contract performance failure.



If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

**Termination:** AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract and as authorized by Medicaid Managed Care Regulations and 42 CFR 438.708. If the Contractor is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to the Contractor by certified mail, return receipt requested. Pursuant to Medicaid Managed Care Regulations and 42 CFR 438.708, AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to AHCCCS on demand.

AHCCCS may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

## 19. TERMINATION - AVAILABILITY OF FUNDS

Availability of Funds for the current State fiscal year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these goods or services are not funded, the State may take any of the following actions:

- a. Accept a decrease in price offered by the Contractor;
- b. Cancel the contract; or
- c. Cancel the contract and re-solicit the requirements.

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

**20. RIGHT OF OFFSET**

AHCCCS shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by AHCCCS, or damages assessed by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract, including but not limited to expenses, costs and damages.

**21. NON-EXCLUSIVE REMEDIES**

The rights and the remedies of AHCCCS under this contract are not exclusive.

**22. NON-DISCRIMINATION**

In accordance with ARS 41-1461 et seq. and Executive Order 2009-09, the Contractor shall provide equal employment opportunities for all persons, regardless of race, color, religion, creed, sex, age, national origin, disability or political affiliation. The Contractor shall comply with the Americans with Disabilities Act.

**23. EFFECTIVE DATE**

The effective date of this contract shall be the Offer and Acceptance date referenced on page 1 of this contract.

**24. TERM OF CONTRACT AND OPTION TO RENEW**

The initial term of this contract shall be for three (3) initial years, with two (2) one-year options to extend, not to exceed a total contracting period of five (5) years. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment, and shall be at the sole option of AHCCCS.

If the Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCS may renew the Contractor's contract in one GSA, but not in another. In the event AHCCCS determines there are issues of noncompliance by the Contractor in one GSA, AHCCCS may request an enrollment cap for the Contractor's contracts in all other GSAs. Further, AHCCCS may require the Contractor to renew all currently awarded GSAs, or may terminate the contract if the Contractor does not agree to renew all currently awarded GSAs.

When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days after the date of mailing by the Contracting Officer, even if the extension amendment has not been signed by the Contractor, unless within that time the Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. If the Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

If the Contractor chooses not to renew this contract, the Contractor may be liable for certain costs associated with the transition of its members to a different Contractor. The Contractor is required to provide 180 days advance written notice to the Contracts and Purchasing Administrator of its intent not to renew the contract. If the Contractor provides the Contracts and Purchasing Administrator written notice of its intent not to renew this contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

**25. INSURANCE**

A certificate of insurance naming the State of Arizona and AHCCCS as the "additional insured" must be submitted to AHCCCS within 10 days of notification of contract award and prior to commencement of any services under this contract. This insurance shall be provided by carriers rated as "A+" or higher by the A.M. Best Rating Service. The following types and levels of insurance coverage are required for this contract:

- a. Commercial General Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others as a result of accidents on the premises of or as the result of operations of the Contractor.
- b. Commercial Automobile Liability: Provides coverage of at least \$1,000,000 for each occurrence for bodily injury and property damage to others resulting from accidents caused by vehicles operated by the Contractor.
- c. Workers Compensation: Provides coverage to employees of the Contractor for injuries sustained in the course of their employment. Coverage must meet the obligations imposed by Federal and State statutes and must also include Employer's Liability minimum coverage of \$100,000. Evidence of qualified self-insured status will also be considered.
- d. Professional Liability (if applicable): Provides coverage for alleged professional misconduct or lack of ordinary skills in the performance of a professional act of service.

*The above coverages may be evidenced by either one of the following:*

- a. The State of Arizona Certificate of Insurance: This is a form with the special conditions required by the contract already pre-printed on the form. The Contractor's agent or broker must fill in the pertinent policy information and ensure the required special conditions are included in the Contractor's policy.
- b. The Accord form: This standard insurance industry certificate of insurance does not contain the pre-printed special conditions required by this contract. These conditions must be entered on the certificate by the agent or broker and read as follows:

The State of Arizona and Arizona Health Care Cost Containment System are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies, boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be canceled or materially changed without 30 days written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company.

- c. If the Contractor is insured pursuant to A.R.S. § 11-981, the Insurance provisions required by the contract are satisfied.

**26. DISPUTES**

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this contract.

Except as provided by 9AAC Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and ARS §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, the

Contractor shall proceed with performance of this contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

**27. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS**

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

**28. CONTRACT**

The contract between AHCCCS and the Contractor shall consist of (1) the Request for Proposal (RFP) and any amendments thereto, (2) the proposal submitted by the Contractor in response to the RFP, (3) any Best and Final Offers including any attachments, (4) executed amendments and modifications and (5) AHCCCS policies and procedures. In the event of a conflict in language between the two documents referenced, the provisions and requirements set forth and/or referenced in the RFP shall govern. However, AHCCCS reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Contractor's proposal. In all other matters not affected by the written clarification, if any, the RFP shall govern.

The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the contract until funds have been encumbered.

**29. COVENANT AGAINST CONTINGENT FEES**

The Contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

**30. CHANGES**

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by AHCCCS, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

**31. TYPE OF CONTRACT**

Firm Fixed-Price stated as capitated per member per month except as otherwise provided.

**32. AMERICANS WITH DISABILITIES ACT**

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting the Solicitation Contact person.

**33. WARRANTY OF SERVICES**

The Contractor warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

**34. NO GUARANTEED QUANTITIES**

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

**35. CONFLICT OF INTEREST**

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

**36. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION**

The Contractor shall safeguard confidential information in accordance with Federal and State laws and regulations, including but not limited to, 42 CFR 431, Subpart F, ARS §§ 36-107, 36-2903 (for Acute), 36-2932 (for ALTCS), 41-1959 and 46-135, the Health Insurance Portability and Accountability Act (Public Law 107-191 Statutes 1936), 45 CFR parts 160 and 164, and AHCCCS Rules.

The Contractor shall establish and maintain procedures and controls that are acceptable to AHCCCS for the purpose of assuring that no information contained in its records or obtained from AHCCCS or others carrying out its functions under the contract shall be used or disclosed by its agents, officers or employees, except as required to efficiently perform duties under the contract. Except as required or permitted by law, the Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to, in writing, by AHCCCS.

The Contractor shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

**37. COOPERATION WITH OTHER CONTRACTORS**

AHCCCS may award other contracts for additional work related to this contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by AHCCCS employees.

**38. ASSIGNMENT OF CONTRACT AND BANKRUPTCY**

This contract is voidable and subject to immediate cancellation by AHCCCS upon the Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCS.

**39. OWNERSHIP OF INFORMATION AND DATA**

Materials, reports and other deliverables created under this contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this contract, as otherwise allowed under this contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable State and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such.

At the termination of the contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by the Contractor in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. The Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 92.

**40. AUDITS AND INSPECTIONS**

The Contractor shall comply with all provisions specified in applicable A.R.S. 35-214 and 35-215 and AHCCCS Rules and policies and procedures relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. The Contractor shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

**41. LOBBYING**

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the

extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

#### **42. CHOICE OF FORUM**

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

#### **43. DATA CERTIFICATION**

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who reports directly to the CEO or CFO. [42 CFR 438.604 et. seq.]

#### **44. OFF-SHORE PERFORMANCE OF WORK PROHIBITED**

Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and involve access to secure or sensitive data or personal client data shall be performed within the defined territories of the United States. Unless specifically stated otherwise in the specifications, this paragraph does not apply to indirect or 'overhead' services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

#### **45. FEDERAL IMMIGRATION AND NATIONALITY ACT**

The Contractor shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Contractor.

#### **46. IRS W9 FORM**

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W9 Form on file with the State of Arizona.

#### **47. CONTINUATION OF PERFORMANCE THROUGH TERMINATION**

The Contractor shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

#### **48. E-VERIFYING REQUIREMENTS**

In accordance with A.R.S 41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. 23-214, Subsection A.

#### **49. SCRUTINIZED BUSINESSES**

In accordance with A.R.S. 35-391 and A.R.S. 35-393, Contractor certifies that the Contractor does not have scrutinized business operations in Sudan or Iran.



**SECTION F. ATTACHMENTS**

**ATTACHMENT A. RESERVED**

This Minimum Subcontract Provisions document is available on the AHCCCS Website at:

<http://www.azahcccs.gov/commercial/default.aspx>

**ATTACHMENT B(1). ENROLLEE GRIEVANCE SYSTEM**

The Contractor shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall provide the AHCCCS Grievance System Reporting Guide to all providers and subcontractors at the time of contract. The Contractor shall also furnish this information to enrollees within a reasonable time after the Contractor receives notice of the enrollment. Additionally, the Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to enrollees describing the Grievance System including the grievance process, the appeal process, enrollee rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the Contractor's service area and in an easily understood language and format. The Contractor shall inform enrollees that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how enrollees may obtain this information.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be translated in the enrollee's language if information is received by the Contractor, orally or in writing, indicating that the enrollee has a limited English proficiency. Otherwise, these documents shall be translated in the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the enrollee that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how enrollees may obtain this information. This information must be in large, bold print appearing in a prominent location on the first page of the document.

At a minimum, the Contractor's Grievance System Standards and Policy shall specify:

1. That the Contractor shall maintain records of all grievances, appeals and requests for hearings.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes describing the right to hearing, the method for obtaining a hearing, the Rules which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance, appeal or request for hearing.
3. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone if requested by the enrollee.
4. That the Contractor shall acknowledge receipt of each grievance and appeal. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.
5. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

6. That the Contractor shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the enrollee's condition or disease.
7. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.
8. That if the Contractor extends the timeframe for resolution of an appeal when not requested by the enrollee, the Contractor shall provide the enrollee with written notice of the reason for the delay.
9. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.
10. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with AHCCCS.
11. That the Contractor must dispose of each grievance in accordance with the AHCCCS Grievance System Reporting Guide, but in no case shall the timeframe exceed 90 days.
12. The definition of action as the [42 CFR 438.400(b)]:
  - a. Denial or limited authorization of a requested service, including the type or level of service;
  - b. Reduction, suspension, or termination of a previously authorized service;
  - c. Denial, in whole or in part, of payment for a service;
  - d. Failure to provide services in a timely manner;
  - e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
  - f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.
13. The definition of a service authorization request as an enrollee's request for the provision of a service [42 CFR 431.201].
14. The definition of appeal as the request for review of an action, as defined above.
15. Information explaining that a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.
16. That an enrollee may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of the Contractor to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii) when the Contractor is the only Contractor in the rural area.

17. The definition of a standard authorization request. For standard authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's best interest [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.
18. The definition of an expedited authorization request. For expedited authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than three business days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest [42 CFR 438.210(d)(2)].
19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the Contractor must give the enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
20. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider must be written.
21. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
22. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.
23. That if the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30 day timeframe for a standard appeal. The Contractor must make reasonable efforts to give the enrollee prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.
24. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.
25. That the Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least five days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14

days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request, unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:

- a. The Contractor receives notification of the death of an enrollee;
  - b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
  - c. The enrollee is admitted to an institution where he is ineligible for further services;
  - d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
  - e. The enrollee has been accepted for Medicaid in another local jurisdiction.
26. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.
27. That the Notice of Action must explain: 1) the action the Contractor has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.
28. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or b) the appeal involves a denial and the physician asserts that the requested service/treatment is a necessary continuation of a previous authorized service, 3) the services were ordered by an authorized provider, and 4) the enrollee requests a continuation of benefits.
- For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction or suspension which has been appealed.
29. That for appeals, the Contractor provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that the Contractor informs the enrollee of the limited time available in cases involving expedited resolution.
30. That for appeals, the Contractor provides the enrollee and his representative the opportunity before and during the appeals process to examine the enrollee's case file including medical records and other documents considered during the appeals process.
31. That the Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.
32. That the Contractor shall provide written Notice of Appeal Resolution to the enrollee and the enrollee's representative or the representative of the deceased enrollee's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of enrollees: a) the enrollee's right

to request a State fair hearing (including the requirement that the enrollee must file the request for a hearing in writing) no later than 30 days after the date the enrollee receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds the Contractor.

33. That the Contractor continues extended benefits originally provided to the enrollee until any of the following occurs: 1) the enrollee withdraws appeal, 2) the enrollee has not specifically requested continued benefits pending a hearing decision within 10 days of the Contractor mailing of the appeal resolution notice or, 3) AHCCCS issues a state fair hearing decision adverse to the enrollee.
34. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:
  - a. Enrollee's name
  - b. Enrollee's AHCCCS I.D. number
  - c. Enrollee's address
  - d. Enrollee's phone number (if applicable)
  - e. Date of receipt of the appeal
  - f. Summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution
35. The following material shall be included in the file sent by the Contractor:
  - a. The Enrollee's written request for hearing
  - b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records
  - c. The Contractor's Notice of Appeal Resolution
  - d. Other information relevant to the resolution of the appeal
36. That if the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the appeal or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.
37. That if the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation.
38. That if the Contractor or the Director's Decision reverses a decision to deny, limit, or delay authorization of services, and the member received the disputed services while the appeal was pending, the Contractor shall process a claim for payment from the provider in a manner consistent with the Contractor's or Director's Decision and applicable statutes, Rules, policies, and contract terms. The provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for untimeliness if they are submitted within the 90 day timeframe. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

39. That if the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor may recover the cost of those services from the enrollee.
- 40.

#### **ATTACHMENT B(2). PROVIDER CLAIM DISPUTE SYSTEM STANDARDS AND POLICY**

The Contractor shall have in place a written claims dispute policy for providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claims dispute policy shall include the following provisions:

1. The Provider Claims Dispute Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claims dispute policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
2. The Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.
3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claims dispute process.
4. A log is maintained for all claims disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claims dispute and the date the claims dispute is resolved. Separate logs must be maintained for provider and behavioral health recipient claims disputes.
5. Within five business days of receipt, the Complainant is informed by letter that the claims dispute has been received.
6. Each claims dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.
7. All documentation received by the Contractor during the claims dispute process is dated upon receipt.
8. All claim disputes are filed in a secure designated area and are retained for five years following the Contractor's decision, AHCCCS' decision, judicial appeal or close of the claims dispute, whichever is later, unless otherwise provided by law.
9. A copy of the Contractor's Notice of Decision (hereafter referred to as Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:
  - a. The nature of the claims dispute
  - b. The issues involved
  - c. The reasons supporting the Contractor's Decision, including references to applicable statute, Rule, applicable contractual provisions, policy and procedure
  - d. The Provider's right to request a hearing by filing a written request for hearing to the Contractor no later than 30 days after the date the Provider receives the Contractor's decision

- e. If the claim dispute is overturned, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision



10. If the Provider files a written request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS), no later than five business days from the date the Contractor receives the provider's written hearing request. The file sent by the Contractor must contain a cover letter that includes:
  - a. Provider's name
  - b. Provider's Address
  - c. Member's Name and AHCCCS Identification Number
  - d. Provider's phone number (if applicable)
  - e. The date of receipt of claim dispute
  - f. A summary of the Contractor's actions undertaken to resolve the claim dispute and basis of the determination
  
11. The following material shall be included in the file sent by the Contractor:
  - a. Written request for hearing filed by the Provider
  - b. Copies of the entire file which includes pertinent records; and the Contractor's Decision
  - c. Other information relevant to the Notice of Decision of the claim dispute
  
12. If the Contractor's Decision regarding a claim dispute is reversed through the claim dispute or hearing process, the Contractor shall reprocess and pay the claim (s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

**ATTACHMENT C: RESERVED**

**ATTACHMENT D. CONTRACTORS CHART OF DELIVERABLES**

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated. If the due date falls on a weekend or a State Holiday, the due date is 5:00 PM on the next business day.

If a Contractor is in compliance with the contractual standards on the deliverables below marked with an asterisk (\*), for a period of three consecutive months, the Contractor may request to submit data on a quarterly basis. However, if the Contractor is non-compliant with any standard on the deliverable or AHCCCS has concerns during the reporting quarter, the Contractor must immediately begin to submit on a monthly basis until three consecutive months of compliance are achieved.

**CONTRACTS**

<b>REPORT</b>	<b>DATE DUE</b>	<b>SEND TO:</b>	<b>SUBMITTED VIA</b>
Certificate of insurance naming AHCCCS as "additional insured" (Section E, ¶ 26)	Within 10 days of contract award	Contracts & Purchasing Administrator (DBF)	Hardcopy
Proof of minimum capitalization (Section D, ¶ 45)	30 days after notification from AHCCCS of contract award	Contracts and Purchasing Administrator (DBF)	Hardcopy
Performance Bond or Bond Substitute (Section D, ¶ 46)	30 days after notification from AHCCCS of the amount required	ALTCS Financial Coordinator (DHCM)	Hardcopy
Subcontracts for: <ul style="list-style-type: none"> <li>• Delegated Agreements</li> <li>• Management Services Agreements</li> <li>• Service Level Agreements</li> <li>• (Section D, ¶ 33)</li> </ul>	60 days prior to start date	Operations and Compliance Officer	FTP server with email notification
Administrative Services Annual Subcontractor Assignment and Evaluation Report (Section D, ¶ 33)	90 days from the start of the contract year	Operations and Compliance Officer (DHCM)	FTP server with email notification
Advertisements or published information for commercial benefit (Section E, ¶ 11)	Prior approval required	Contracts & Purchasing Administrator (DBF)	Hardcopy
Insurance policy cancellation, expiration, or material change (Section E, ¶ 26)	30 days prior notice to AHCCCS	Contracts & Purchasing Administrator (DBF)	Hardcopy
Request to assign any right or delegate all duties (Section E, ¶ 7)	Approval required prior to assignment	Contracts & Purchasing Administrator (DBF)	Email signature page

## DATA ANALYSIS AND RESEARCH

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Corrected Pended Encounter Data (Section D, ¶ 74 ) Encounter Reporting User Manual	Monthly, according to established schedule	Encounter Administrator (DHCM)	FTP server with email notification
New Day Encounter (Section D, ¶ 74) Encounter Reporting User Manual	Monthly according to established schedule	Encounter Administrator (DHCM)	FTP server with email notification
Medical Records for Data Validation (Section D, ¶ 74, Data Validation User Manual)	90 days after the request received from AHCCCS	Encounter Administrator (DHCM)	FTP server with email notification
Encounter Submission and Tracking (Section D, ¶ 74 and the AHCCCS Encounter Manual)	Quarterly, 15 days after the end of each quarter	Encounter Administrator (DHCM)	FTP server with email notification
Plan Overrides (Section D, ¶ 73)	15 days after the end of each quarter	DHCM, Encounter Administrator	FTP server with email notification
Plan Voids (Section D, ¶ 73)	15 days after the end of each quarter	DHCM, Encounter Administrator	FTP server with email notification

## EXECUTIVE MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Cultural Competency Annual Evaluation (Section D, ¶ 69)	November 15	Operations and Compliance Officer	FTP server with email notification
Network Development and Management Plan (Section D, ¶ 28)	November 15	Operations and Compliance Officer	FTP server with email notification
Member Council Annual Plan (Section D, ¶ 24)	December 15	Operations and Compliance Officer (DHCM)	FTP server with email notification
Member Council correspondence including agendas and minutes. (Section D, ¶ 24)	[See Sec. D, ¶24]	Operations and Compliance Officer(DHCM)	FTP server with email notification
Modifications of Operational & Financial Review Corrective Action Plan (Section D, ¶ 79)	Prior to implementation of modification	Operations and Compliance Officer (DHCM)	FTP server with email notification
Proposed merger, reorganization or ownership change (Section D, ¶ 54)	Prior approval required	Operations and Compliance Officer (DHCM)	FTP server with email notification
Related party subcontracts (Section D, ¶ 55)	Prior approval required	Operations and Compliance Officer (DHCM)	FTP server with email notification
Staff functions located outside of Arizona (Section D, ¶ 25)	October 1,	DHCM Operations	FTP server with email notification
Organizational Chart with "Key Staff" positions (Section D, ¶ 25)	October 15	Operations and Compliance Officer (DHCM)	FTP server with email notification
Functional Organizational Chart with key program areas, responsibilities and reporting lines. (Section D, ¶ 25)	October 15	Operations and Compliance Officer	FTP server with email notification
Key Staff Demographics for Staff Listed in a., b., & c. (Section D, ¶ 25)	October 15	ALTCS Valarie Noor, HC Health Program Manager III, OIG/Provider Relations; MD 4500, 701 E. Jefferson, Phoenix, AZ 85034Operations	FTP server with email notification
Attestation of Disclosure Information of: Ownership &	October 15	Operations and Compliance Officer	FTP server with email notification

Control and Persons Convicted of a Crime			
All Hospital sub-contracts and any amendments	After execution	Operations and Compliance Officer	FTP server with email notification
Resignation and addition of any key staff (Section D, ¶ 25)	Within seven days of learning of resignation	Operations and Compliance Officer	Hardcopy
All physician incentive agreements upon contract renewal, prior to initiation of new contract or upon request from AHCCCS or CMS (Section D, ¶ 39)	45 days prior to implementation	Operations and Compliance Officer	FTP server with email notification
Provider Fraud/Abuse Report (Section D, ¶ 70)	Within ten days of discovery	Office of the Inspector General (OIG)	Secure email or web portal
Eligible Persons Fraud/Abuse Report (Section D, ¶ 70)	Within ten days of discovery	Office of the Inspector General (OIG)	Secure email or web portal
Marketing Materials (Section D, ¶ 65 and Section E, ¶ 11)	30 days prior to planned dissemination	Marketing Committee Chairperson	FTP server with email notification
Marketing Attestation Statement (Section D, ¶ 65, Section E, ¶ 11 and ACOM Policy 101)	45 days after start of contract	Operations and Compliance Officer	FTP server with email notification
Business Continuity and Recovery Plan Summary (Section D, ¶ 83)	October 15	Operations and Compliance Officer	FTP server with email notification
Signed Agreement with an independent auditing firm with a schedule of completion for the independent audits of the Claims Payment/Health Information System (Section D, ¶ 44)	December 31, 2013 Suspended	Operations and Compliance Officer	FTP server with email notification
Independent Audits of Claims Payment/Health Information Systems (Section D, ¶ 44)	September 30, 2013 Suspended	Operations and Compliance Officer	FTP server with email notification
Annual Website Certification (Section D, ¶17)	Within 45 days after the beginning of the contract year	Operations and Compliance Officer	FTP server with email notification
Shared Savings Project Outline and Work Plan	January 1 <sup>st</sup>	Operations and Compliance Officer	FTP server with email notification

## FINANCE

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Summary of Contractor's contract rates for long term care, behavioral health and home and community based services (See Financial Reporting Guide for format)	October 15	Finance Manager(DHCM)	FTP server with email notification
* Monthly Claims Dashboard Report (Section D, ¶ 44)	15 days after month end	Finance Manager (DHCM)	FTP server with email notification
Monthly Financial statement (not including months that are also a quarter end) in Contractor's standard format (Section D, ¶ 75)	30 days after month end	Finance Manager (DHCM)	FTP server with email notification
Advances, Distributions, Loans (Section D, ¶ 50)	Prior approval required	Finance Manager (DHCM)	FTP server with email notification
Claims recoupments exceeding	Prior approval	Finance Manager (DHCM)	FTP server with email

\$50,000 per provider within a contract year (Section D, ¶ 44)	required		notification
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**FINANCE**

<b>REPORT</b>	<b>DATE DUE</b>	<b>SEND TO:</b>	<b>SUBMITTED VIA</b>
Corporate cost allocation plans, adjustment in management fees, fund distributions affecting equity (Section D, ¶ 49 & 50)	Prior approval required	Finance Manager (DHCM)	FTP server with email notification
Quarterly Financial Statement (Section D, ¶ 75)	60 days after quarter end	Finance Manager (DHCM)	FTP server with email notification
FQHC Member Month Information (Section D, ¶ 75)	60 days after quarter end	Finance Manager (DHCM)	FTP server with email notification
Draft Audited Financial Statement (Section D, ¶ 75)	90 days after year end	Finance Manager (DHCM)	FTP server with email notification
Annual Reconciliation to Draft Audit (Section D, ¶ 75)	90 days after year end	Finance Manager (DHCM)	FTP server with email notification
Final Audited Financial Statement (Section D, ¶ 75)	120 days after year end	Finance Manager (DHCM)	FTP server with email notification
Final Management Letter (Section D, ¶ 75)	120 days after year end	Finance Manager (DHCM)	FTP server with email notification
Annual Disclosure Statement (Section D, ¶ 75)	120 days after year end	Finance Manager (DHCM)	FTP server with email notification
Quarterly Verification of Receipt of Paid Services (Section D, ¶66 and ACOM Policy 424)	Due the 15 <sup>th</sup> day after the end of the quarter that follows the reporting quarter Oct – Dec due April 15 Jan – March due July 15 April – June due Oct. 15 July – Sept due Jan. 15	Finance Manager Finance Manager (DHCM)	FTP server with email notification
Quarterly Cost Avoidance/Recovery Report (Section D, ¶ 63 and the AHCCCS Program Integrity Reporting Guide)	Due 45 days after the reporting quarter Oct - Dec due Feb 14 Jan – March due May 15 Apr – June due August 14 July – Sept due November 14	Finance Manager (DHCM)	FTP server with email notification

**GRIEVANCE SYSTEM**

<b>REPORT</b>	<b>DATE DUE</b>	<b>SEND TO:</b>	<b>SUBMITTED VIA</b>
Grievance System Report (Section D, ¶ 22)	First Day of 2 <sup>nd</sup> Month Following Month Being Reported	Operations and Compliance Officer	FTP server with email notification
Enrollee Grievance Report (Section D, ¶ 22)	First Day of 2 <sup>nd</sup> Month Following Month Being Reported	Operations and Compliance Officer	FTP server with email notification

Request for Hearing Files (Section F, Attachment B)	5 business days from the date appeal is received	Office of Administrative Legal Services	Hardcopy
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MEMBER SERVICES/CASE MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Case Management Plan (Section D, ¶ 16)	November 15	ALTCS Case Management Manager (DHCM)	FTP server with email notification
Case management internal monitoring process, results and continuous improvement strategies (Section D, ¶ 16)	As requested	ALTCS Case Management Manager (DHCM)	FTP server with email notification

OPERATIONS

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Annual Member Survey (Section D, ¶ 66)	Prior to Distribution	Operations and Compliance Officer (DHCM)	FTP server with email notification
Annual Member Survey results, analysis and improvement strategies (Section D, ¶ 66)	45 days after finalized	Operations and Compliance Officer (DHCM)	FTP server with email notification
Member Handbook (Section D, ¶ 17)	Within four weeks of receiving the annual renewal amendment and upon any changes prior to distribution	Operations and Compliance Officer (DHCM)	FTP server with email notification
All Member Informational Materials (Newsletters, Brochures, etc.) (Section D, ¶ 17)	Prior to Distribution	Operations and Compliance Officer (DHCM)	FTP server with email notification
Placement outside the state (Section D, ¶ 14)	Prior approval required	ALTCS Case Management Manager (DHCM)	FTP server with email notification
Changes or corrections to member’s circumstances (income, living arrangements, TPL, services, etc.) (Section D, ¶ 18)	ALTCS electronic member change report) requirements	AHCCCS Electronic Submission	Web portal
Annual HIPAA Security and Privacy Audit Review (Section D, ¶ 73)	90 days after the beginning of the contract year	Operations and Compliance Officer (DHCM) <b>(Report Suspended)</b>	FTP server with email notification

NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Network Summary (Section D, ¶ 32)	10/15, 4/15	Operations and Compliance Officer (DHCM)	FTP server with email notification
All material changes in provider network (Section D, ¶ 29)	60 days in advance of the change	Operations and Compliance Officer (DHCM)	FTP server with email notification
Unexpected major network changes (Section D, ¶ 29)	Within 1 day of change	Operations and Compliance Officer	FTP server with email notification
Ball v Betlach Semi-Annual Report (Section D, ¶ 28)	May 15 – (Oct, Nov, Dec, Jan, Feb, Mar.) Nov. 15 – (Apr, May, Jun, Jul, Aug, Sep.)	Operations and Compliance Officer (DHCM)	FTP server with email notification
Provider who refuses to sign a contract (if providing more than 25	Document refusal within 7 days of final	Operations and Compliance Officer	FTP server with email notification

services in the contract year) (Section D, ¶ 33)	attempt to gain contract		
Non-Provision of Services Log (Section D, ¶ 16 and ACOM Policy 413)	10 <sup>th</sup> business day following the reporting month	Operations and Compliance Officer ) (DHCM)	Secure email

## NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Gap in Services Log (Section D, ¶ 16 and ACOM Policy 413)	10 <sup>th</sup> business day following the reporting month	Operations and Compliance Officer s (DHCM)	Secure email
Quarterly Provider/Network Changes Due To Rates (ACOM Policy 415)	15 days after the end of each quarter	Operations and Compliance Officer (DHCM)	FTP server with email notification

## THIRD PARTY LIABILITY

REPORT	DATE DUE	SEND TO:	SUBMITTED VIA
Third Party Liability Reporting (Section D, ¶ 63)	Within 10 business days of discovery	AHCCCS TPL Administrator	Third Party Leads Submission File

## CLINICAL QUALITY MANAGEMENT

REPORT	DATE DUE	SEND TO	SUBMITTED VIA
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with the Document) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Maternity Care Plan (Section D, ¶ 20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Stillbirth Report (Section D, ¶ 20) (AMPM Chapter 400)	Immediately following procedure	Clinical Quality Management Unit (DHCM)	Secure email to CQM Administrator or fax to 602-417-4162
EPSDT Annual Plan and Evaluation (Section D, ¶ 20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification
EPSDT Improvement and Adult Quarterly Monitoring Report (Template must be used) (Section D, ¶ 20) (AMPM Chapter 400)	15 days after the end of each quarter (See Suspension list for specific items being suspended.)	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Credentialing Quarterly Report (Section D, ¶ 20)	30 days after the end of each quarter	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Monthly Pregnancy Termination Report (Section D, ¶ 20) (AMPM Chapter 400)	End of the month following the pregnancy termination	Clinical Quality Management Unit (DHCM)	Secure email to CQM Administrator or fax to 602-417-4162
Semi-Annual Report of number of pregnant women who are HIV/AIDS positive (Section D, ¶ 10, Maternity)	30 days after the reporting periods of: [10/1 through 9/30] & [4/1 through 9/30]	Clinical Quality Management Unit (DHCM)	FTP server with email notification
Performance Improvement Project Baseline Report(Standardized format to be utilized) (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification



(AMPM Chapter 900)			
Performance Improvement Project Re-measurement Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)	FTP server with email notification

**CLINICAL QUALITY MANAGEMENT**

<b>REPORT</b>	<b>DATE DUE</b>	<b>SEND TO</b>	<b>SUBMITTED VIA</b>
Performance Improvement Project Final Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	Clinical Quality Management Unit (DHCM)	FTP server with email notification
QM Quarterly Report (Section D, ¶ 20)	45 days after end of each quarter	Clinical Quality Management Unit (DHCM)	FTP server with email notification

**MEDICAL MANAGEMENT**

<b>REPORT</b>	<b>DATE DUE</b>	<b>SEND TO</b>	<b>SUBMITTED VIA</b>
MM/UM Plan and Evaluation (Section D, ¶ 21)	December 15	Medical Management Unit (DHCM)	FTP server with email notification
Quarterly Inpatient Hospital Showings (Section D, ¶ 21)	15 days after the end of each quarter. (15th of Jan., Apr., July & Oct.)	Medical Management Unit (DHCM)	FTP server with email notification
HIV Specialty Provider List (Section D, ¶ 21, Chapter 300 AMPM)	December 15	Medical Management Unit (DHCM)	FTP server with email notification
Quarterly Transplant Report (Section D, ¶ 21, AMPM Chapter 1000)	15 days after the end of each quarter. (15th of Jan., Apr., July & Oct.)	Medical Management Unit (DHCM)	FTP server with email notification
Non-Transplant and Catastrophic Reinsurance covered Diseases and Biological Medications (Section D, ¶ 58)	Annually, by October 30 of each contract year, and when newly enrolled in the plan or newly diagnosed.	Medical Management Unit (DHCM)	FTP server with email notification
Notification of Reinsurance Case that Reaches \$650,000 (Section D, ¶ 58)	Upon identification	Medical Management Unit (DHCM)	FTP server with email notification
Prior Authorization Requirements Report (Section D, ¶ 21)	Suspended	Medical Management Unit (DHCM)	FTP server with email notification

**Suspensions**

The following describes suspensions made during the current contract or renewal period. Suspensions are defined as a temporary release from the deliverable requirement as presented in contract for the term shown in this Attachment. The following suspensions will be in effect for the period from October 1, 2012 through September 30, 2013.

**Section D, Paragraph 20, Quality Management**

Certain requirements contained in the EPSDT Quarterly Report are being suspended. The reporting requirements are being reduced by suspending the PEDS tracking, Obesity Tracking, and Performance Measure reporting contained in the EPSDT Quarterly Report are suspended.

**Section D, Paragraph 21, Medical Management**

The Medical Management UM Quarterly Report is suspended.

**Section D, Paragraph 44, Claims Payment/Health Information System**

Signed Agreement with an independent auditing firm with a schedule of completion for the independent audits of the Claims Payment/Health Information System

Independent Audits of Claims Payment/Health Information Systems

**Section D, Paragraph 73, Data Exchange Requirements**

Annual HIPAA Security and Privacy Audit Review