

SECTION A: CONTRACT AMENDMENT

1. AMENDMENT # <p style="text-align: center;">14</p>	2. CONTRACT # AHCCCS: YH15-0001 DCS: ADCS15-074550	3. EFFECTIVE DATE OF AMENDMENT: OCTOBER 1, 2019	4. PROGRAM DHCM-DCS/CMDP
5. CONTRACTOR NAME AND ADDRESS <p style="text-align: center;">Department of Child Safety (DCS) Comprehensive Medical and Dental Program (CMDP) PO Box 29202, Site Code 942C Phoenix, Arizona 85038-9202</p>			
6. PURPOSE: To amend Section D, Program Requirements and Section F, Attachment F3, Contractor Chart of Deliverables.			
7. THE ABOVE REFERENCED CONTRACT IS HEREBY AMENDED AS FOLLOWS: Contract Section D and Section F, Attachment F3 are REMOVED IN THEIR ENTIRETY and REPLACED with the documents attached hereto as of the Effective Date of this Amendment. All other sections of the Contract are unchanged.			
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. SIGNATURE OF AUTHORIZED REPRESENTATIVE: <p style="text-align: center;">DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</p>		10. SIGNATURE OF AHCCCS CONTRACTING OFFICER: <p style="text-align: center;">DO NOT SIGN SEE SEPARATE SIGNATURE PAGE</p>	
TYPED NAME:		TYPED NAME:	
TITLE:		TITLE:	
DATE:		DATE:	

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SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS

The Contractor shall provide services as described in this Contract. In consideration for these services, the Contractor will be paid the following rate per member per month for the period October 1, 2019 through September 30, 2020 unless otherwise modified by Contract amendment.

**ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)**

Capitation Rates:

Capitation Rates 10/01/19 – 09/30/20
\$325.55

Contractor Specific Requirements:

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

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

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

High Need/High Cost Program: The Contractor shall collaborate with the Regional Behavioral Health Authority (RBHA) to select members for the High Need/High Cost Program and implement interventions for care coordination in order to promote appropriate utilization of services and improve member outcomes.

[END OF SECTION B: CAPITATION RATES AND CONTRACTOR SPECIFIC REQUIREMENTS]

SECTION C: DEFINITIONS

PART 1. DEFINITIONS PERTAINING TO ALL AHCCCS CONTRACTS

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

638 TRIBAL FACILITY	A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facilities, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.
ABUSE OF THE AHCCCS PROGRAM	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, noncompliance with licensure standards, misuse of billing numbers, or misuse or abuse of billing privileges. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program [42 CFR 455.2].
ACTUARY	An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates [42 CFR 438.2].
ADJUDICATED CLAIM	A claim that has been received and processed by the Contractor, which resulted in a payment or denial of payment.
ADMINISTRATIVE SERVICES SUBCONTRACT/SUBCONTRACTOR	<p>An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:</p> <ol style="list-style-type: none"> 1. Claims processing, including pharmacy claims, 2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization), 3. Management Service Agreements; 4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner, 5. DDD Subcontracted Health Plan. <p>A person (individual or entity) who holds an Administrative Services Subcontract is an Administrative Services Subcontractor.</p> <p>Providers are not Administrative Services Subcontractors.</p>

ADULT	An individual person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.
AGENT	Any individual who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].
AHCCCS AMERICAN INDIAN HEALTH PROGRAM (AIHP)	A Fee-For-Service program administered by AHCCCS for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.
AHCCCS COMPLETE CARE CONTRACTOR	A contracted Managed Care Organization (also known as a health plan) that, except in limited circumstances, is responsible for the provision of both physical and behavioral health services to eligible Title XIX/XXI persons enrolled by the administration.
AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)	The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS ELIGIBILITY DETERMINATION	The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.
AHCCCS MEDICAL POLICY MANUAL (AMPM)	The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov .
AHCCCS MEMBER	See "MEMBER."
AHCCCS RULES	See "ARIZONA ADMINISTRATIVE CODE."
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and/or other health care providers.
AMERICANS WITH DISABILITIES ACT (ADA)	The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.
APPEAL	The request for review of an adverse benefit determination.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.

ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. Referred to in Contract as “Rules.” AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.
ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)	The State agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)	Arizona’s Medicaid Program, approved by the Centers for Medicare and Medicaid Services as a Section 1115 Waiver Demonstration Program, and described in A.R.S. Title 36, Chapter 29.
ARIZONA LONG TERM CARE SYSTEM (ALTCS)	An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. §36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.
ARIZONA REVISED STATUTES (A.R.S.)	Laws of the State of Arizona.
ATTACHMENT	Any item labeled as an Attachment in the Contract or placed in the Attachments section of the Contract.
AUTHORIZED REPRESENTATIVE	An individual who is authorized to apply for medical assistance or act on behalf of another individual (A.A.C. R9-22-101).
BALANCED BUDGET ACT (BBA)	See “MEDICAID MANAGED CARE REGULATIONS.”
BEHAVIORAL HEALTH (BH)	Mental health and substance use collectively.
BEHAVIORAL HEALTH DISORDER	Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders (DSM) excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance use treatment.

BEHAVIORAL HEALTH PROFESSIONAL	<ol style="list-style-type: none"> 1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to: <ol style="list-style-type: none"> i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101: 2. A psychiatrist as defined in A.R.S. §36-501, 3. A psychologist as defined in A.R.S. §32-2061, 4. A physician, 5. A behavior analyst as defined in A.R.S. §32-2091, or 6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or 7. A registered nurse with: <ol style="list-style-type: none"> a. A psychiatric-mental health nursing certification, or b. One year of experience providing behavioral health services.
BEHAVIORAL HEALTH SERVICES	Physician or practitioner services, nursing services, health-related services, or ancillary services provided to an individual to address the individual's behavioral health issue. See also "COVERED SERVICES."
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification and when applicable, requirements for maintenance of certification.
BORDER COMMUNITIES	Cities, towns, or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.
CAPITATION	Payment to a Contractor by AHCCCS of a fixed monthly payment per person in advance, for which the Contractor provides a full range of covered services as authorized under A.R.S. §36-2904 and A.R.S. §36-2907.
CENTERS OF EXCELLENCE	A facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)	An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.

CHILD	An individual under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.
CHILD AND FAMILY TEAM (CFT)	A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the child.
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.
CLIENT INFORMATION SYSTEM (CIS)	The centralized processing system for files from each TRBHA/RBHA to AHCCCS as well as an informational repository for a variety of BH related reporting. The CIS system includes Member Enrollment and Eligibility, Encounter processing data, Demographics, and SMI determination processes.
CODE OF FEDERAL REGULATIONS (CFR)	The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

COMPREHENSIVE RISK CONTRACT	<p>A risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services [42 CFR 438.2]:</p> <ol style="list-style-type: none">1. Outpatient hospital services,2. Rural health clinic services,3. Federally Qualified Health Center (FQHC) services,4. Other laboratory and X-ray services,5. Nursing facility (NF) services,6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services,7. Family planning services,8. Physician services, and9. Home health services.
CONTRACT SERVICES	See "COVERED SERVICES."
CONTRACTOR	An organization or entity that has a prepaid capitated contract with AHCCCS pursuant to A.R.S. §36-2904, A.R.S. §36-2940, A.R.S. §36-2944, or Chapter 34 of A.R.S. Title 36, to provide goods and services to members either directly or through subcontracts with providers, in conformance with contractual requirements and State and Federal law, rule, regulations, and policies.
CONVICTED	A judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.
COPAYMENT	A monetary amount that a member pays directly to a provider at the time a covered service is rendered (R9 -22-711).
CORRECTIVE ACTION PLAN (CAP)	A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to be taken to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the Contractor and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.
COST AVOIDANCE	The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.
COVERED SERVICES	The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements, or the Scope of Work Section.

CREDENTIALING	The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.
DAY	A calendar day unless otherwise specified.
DAY – BUSINESS/WORKING	Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or individual to perform one or more functions required to be performed by the Contractor pursuant to this Contract.
DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)	The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS Contracts with DES/DDD to serve Medicaid eligible individuals with a developmental/intellectual disability.
DISENROLLMENT	The discontinuance of a member’s ability to receive covered services through a Contractor.
DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)	The State agency that formerly had the duties set forth by the legislature to provide BH services within Arizona.
DIVISION OF HEALTH CARE MANAGEMENT (DHCM)	The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.
DUAL ELIGIBLE MEMBER	A member who is eligible for both Medicare and Medicaid. There are two types of Dual Eligible Members: a Qualified Medicare Beneficiary (QMB) Dual Eligible Member (a QMB Plus or a QMB Only), and a Non-QMB Dual Eligible Member (a Special Low-Income Beneficiary [SLMB] Plus or an Other Full Benefit Dual Eligible).
DURABLE MEDICAL EQUIPMENT (DME)	Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home. See also Medical Equipment and Appliances.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)	A comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].
EMERGENCY SERVICES	Medical or behavioral health services provided for the treatment of an emergency medical condition.
ENCOUNTER	A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.2].
ENROLLMENT	The process by which an eligible individual becomes a member of a Contractor's plan.
EVIDENCE-BASED PRACTICE	An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of health care professionals; and the unique needs, concerns and preferences of the individual receiving services.

EXCLUDED	Services not covered under the State Plan or the 1115 Waiver, including but not limited to, services that are above a prescribed limit, experimental services, or services that are not medically necessary.
EXHIBITS	All items attached as part of the original Solicitation.
FEDERAL FINANCIAL PARTICIPATION (FFP)	FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.
FEE-FOR-SERVICE (FFS)	A method of payment to an AHCCCS registered provider on an amount-per-service basis for services reimbursed directly by AHCCCS for members not enrolled with a managed care Contractor.
FEE-FOR-SERVICE MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.
FISCAL AGENT	A Contractor that processes or pays vendor claims on behalf of the Medicaid agency [42 CFR 455.101].
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.
GEOGRAPHIC SERVICE AREA (GSA)	An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.
GRIEVANCE	A member's expression of dissatisfaction with any matter, other than an adverse benefit determination.
GRIEVANCE AND APPEAL SYSTEM	A system that includes a process for member grievances and appeals including, SMI grievances and member appeals, provider claim disputes. The Grievance and Appeal system provides access to the State fair hearing process.
HEALTH CARE DECISION MAKER	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.
HEALTH INSURANCE	Coverage against expenses incurred through illness or injury of the individual whose life or physical well-being is the subject of coverage.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.
HEALTH PLAN	See "CONTRACTOR."
HOME HEALTH CARE	See "HOME HEALTH SERVICES"
HOME HEALTH SERVICES	Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on his or her physician's orders as part of a written plan of care [42 CFR 440.70].
HOSPICE SERVICES	Palliative and support care for members who are certified by a physician as being terminally ill and having six months or less to live.
HOSPITALIZATION	Admission to, or period of stay in, a health care institution that is licensed as a hospital as defined in R9-22-101.
INCURRED BUT NOT REPORTED (IBNR)	Liability for services rendered for which claims have not been received.
INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)	See "SERVICE PLAN"
INDIAN HEALTH SERVICES (IHS)	The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of Federally recognized Tribes and Alaska Natives as outlined in 25 U.S.C. 1661.

INFORMATION SYSTEMS	The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).
IN-NETWORK PROVIDER	An individual or entity which has signed a provider agreement as specified in A.R.S. §36-2904 and that has a subcontract is authorized through a subcontract with an AHCCCS Contractor to provide services prescribed in A.R.S. §36-2901 et seq. for members enrolled with the Contractor.
INSTITUTION FOR MENTAL DISEASE (IMD)	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases [42 CFR 435.1010].
INTERGOVERNMENTAL AGREEMENT (IGA)	When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to contract for or perform some or all of the services specified in the contract or agreement or exercise those powers jointly held by the contracting parties A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).
LIABLE PARTY	An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in A.A.C. R9-22-1001.
LIEN	A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
LIMITED ENGLISH PROFICIENCY (LEP)	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

LONG TERM SERVICES AND SUPPORTS (LTSS)	Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2].
MAJOR UPGRADE	Any systems upgrade or change to a major business component that may result in a disruption to the following: loading of contracts, providers, or members, issuing prior authorizations or the adjudication of claims.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.
MANAGED CARE ORGANIZATION	<p>An entity that has, or is seeking to qualify for, a comprehensive risk Contract under 42 CFR Part 438 and that is [42 CFR 438.2]:</p> <ol style="list-style-type: none">1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489, or2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:<ol style="list-style-type: none">a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.b. Meets the solvency standards of 42 CFR438.116.
MANAGED CARE PROGRAM	A managed care delivery system operated by a State as authorized under Section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].
MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency [42 CFR 455.101].

**MATERIAL CHANGE TO
BUSINESS OPERATIONS**

Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA. Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Additional changes may also include the addition or change in:

1. PBM,
2. Dental Benefit Manager,
3. Transportation vendor,
4. Claims Processing system,
5. System changes and upgrades,
6. Member ID Card vendor,
7. Call center system,
8. Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment,
9. MSA, and
10. Any other Administrative Services Subcontract.

**MATERIAL CHANGE TO
PROVIDER NETWORK**

Any change in composition of or payments to a Contractor's provider network that affects, or can reasonably be foreseen to affect, the Contractor's adequacy of capacity and services necessary to meet the performance and/or provider network standards as described in Contract. Changes to provider network may include, but are not limited to:

1. A change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.
2. Any change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area, or operates in an area with limited alternate sources of the service.

MATERIAL OMISSION

A fact, data or other information excluded from a report, Contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

MEDICAID

A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

MEDICAID MANAGED CARE REGULATIONS	The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.
MEDICAL EQUIPMENT AND APPLIANCES	<p>Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic; and</p> <ol style="list-style-type: none">1. Is customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of an illness, disability, or injury,2. Can withstand repeated use, and3. Can be reusable by others or removable. <p>Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).</p>
MEDICAL MANAGEMENT (MM)	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to hospice).
MEDICAL RECORDS	A chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the provider's physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider (PCP), attending physician, or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
MEDICAL SUPPLIES	Health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].
MEDICALLY NECESSARY	A covered service provided by a physician or other licensed practitioner of the health arts within the scope of practice under State law to prevent disease, disability or other adverse conditions or their progression, or to prolong life (A.A.C. R9-22-101).
MEDICALLY NECESSARY SERVICES	Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.

MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICATION ASSISTED TREATMENT (MAT)	The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
MEMBER	An eligible individual who is enrolled in AHCCCS, as defined in A.R.S. §36-2931, §36-2901, §36-2901.01 and A.R.S. §36-2981. Also referred to as Title XIX/XXI Member or Medicaid Member.
MEMBER INFORMATION MATERIALS	Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.
MINIMUM PERFORMANCE STANDARD (MPS)	The minimal expected level of performance by the Contractor.
NATIONAL PROVIDER IDENTIFIER (NPI)	A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.
NETWORK	A list of doctors, or other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members.
NON-CONTRACTING PROVIDER	An individual or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.
OUT OF NETWORK PROVIDER	An individual or entity that has a provider agreement with the AHCCCS Administration pursuant to A.R.S. §36-2904 it is not authorized through a subcontract with an AHCCCS Contractor to provide services specified in A.R.S. §36-2901 et seq. for members enrolled with the Contractor.
PARENT	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

PERFORMANCE IMPROVEMENT PROJECT (PIP)	A planned process of data gathering, evaluation, and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).
PERFORMANCE STANDARDS	A set of standardized measures designed to assist AHCCCS in evaluating, comparing, and improving the performance of its Contractors.
PHYSICIAN SERVICES	Medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.
PLAN	See "SERVICE PLAN".
POSTSTABILIZATION CARE SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438.114(a)].
POTENTIAL ENROLLEE	A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].
PREMIUM	The amount an individual pays for health insurance every month. In addition to the premium, an individual usually has to pay other costs for his/her health care, including a deductible, copayments, and coinsurance.
PREMIUM TAX	The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 and A.R.S. §36-2944.01 for all payments made to Contractors for the Contract Year.
PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)	An integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements.
PRESCRIPTION DRUGS	Any prescription medication as defined in A.R.S §32-1901 is prescribed by a health care professional to a subscriber to treat the subscriber's condition.

PRIMARY CARE	All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them [42 CFR 438.2].
PRIMARY CARE PHYSICIAN	A physician defined as an individual licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 and who otherwise meets the definition of Primary Care Provider (PCP).
PRIMARY CARE PROVIDER (PCP)	An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as an individual licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of individuals, such as a clinic.
PRIMARY PREVENTION	The focus on methods to reduce, control, eliminate, and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.
PRIOR AUTHORIZATION	Process by which the Administration or Contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article, and any applicable contract provisions. Prior authorization is not a guarantee of payment (A.A.C. R9-22-101).
PRIOR PERIOD	See "PRIOR PERIOD COVERAGE."
PRIOR PERIOD COVERAGE (PPC)	For Title XIX members, the period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee For Service and the member will be enrolled with the Contractor only on a prospective basis.

PRIOR QUARTER COVERAGE	<p>The period of time prior to an individual's month of application for AHCCCS coverage, during which a member (limited to children under 19, individuals who are pregnant, and individuals who are in the 60-day postpartum period beginning the last day of pregnancy) may be eligible for covered services. Prior Quarter Coverage is limited to the three month time period prior to the month of application. An applicant may be eligible during any of the three months prior to application if the applicant:</p> <ol style="list-style-type: none"> 1. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month, and 2. Would have qualified for Medicaid at the time services were received if the individual had applied regardless of whether the individual is alive when the application is made. Refer to A.A.C. R9-22-303. <p>AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.</p>
PROGRAM CONTRACTOR	See "CONTRACTOR"
PROVIDER	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, pursuant to 42 CFR 438.2.
PROVIDER GROUP	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).
PRUDENT LAYPERSON (for purposes of determining whether an emergency medical condition exists)	An individual without medical training who relies on the experience, knowledge and judgment of a reasonable individual to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE MEMBER (QMB DUAL)	An individual determined eligible under A.A.C. R9-29 Article 2 for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in 9 A.A.C. Chapter 22 or ALTCS services provided for in 9 A.A.C. R Chapter 28. A QMB Dual receives both Medicare and Medicaid services and cost sharing assistance.
QUALITY MANAGEMENT	The evaluation and assessment of member care and services to ensure adherence to standards of care and appropriateness of services; can be assessed at a member, provider, or population level.

REFERRAL	A verbal, written, telephonic, electronic, or in-person request for health services.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	A contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration and provision of comprehensive physical health services to eligible individuals with a Serious Mental Illness enrolled by the Administration.
REHABILITATION	Physical, occupational, and speech therapies, and items to assist in improving or restoring an individual's functional level (A.A.C. R9-22-101).
REINSURANCE	A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain contract service costs incurred for a member beyond a predetermined monetary threshold.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, individuals with an ownership or controlling interest in the Contractor 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 individuals.
REQUEST FOR PROPOSAL (RFP)	A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a Proposal under 9 A.A.C. 22 Article 6 and 9 A.A.C. 28 Article 6.
RISK CONTRACT	<p>A Contract between the State and MCO, under which the Contractor:</p> <ol style="list-style-type: none"> 1. Assumes risk for the cost of the services covered under the Contract, and 2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract [42 CFR 438.2].
ROOM AND BOARD (or ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual 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 HCBS setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.

SCOPE OF SERVICES	See "COVERED SERVICES."
SERVICE LEVEL AGREEMENT	A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract.
SERVICE PLAN	A complete written description of all covered health services and other informal supports which includes individualized goals, peer-and-recovery support and family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.
SPECIAL HEALTH CARE NEEDS (SHCN)	Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.
SPECIALIST	A Board-eligible or certified physician who declares himself or herself as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.
SPECIALTY PHYSICIAN	A physician who is specially trained in a certain branch of medicine related to specific services or procedures, certain age categories of patients, certain body systems, or certain types of diseases.
STATE	The State of Arizona and Department or Agency of the State that executes the Contract.
STATEWIDE	Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.
STATE FISCAL YEAR	The budget year-State fiscal year: July 1 through June 30.
STATE PLAN	The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.

SUBCONTRACT	An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or individual who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract, as defined in 9 A.A.C. 22 Article 1.
SUBCONTRACTOR	<ol style="list-style-type: none">1. A provider of health care who agrees to furnish covered services to members.2. An individual, agency, or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.3. An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.
SUBSIDIARY	An entity owned or controlled by the Contractor.
SUBSTANCE USE DISORDER (SUD)	A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY (TPL)	See "LIABLE PARTY."
TITLE XIX	Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation, and other services, to help those families and individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which includes those populations described in 42 U.S.C. 1396 a (a)(10)(A).

TITLE XIX MEMBER	Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults \leq 106%), Adult Group above 106% Federal Poverty Level (Adults $>$ 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.
TREATMENT	A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue. Refer to A.A.C. R9-10-101.
TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)	A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.

[END OF PART 1 DEFINITIONS]

SECTION C: DEFINITIONS**PART 2: DEFINITIONS PERTAINING TO ONE OR MORE AHCCCS CONTRACTS**

ABUSE (OF A CHILD)	<p>The infliction or allowing of physical injury, impairment of bodily function or disfigurement or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody and control of a child. As specified in A.R.S. § 8-201(2), abuse includes:</p> <ol style="list-style-type: none">1. Inflicting or allowing sexual abuse, sexual conduct with a minor, sexual assault, molestation of a child, commercial sexual exploitation of a minor, sexual exploitation of a minor, incest, or child sex trafficking as those acts are described in the Arizona Revised Statutes, Title 13, Chapter 14.2. Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic or flammable chemicals are found or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in section 13-3401.3. Unreasonable confinement of a child.
ABUSE (OF A MEMBER)	<p>Abuse of a Vulnerable Adult or the Abuse of a Child who is a member as specified in A.R.S. §46-451(A)(1), A.R.S. §8-201(2), A.R.S. §46-451(A)(9).</p>
ABUSE (OF A VULNERABLE ADULT)	<p>An intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, and sexual abuse or sexual assault as specified in A.R.S. §46-451(A)(1).</p>
ACTIVE TREATMENT	<p>A current need for treatment. The treatment is identified on the member's service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.</p>

ACUTE CARE ONLY (ACO)	The enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who; 1) refuses HCBS offered by the case manager; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Services and Supports (LTSS) cannot be provided; or 4) has equity value in a home that exceeds \$552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive LTC institutional, alternative residential or HCBS.
ADMINISTRATIVE OFFICE OF THE COURTS (AOC)	The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.
ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)	Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).
ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS <= 106%)	Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).
AFFILIATED ORGANIZATION	A party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.
ANNIVERSARY DATE	The anniversary date is 12 months from the date the member is enrolled with the Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Contractors or the last date the member was given an opportunity to change.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for an individual to change Contractors every 12 months.

ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)	<p>The department established pursuant to A.R.S. §8-451 to protect children and to perform the following:</p> <ol style="list-style-type: none"> 1. Investigate reports of abuse and neglect. 2. Assess, promote, and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect. 3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations. 4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family, and provide prevention, intervention and treatment services pursuant to this chapter.
ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)	<p>The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.</p>
BED HOLD	<p>A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and therapeutic leave. Refer to the Arizona Medicaid State Plan 42 CFR 447.40 and 42 CFR 483.12, 9 A.A.C. 28 and AMPM Chapter 100.</p>
BEHAVIORAL HEALTH PARAPROFESSIONAL	<p>As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:</p> <ol style="list-style-type: none"> 1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and 2. Are provided under supervision by a behavioral health professional.
BEHAVIORAL HEALTH RESIDENTIAL FACILITY	<p>As specified in A.A.C. R9-10-101, health care institution that provides treatment to an individual experiencing a behavioral health issue that:</p> <ol style="list-style-type: none"> 1. Limits the individual's ability to be independent, or 2. Causes the individual to require treatment to maintain or enhance independence.

BEHAVIORAL HEALTH TECHNICIAN	<p>As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:</p> <ol style="list-style-type: none">1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and2. Are provided with clinical oversight by a behavioral health professional.
BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)	<p>Eligible individuals under the Title XIX expansion program for women with income up to 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs providing full Title XIX services. Qualifying individuals cannot have other creditable health insurance coverage, including Medicare.</p>
CARE MANAGEMENT PROGRAM (CMP)	<p>Activities to identify the top tier of high need/high cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care management is an administrative function performed by the health plan. Distinct from case management, Care Managers should not perform the day-to-day duties of service delivery.</p>
CARE MANAGEMENT	<p>A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.</p>
CASE MANAGEMENT	<p>A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Contractor Case management for DES/DDD is referred to as Support Coordination.</p>
CASH MANAGEMENT IMPROVEMENT ACT (CMIA)	<p>Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.</p>
CHILDREN	<p>Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.</p>

CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)	A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors.
COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)	A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.
COMPETITIVE BID PROCESS	A State procurement system used to select Contractors to provide covered services on a geographic basis.
COUNTY OF FISCAL RESPONSIBILITY	The county of fiscal responsibility is the Arizona county that is responsible for paying the State's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
DES/DDD AMERICAN INDIAN HEALTH PLAN (DDD-AIHP)	A Fee for Service (FFS) program administered by DES/DDD for Title XIX/XXI eligible American Indians which reimburses for physical and behavioral health services provided by any AHCCCS registered provider, and for TXIX members, that are not provided by or through the Indian Health Services tribal health programs operated under 638. In this Contract DDD's Program is referred to as DDD-AIHP.
DEVELOPMENTAL DISABILITY (DD)	<p>As defined in A.R.S. §36-551, a strongly demonstrated potential that a child under six years of age has a developmental disability or will become a child with a developmental disability, as determined by a test performed pursuant to A.R.S. §36-694 or by other appropriate tests, or a severe, chronic disability that:</p> <ol style="list-style-type: none"> 1. Is attributable to cognitive disability, cerebral palsy, epilepsy, or autism. 2. Is manifested before age eighteen. 3. Is likely to continue indefinitely. 4. Results in substantial functional limitations in three or more of the following areas of major life activity: <ol style="list-style-type: none"> a. Self-care, b. Receptive and expressive language, c. Learning, d. Mobility, e. Self-direction, f. Capacity for independent living, and g. Economic self-sufficiency. 5. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary, or generic care, treatment or other services that are of lifelong or extended duration.

EQUITY PARTNERS	The sponsoring organizations or parent companies of the managed care organization that share in the returns generated by the organization, both profits and liabilities.
FAMILY-CENTERED	Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate, the member directs the involvement of the family to ensure person centered care.
FAMILY OR FAMILY MEMBER	A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members, which includes informal supports.
FAMILY-RUN ORGANIZATION	An entity that has a board of directors made up of more than 50% family members who have primary responsibility for the raising of a child, youth, adolescent or young adult with a Serious Emotional Disturbance (SED), or have the lived experience as a primary informal support for an adult with emotional, behavioral, mental health or substance use needs.
FEDERAL EMERGENCY SERVICES (FES)	A program delineated in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.
FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE	A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of "health center" under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.
FIELD CLINIC	A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

FREEDOM OF CHOICE (FC)	The opportunity given to each member who does not specify a Contractor preference at the time of enrollment to choose between the Contractors available within the Geographic Service Area (GSA) in which the member is enrolled.
GENERAL MENTAL HEALTH/SUBSTANCE USE (GMH/SU)	Behavioral health services provided to adult members age 18 and older who have not been determined to have a Serious Mental Illness.
GENERALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS	Configure their program operations to the needs of the Child and Family Team without arbitrary limits on frequency, duration, type of service, age, gender, population, or other factors associated with the delivery of Support and Rehabilitation Services.
GUEST DOSING	A mechanism for patients who are not eligible for take-home medication to travel from their home clinic for business, pleasure, or family emergencies and which also provides an option for patients who need to travel for a period of time that exceeds the amount of eligible take-home doses.
HABILITATION	The process by which an individual is assisted to acquire and maintain those life skills that enable the individual to cope more effectively with personal and environmental demands and to raise the level of the individual's physical, mental and social efficiency (A.R.S. §36-551 (18)).
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment, or other similar shelter. A home is not a facility, a setting or an institution, or a portion of and any of these, licensed or certified by a regulatory agency of the State as defined in A.A.C. R9-28-101.
HOME AND COMMUNITY BASED SERVICES (HCBS)	Home and community-based services, as defined in A.R.S. §36-2931 and A.R.S. §36-2939.
INTEGRATED MEDICAL RECORD	A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.
INTERDISCIPLINARY CARE	A meeting of the interdisciplinary team members or coordination of care among interdisciplinary treatment team members to address the totality of the treatment and service plans for the member based on the most current information available.

INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF/IID)	A facility that primarily provides health and rehabilitative services to persons with developmental disabilities that are above the service level of room and board or supervisory care services or personal care services as defined in section 36-401 but that are less intensive than skilled nursing services (A.R.S. §36-551 (28)).
JUVENILE PROBATION OFFICE (JPO)	An officer within the Arizona Department of Juvenile Corrections assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile's who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program (A.R.S. §8-353).
KIDSCARE (TITLE XXI)	Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).
MEDICAL PRACTITIONER	A physician, physician assistant or registered nurse practitioner.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)	An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.
PARENTS/CARETAKER RELATIVES	Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL).
PEER-RUN ORGANIZATION	Peer-Operated Services that are: <ol style="list-style-type: none">1. Independent - Owned, administratively controlled, and managed by peers,2. Autonomous - All decisions are made by the program,3. Accountable - Responsibility for decisions rests with the program, and4. Peer – controlled - Governance board is at least 51% peers.

PERFORMANCE BOND	A written promise by a Surety to pay AHCCCS (as the obligee) an amount specified in Contract and ACOM Policy 305, if the Contractor (as the principal), fails to meet the Contractor's obligation under the Contract. A Performance Bond is also called a Surety Bond.
PERSON-CENTERED	An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.
PERSON WITH A DEVELOPMENTAL/INTELLECTUAL DISABILITY	An individual who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). Services for AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.
PRE-ADMISSION SCREENING (PAS)	A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.
PREGNANT WOMEN	Eligible pregnant women, with income at or below 156% of the FPL.
PRESCRIPTION DRUG COVERAGE	Prescription medications prescribed by an AHCCCS registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and state law including 42 U.S.C 1396r-8 and A.A.C. R9-22-209.
RAPID RESPONSE	A process in which, a behavioral health service provider is dispatched within 72 hours, to assess a child's immediate behavioral health needs, and refer for further assessments through the behavioral health system when a child first enters into DCS custody.
RATE CODE	Eligibility classification for capitation payment purposes.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.
ROSTER BILLING	Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.
RURAL HEALTH CLINIC (RHC)	A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.
SERIOUS MENTAL ILLNESS (SMI)	A designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.

SMI ELIGIBILITY DETERMINATION	A determination as to whether or not an individual meets the diagnostic and functional criteria established for the purpose of determining an individual's eligibility for SMI services.
SPECIALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS	Provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)	State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."
STATE ONLY TRANSPLANT MEMBERS	Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility under a category other than Adult Group due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.
SUBSTANCE ABUSE	As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that: <ol style="list-style-type: none"> 1. Alters the individual's behavior or mental functioning, 2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical, and 3. Impairs, reduces, or destroys the individual's social or economic functioning.
TITLE XXI	Title XXI of the Social Security Act provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner that is coordinated with other sources of child health benefits coverage.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "Children's Health Insurance Program" (CHIP). The Arizona version of CHIP is referred to as "KidsCare."
TREATMENT PLAN	A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

VIRTUAL CLINICS

Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

VULNERABLE ADULT

As defined in A.R.S. §46-451, an individual who is eighteen years of age or older and who is unable to protect himself from abuse, neglect, or exploitation by others because of a physical or mental impairment. Vulnerable adult includes an incapacitated person as defined in A.R.S. §14-5101.

[END OF PART 2 DEFINITIONS]

[END OF SECTION C: DEFINITIONS]

SECTION D: PROGRAM REQUIREMENTS**1. PURPOSE, APPLICABILITY, AND INTRODUCTION*****PURPOSE AND APPLICABILITY***

The purpose of the Contract between AHCCCS and the Contractor is to implement and operate the provisions of the Comprehensive Medical and Dental Program (CMDP) approved under A.R.S. §36-2901 et seq. relating to the furnishing of covered services and items to each enrolled member. The terms of this Contract apply to the Contractor, any provider participating in the Contractor's provider network, and any provider that furnishes items and services to an enrolled member upon the request or authorization of the Contractor.

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

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

INTRODUCTION**AHCCCS Mission and Vision**

AHCCCS' mission and vision are 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. AHCCCS is dedicated to continuously improving the efficiency and effectiveness of the Program while supporting member choice in the delivery of the highest quality care to its customers.

AHCCCS expects the Contractor to implement program innovation and best practices on an ongoing basis. Furthermore, it is important for the Contractor to continuously develop mechanisms to reduce administrative cost and improve program efficiency. Over the term of the Contract, AHCCCS will work collaboratively with the Contractor to evaluate ways to reduce program complexity, improve care coordination and chronic disease management, reduce administrative burdens, leverage joint purchasing power, and reduce unnecessary administrative and medical costs.

AHCCCS has remained a leader in Medicaid Managed Care through the diligent pursuit of excellence and cost effective managed care by its collaboration with Contractors.

The Contractor shall continue to add value to the program. A Contractor adds value when it:

1. Recognizes that Medicaid members are entitled to care and assistance navigating the service delivery system and demonstrates special effort throughout its operations to assure members receive necessary services.
2. Recognizes that Medicaid members with special health care needs or chronic health conditions require care coordination, and provides that coordination.
3. Recognizes that health care providers are an essential partner in the delivery of health care services, and operates the Health Plan in a manner that is efficient and effective for health care providers as well as the Contractor.

4. Recognizes that performance improvement is both clinical and operational in nature and self-monitors and self-corrects as necessary to improve Contract compliance or operational excellence.
5. Recognizes that the program is publicly funded, is subject to public scrutiny, and operates in a manner consistent with the public trust.

2. RESERVED

3. ENROLLMENT AND DISENROLLMENT

In accordance with A.R.S. §8-512, CMDP provides comprehensive medical and dental care for each child who is: a) placed in a foster home; b) in the custody of DCS and placed with a relative, in a certified adoptive home prior to the final order of adoption, or in an independent living program as provided in A.R.S. §8-512; or c) in the custody of the Arizona Department of Juvenile Corrections (ADJC) or the Administrative Office of the Courts/Juvenile Probation Office (AOC/JPO) and placed in foster care.

The Contractor is not responsible for determining eligibility.

AHCCCS has the exclusive authority to enroll and disenroll members. AHCCCS operates as a mandatory managed care program and choice of enrollment or auto-assignment (passive enrollment) is used pursuant to the terms of the Arizona Medicaid Section 1115 Demonstration Waiver, Special Terms and Conditions [42 CFR 438.54(d)].

AHCCCS will enroll the child with CMDP and notify CMDP of the child's AHCCCS enrollment. CMDP is responsible for timely notification to AHCCCS if a member no longer meets the criteria for CMDP coverage as set for in A.R.S. §8-512. Children who are enrolled with CMDP when placed temporarily in detention may remain Title XIX or Title XXI eligible. When it is determined that the child does not meet the "inmate of a public institution" status as determined by the Children in Detention Policy, AHCCCS enrollment will remain with CMDP.

The Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCS [42 CFR 457.1201(m), 42 CFR 457.1212, 42 CFR 438.56(b) (1), 42 CFR 438.56(b) (3)].

The Contractor may not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or [uncooperative or disruptive behavior resulting from his or her special needs [Section 1903(m)(2)(A)(v) of the Social Security Act, 42 CFR 457.1201(m), 42 CFR 457.1212, 42 CFR 438.56(b)(2)].

Consistent with the terms of the Section 1115 Waiver Demonstration the Administration is waived from 42 CFR 438.52 and 438.56 to the extent necessary to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in Comprehensive Medical and Dental Program (CMDP) so long as members in CMDP have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c).

For children with an I/DD who also qualify for CMDP and DES/DDD, the member is enrolled with DES/DDD for provision of physical and behavioral health services.

ALTCS Eligibility Determination During Hospitalization: If determined a member may qualify for ALTCS during an individual's acute hospitalization, AHCCCS will process an application for ALTCS eligibility. Enrollment of an applicant who is determined eligible will be effective during the hospital stay.

KidsCare: Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL). See AMPM Policy 440.

Prior Quarter Coverage: Pursuant to the January 2019 CMS Approval of Waiver authority, AHCCCS is waived from approving Prior Quarter Coverage eligibility (also referred to as Retroactive Coverage in the CMS Waiver Approval) for individuals who are NOT in the following three categories: children under 19, individuals who are pregnant, and individuals who are in the 60-day postpartum period beginning the last day of pregnancy. Effective July, 1, 2019, only the 3 populations above are exempted from the waiver of prior quarter coverage eligibility, and these individuals may be determined to qualify for AHCCCS coverage during any of the 3 months prior to the month of application when they meet the eligibility requirements for that month. Prior Quarter Coverage eligibility expands the time period during which AHCCCS pays for covered services for eligible individuals to any of the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during that particular month. AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter. Upon verification or notification of Prior Quarter Coverage eligibility, providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period.

Prior Period Coverage: AHCCCS provides Prior Period Coverage for Title XIX members for the period of time, prior to the Title XIX member's enrollment during which a member is eligible for covered services. When a child is not already AHCCCS eligible and enrolled with a Contractor, Prior Period Coverage for CMDP members refers to the time frame from the date the child is removed from the home to when the Medicaid eligibility determination is made. The Contractor receives notification from AHCCCS of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services provided to members during Prior Period Coverage. The Contractor is responsible for payment of all claims for medically necessary covered services provided to members during prior period coverage including services provided prior to the Contract year in a Geographic Service Area where the Contractor was not contracted at the time of service delivery. AHCCCS Fee-For-Service is responsible for the payment of claims for Prior Period Coverage for members who are found eligible for AHCCCS initially through hospital presumptive eligibility and later are enrolled with the Contractor. Therefore, for those members, the Contractor is not responsible for Prior Period Coverage.

Hospital Presumptive Eligibility: As required under the Affordable Care Act, AHCCCS has established standards for Hospital Presumptive Eligibility (HPE), in accordance with Federal requirements. Qualified hospitals that elect to participate in the HPE Program will implement a process consistent with AHCCCS standards, which determines applicants presumptively eligible for AHCCCS Medicaid covered services. Individuals determined presumptively eligible who have not submitted a full application to AHCCCS will qualify for Medicaid services from the date the hospital determines the individual to be presumptively eligible through the last day of the month following the month in which the determination of presumptive eligibility was made by the qualified hospital. For individuals who apply for presumptive eligibility and who submit a full application to AHCCCS, coverage of Medicaid services will begin on the date that the hospital determines the individual to be presumptively eligible and will continue through the date that AHCCCS issues a determination on that application. All individuals

determined presumptively eligible for AHCCCS will be enrolled with AHCCCS Fee-For-Service for the duration of the HPE eligibility period. If a member made eligible via HPE is subsequently determined eligible for AHCCCS via the full application process, Prior Period Coverage for the member will also be covered by AHCCCS Fee-For-Service, and the member will be enrolled with the Contractor only on a prospective basis.

Newborns: The Contractor is responsible for notifying AHCCCS of a child's birth to an enrolled member even though the newborn may not be under the custody of the Contractor.

For newborns eligible for CMDP: Capitation for the newborn will be retroactive to the date of birth if notification is received no later than one day from the date of birth. In all other circumstances, capitation for the newborn will begin on the date notification is received by AHCCCS. The effective date of AHCCCS eligibility for the newborn will be the newborn's date of birth, and the Contractor is responsible for all covered services to the newborn, whether or not AHCCCS has received notification of the child's birth. AHCCCS is available to receive notification 24 hours a day, seven days a week via the AHCCCS web site. If the newborn meets statutory requirements for CMDP coverage as set forth in A.R.S. §8-512, CMDP shall remain the newborn's health plan.

For newborns ineligible for CMDP: Newborns who do not meet statutory requirements for CMDP coverage are auto-assigned to an AHCCCS Complete Care Contractor. Mothers of these newborns are sent a Choice Notice advising them of their right to choose a different Contractor for their child, which allows them 90 days to make a choice. See ACOM Policy 401. In the event the mother chooses a different Contractor, AHCCCS will recoup all capitation paid to the originally assigned Contractor and the baby will be enrolled retroactive to the date of birth with the second Contractor. The second Contractor will receive prior period capitation from the date of birth to the day before assignment and prospective capitation from the date of assignment forward. The second Contractor will be responsible for all covered services to the newborn from date of birth.

4. RESERVED

5. RESERVED

6. RESERVED

7. ACCOMMODATING AHCCCS MEMBERS

The Contractor shall ensure that members are provided covered services without regard to race, color, national origin, sex, sexual orientation, gender identity, age or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, age or disability [42 CFR 457.1201(d), 42 CFR 438.3(d)(4), 45 CFR Part 92]. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing a member any covered service or access to an available facility,
2. 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,

3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in any way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service, and
4. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or intellectual disabilities of the participants to be served.

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

The Contractor shall ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams. For example, the Contractor shall provide appropriate auxiliary aids and services to individuals with impaired sensory, manual, or speaking skills. The Contractor shall provide accommodations to members and individuals with disabilities at no cost to afford such individuals an equal opportunity to benefit from the covered services [45 CFR 92.202 – 92.205].

If the Contractor knowingly executes a subcontract with a provider with the intent of allowing or permitting the provider 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 may be in default of its Contract.

If the Contractor identifies a problem involving discrimination or accommodations for individuals with disabilities by one of its providers, the Contractor 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.

8. TRANSITION ACTIVITIES

The Contractor shall develop and implement member transition policies and procedures for the acceptance and transfer of members in accordance with Contract and AHCCCS Policy. The Contractor shall comply with the AMPM Policy 520 and ACOM Policy 402 for member transitions between AHCCCS Programs, Contractors, or Geographical Service Areas (GSAs) and upon termination or expiration of a Contract.

The Contractor shall develop and implement member transition policies and procedures which include but are not limited to:

1. Members with significant medical conditions such as, a high-risk pregnancy or pregnancy within the third trimester, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.,
2. Children under age 19 who are blind, have disabilities, have a CRS condition, are in foster care or other out-of-home placement, or are receiving adoption assistance,
3. Members determined to have a serious or chronic physical, developmental and/or behavioral health condition such as a Serious Mental Illness, serious emotional disorders, autism, intellectual disability,
4. Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, end of life care or hospice, or who are hospitalized at the time of transition,

5. Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth,
6. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media,
7. Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, or nursing home admission,
8. Continuing prescriptions, medical equipment, appliances, supplies and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor, and
9. Medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing AHCCCS Contractor).

When relinquishing members, the relinquishing Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to special needs of transitioning members. Relinquishing Contractors who fail to notify the receiving Contractor or FFS Program of transitioning members with special circumstances will be responsible for covering the members' care for up to 30 days following the transition.

Appropriate medical records for the transitioning member shall be transmitted to the receiving Contractor. The cost, if any, of transition activities including reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor. The Contractor is responsible for coordinating care with the relinquishing Contractor to ensure provision of uninterrupted services, Contractor and service information, emergency numbers, and instructions on how to obtain services. Refer to AMPM Policy 520 and ACOM Policies 401, 402, and 403 for additional Contractor transition requirements.

The Contractor shall implement a transition of care policy consistent with the requirements in [42 CFR 438.62(b)(1)], ACOM Policy 402, and AMPM Policy 520.

The Contractor shall designate a key staff person with appropriate training and experience to act as the Transition Coordinator. The Transition Coordinator shall interact closely with the Transition Coordinator of the relinquishing Contractor for a safe, timely, and orderly transition. See Section D, Paragraph 15, Staffing Requirements, and ACOM Policy 402 for more information regarding the role and responsibilities of the Transition Coordinator.

The Contractor shall be responsible for retaining, preserving and making available records, within the timeframes required by State and Federal law, including but not limited to [45 CFR 164.530(j)(2) and 42 CFR 438.3(u)].

9. SCOPE OF SERVICES

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal and State laws, Arizona Section 1115 Waiver demonstration, regulations, Contract and policies, including those incorporated by reference in this Contract. The services are described in detail in AHCCCS Rules including but not limited to AHCCCS regulations in A.A.C. R9-22 Article 2, 12, and 13, the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Contractor Operations Manual (ACOM), and AMPM Policy 310-B and AMPM Exhibit 300-2A, all of which are incorporated herein by reference and may be found on the AHCCCS website [42 CFR 438.210(a)(1)]. To be covered, services must be medically

necessary and cost effective. Covered services are briefly described below. See also AMPM Exhibit 300-1 and AMPM Exhibit 300-2A.

The Contractor shall ensure the coordination of services it provides with services the member receives from other entities, including behavioral health services the member receives through a RBHA provider. The Contractor shall ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements including, but not limited to, 45 CFR Parts 160 and 164, Subparts A and E, and Arizona statute, to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224].

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

Services shall be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. The Contractor shall provide the same standard of care for all members, regardless of the member's eligibility category. The Contractor shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished [42 CFR 434.6(a)(4)]. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member [42 CFR 438.210(a)(3)(ii)]. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose [42 CFR 438.210(a)(3)(i), and 42 CFR 438.210(a)(4)].

The Contractor is prohibited from avoiding costs for services covered in its Contract by referring members to publicly supported health care resources [42 CFR 457.1201(p)].

Moral or Religious Objections: The Contractor shall notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide or reimburse for a covered service [42 CFR 438.102(a)(2)]. The Contractor shall submit a Proposal addressing members' access to the services [Section 1932(b)(3)(B)(i) of the Social Security Act, 42 CFR 438.102(b)(1)(i)(A)(2)]. AHCCCS does not intend to offer the services on a Fee-For-Service basis to the Contractor's members. In the event the Proposal is not approved, AHCCCS will notify the Contractor.

The Proposal shall:

1. Be submitted to AHCCCS in writing prior to entering into a Contract with AHCCCS or at least 60 days prior to the intended effective date of the change in the scope of services based on moral or religious grounds,
2. Place no financial or administrative burden on AHCCCS,
3. Place no significant burden on members' access to the services,
4. Be accepted by AHCCCS in writing, and
5. Acknowledge an adjustment to capitation, depending on the nature of the proposed solution.

If AHCCCS approves the Contractor's Proposal for its members to access the services, the Contractor shall immediately develop a policy implementing the Proposal along with a notification to members of

how to access these services. The notification and policy shall be consistent with the provisions of [42 CFR 438.10], and shall be approved by AHCCCS prior to dissemination. The notification shall be provided to newly assigned members within 12 days of enrollment, and shall be provided to all current members at least 30 days prior to the effective date of the Proposal [42 CFR 438.102, 42 CFR 438.102(b)(1)(i)(B), 42 CFR 438.10(g)(4)].

Authorization of Services: The Contractor shall have in place and follow written policies and procedures for the processing of requests for initial and continuing authorizations of services [42 CFR 438.210(b)(1), 42 CFR 438.910(d)]. The Contractor shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions [42 CFR 438.210(b)(2)(i)]. The Contractor shall consult with the requesting provider for medical services when appropriate [42 CFR 438.210(b)(2)(ii)]. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, shall 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)(3)]. Refer to AMPM Chapter 1000 and Attachment F1, Member Grievance and Appeal System Standards for additional service authorization requirements.

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

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 [Section 1932(b)(3)(A) of the Social Security Act, 42 CFR 438.102(a)(1)(i)-(iv)]:

1. The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)],
2. Any information the member needs in order to decide among all relevant treatment options,
3. The risks, benefits, and consequences of treatment or non-treatment, and
4. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.100(b)(2)(iv)].

The Contractor shall conduct a self-audit of Notice of Adverse Benefit Determination letters and submit a NOA Self-Audit Executive Summary as specified in the ACOM Policy 414 and Section F, Attachment F3, Contractor Chart of Deliverables.

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 Member – Service Provision: The Contractor is responsible for coverage of services under this Contract for members who are American Indians choosing to enroll with the Contractor. American Indian members, title XIX and XXI, on- or off-reservation, eligible to receive

services, may choose to receive services at any time from an American Indian Health Facility, Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) [ARRA Section 5006(d), and SMDL letter 10-001]. The Contractor shall not impose enrollment fees, premiums, or similar charges on American Indians served by an American Indian Health Facility, Indian Health Service (IHS) Facility, a Tribally-Operated 638 Health Program, or an Urban Indian Health Program (I/T/U) (ARRA Section 5006(d), SMDL letter 10-001).

AHCCCS/DFSM will reimburse for medically-necessary, acute-care services that are eligible for 100% Federal reimbursement and are provided by an IHS or 638 tribal facility to a Title XIX member enrolled with the Contractor who is eligible to receive services through an IHS or 638 tribal facility. Encounters for Title XIX services billed by IHS or 638 tribal facilities will not be accepted by AHCCCS or considered in capitation rate development.

The Contractor is responsible for reimbursement to IHS or tribal facilities for services provided to Title XXI American Indian members enrolled with the Contractor. Payment rates shall be at least equal to the AHCCCS Fee-For-Service rates. The Contractor may choose to subcontract with an IHS or 638 tribal facility as part of its provider network for the delivery of Title XXI covered services. Expenses incurred by the Contractor for Title XXI services billed by an IHS or 638 tribal facility shall be encountered and considered in capitation rate development.

The Contractor shall demonstrate that there are sufficient Indian Health Care Providers (IHCPs) contracted in the provider network to ensure timely access to services available under the Contract from such providers for American Indian members who are eligible to receive services [42 CFR 438.14(b)(1), 42 CFR 438.14(b)(5)]. For the purposes of this section, "IHCP" does not include health care programs operated by the Indian Health Service or a 638 tribal facility that provide services to Title XIX members enrolled with the Contractor that are reimbursed by AHCCCS/DFSM and are eligible for 100% Federal reimbursement.

The Contractor will make payment to IHCPs for covered services provided to American Indian members who are eligible to receive services through the IHCP regardless of whether the IHCP is an in-network provider. The Contractor may negotiate a rate for the services provided by an IHCP or, in the absence of a negotiated rate, the Contractor will reimburse the IHCP for its services at a rate not less than the level and amount the Contractor would pay to the same type of in-network provider that is not an IHCP [42 CFR 438.14(b)(2)(i) - (ii)]. In the event the amount the IHCP receives from the Contractor is less than the amount the IHCP would have received under FFS or the applicable encounter rate published annually in the Federal Register by the IHS, AHCCCS will make a supplemental payment to the IHCP to make up the difference between the amount the Contractor pays and the amount the IHCP would have received under FFS or the applicable encounter rate [42 CFR 438.14(c)(3)].

American Indian members shall be permitted to obtain covered services from out-of-network IHCPs from whom the member is otherwise eligible to receive such services [42 CFR 438.14(b)(4)]. The Contractor must permit an out-of-network IHCP to refer an American Indian member to a network provider [42 CFR 438.14(b)(6)].

Anti-Hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and Von Willebrand's disease. See Section D, Paragraph 55, Reinsurance.

Audiology Services: 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.

Breast Reconstruction: Breast reconstruction surgery for the purposes of breast reconstruction post-mastectomy is a covered service for AHCCCS eligible members consistent with AMPM Policy 310-C.

Behavioral Health Services: The Contractor shall provide behavioral health services as described in Section D, Paragraph 11, Behavioral Health Services.

Children's Rehabilitative Services: The Contractor shall refer children to AHCCCS/DMS who are potentially in need of services related to a Children's Rehabilitative Services (CRS) qualifying condition, as specified in A.A.C. R9-22, Article 13 and A.R.S. Title 36. The Contractor shall notify the member or his/her parent/guardian/designated representative when a referral to a specialist for an evaluation of a CRS condition will be made. See ACOM Policy 426 for the processes used to process referrals for a CRS designation. The Contractor shall provide covered services necessary to treat the CRS qualifying condition as well as other services described within this Contract. The Contractor shall establish a process for the identification of members with a CRS designation who have completed treatment for the CRS condition, and do not have any other CRS eligible conditions. The Contractor is responsible for notifying the AHCCCS/DMS of the date when a member with a CRS designation is no longer in need of treatment for the CRS qualifying condition(s) as specified in Section F, Attachment F3, Contractor Chart of Deliverable and ACOM Policy 426. In addition, the Contractor shall consider members with a CRS qualifying condition to be members with special health care needs. Refer to Section D, Paragraph 10, Special Health Care Needs. The Contractor shall accept historical CRS identification numbers (IDs) as alternative member IDs for claims processing, as applicable.

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

Dental Services: The Contractor shall adhere to the Uniform Warranty List as outlined in AMPM Policy 431. Requests for changes to the List must be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

For members under the age of 21: The Contractor shall provide all members under the age of 21 years with all medically necessary dental services including emergency dental services, dental screening, preventive services, therapeutic services and dental appliances in accordance with the AHCCCS Dental Periodicity Schedule. The Contractor shall monitor compliance with the AHCCCS Dental Periodicity Schedule for dental screening services. The Contractor must develop processes to assign members to a dental home by one year of age and communicate that assignment to the member. The Contractor must regularly notify the oral health professional which members have been assigned to the provider's dental home for routine preventative care as outlined in AMPM Policy 431. The Contractor is required to meet specific utilization rates for members as described in Section D, Paragraph 22, Quality Management and Performance Improvement. The Contractor shall ensure that members are notified in writing when dental screenings are due, if the member has not been scheduled for a visit. If a dental screening is not received by the member, a second written notice must be sent. Members under the age of 21

may request dental services without referral and may choose a dental provider from the Contractor's provider network.

Pursuant to A.R.S §36-2907(A) as amended by Arizona Senate Bill 1527 (2017), the Contractor shall provide adult members 21 years of age and older with emergency dental services, limited to a \$1,000 per member per Contract Year as outlined in AMPM Policy 310-D1.

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

Emergency Services: The Contractor shall provide emergency services per the following [Section 1852(d)(2) of the Social Security Act, 42 CFR 438.114(b), 42 CFR 422.113(c)]:

1. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, seven-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule 9 A.A.C. 28 Article 1. Emergency medical (physical and behavioral health) services, including Crisis Intervention Services are covered without prior authorization. The Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies [42 CFR 438.206(c)(1)(i)]. The Contractor shall monitor emergency service 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 purpose of this Contract, a prudent layperson is an individual who possesses an average knowledge of health and medicine,
2. All medical services necessary to rule out an emergency condition, and
3. Emergency transportation.

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

The Contractor must cover and pay for emergency services regardless of whether the provider that furnishes the service has a Contract with the Contractor. The Contractor may not deny payment for treatment obtained under either of the following circumstances [Section 1932(b)(2) of the Social Security Act, 42 CFR 438.114(c)(1)(i), 42 CFR 438.114(c)(1)(ii)(A)-(B)]:

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 [42 CFR 438.114(d)(1)(i)].
2. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claims submission by the hospital within 10 calendar days of the member's presentation for the emergency services constitutes notice to the Contractor. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)].
3. Require notification of Emergency Department treat and release visits as a condition of payment unless the plan has prior approval from 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 [42 CFR 438.114(d)(2)].

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 [42 CFR 438.114, 42 CFR 422.113].

For additional information and requirements regarding emergency services, refer to AHCCCS Rules A.A.C. R9-22-201 et seq. and [42 CFR 438.114].

End of Life Care: A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness. See AMPM Policy 310-HH.

Experimental Services: AHCCCS does not cover experimental services (A.A.C. R9-22-203). However, refer to AMPM Policy 320-B for additional requirements and considerations for AHCCCS members who participate in experimental services.

Family Planning Services: The Contractor shall provide family planning services in accordance with the AMPM, and consistent with the terms of the Section 1115 Waiver Demonstration, for all members who

choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, are also included. If the Contractor does not provide family planning services due to moral and religious objections, it must contract for these services through another health care delivery system or have an approved alternative in place. The Contractor shall submit a Sterilization Report as specified in AMPM Policy 420 and Section F, Attachment F3, Contractor Chart of Deliverables.

Genetic Testing: Genetic testing and counseling are considered medically necessary when criteria are met as delineated in AMPM Policy 310-II.

Home and Community Based Services: Assisted living facility, alternative residential setting, or Home and Community Based Services (HCBS) as defined in A.A.C. R9-22, Article 2 and A.A.C. R9-28, Article 2 that meet the provider standards described in A.A.C. R9-28, Article 5, and subject to the limitations set forth in the AMPM. This service is covered in lieu of a nursing facility. Refer also to Section D, Paragraph 40, Responsibility for Nursing Facility Reimbursement for notification requirements.

The Contractor shall notify the Assistant Director of AHCCCS/DMS, by Email, when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential Fee-For-Service coverage, if the stay goes beyond the 90 day per Contract Year maximum. The notice shall be sent via e-mail to HealthPlan45DayNotice@azahcccs.gov.

Notifications must include:

1. Member Name,
2. AHCCCS ID,
3. Date of Birth,
4. Name of Facility,
5. Admission Date to the Facility,
6. Date the member will reach the 90 days, and
7. Name of Contractor of enrollment.

Home Health Services: This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis. The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless AHCCCS Provider Enrollment verifies compliance with the surety bond requirements specified in Sections 1861(o)(7) and 1903(i)(18) of the Social Security Act. See AMPM Policy 310-I.

Hospice Services: Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. These services are covered for members who are certified by a physician as being terminally ill and having six months or less to live. See the AMPM for details on covered hospice services. See AMPM Policy 310-J.

Hospital: The Contractor shall provide hospital services as outlined in Contract and Policy. Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, and obstetrics and newborn nurseries. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. See AMPM Policy 310-K. For requirements regarding member transfers between facilities, see AMPM Policy 530. 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). Observation services may be provided on an outpatient basis if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. Observation services include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability. Refer to the AMPM for limitations on hospital stays. See AMPM Policy 310-S.

Hysterectomy: AHCCCS covers medically necessary hysterectomy services as authorized by federal regulations 42 CFR 441.250 et seq. See AMPM Policy 310-L.

Immunizations: The Contractor shall provide medically necessary immunizations for adults 21 years of age and older. The Contractor is required to meet specific immunization rates for members under the age of 21, which are described in Section D, Paragraph 22, Quality Management and Performance Improvement. See also AMPM Policy 310-M and AMPM Policy 430.

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

Laboratory Services: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a free-standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory with Clinical Laboratory Improvement Act (CLIA) licensure or a Certificate of Waiver. See AMPM Policy 310-N.

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 A.R.S. §36-2903(Q) and (R). The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by AHCCCS.

Lung Volume Reduction Surgery: Long Volume Reduction Surgery (LVRS), or reduction pneumoplasty, is covered for persons with severe emphysema when performed at a facility approved by Medicare to perform this surgery and in accordance with all of the established Medicare guidelines and in accordance with AMPM Policy 320-G.

Maternity Services: 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 the allowable settings for the Contractor, and the Contractor has providers in its network that offer home labor and delivery services. Members receiving maternity services from a certified nurse midwife or a licensed midwife must also be assigned to a PCP for other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all her primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care is not within their scope of practice. Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of Contractual status, to ensure continuity of care. See AMPM Policy 410.

For stillbirths meeting the medical criteria outlined in AMPM Policy 410, the Contractor shall submit maternal and newborn delivery record as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall allow women and their newborns to receive no less than 48 hours of inpatient hospital care after a routine vaginal delivery and no less than 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with, and agreement by the mother, may discharge the mother or newborn prior to the minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the minimum 48 or 96 hour stay, whichever is applicable.

The Contractor shall inform all assigned AHCCCS pregnant women of voluntary prenatal HIV/AIDS testing and the availability of medical counseling, if the test is positive. The Contractor shall provide information in the Member Handbook and annually in the Member Newsletter, to encourage pregnant women to be tested and instructions about where to be tested. The Contractor shall report to AHCCCS, the number of pregnant women who have been newly diagnosed as HIV/AIDS-positive for each quarter during the Contract Year, as specified in Section F, Attachment F3, Contractor Chart of Deliverables and AMPM Policy 410.

Medical Equipment, Medical Supplies, and Prosthetic Devices: Medical equipment including appliances and medical supplies are covered under the home health benefit. Medical equipment, including appliances, medical supplies and prosthetic devices 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. Medical equipment may be rented or purchased only if other sources are not available to 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. See AMPM Policy 310-JJ and AMPM Policy 310-P.

The Contractor shall ensure the provider network includes a choice of subcontractors for customized medical equipment and corrective appliances for members with special healthcare needs. The

Contractor shall develop timeliness standards for creation, repair and delivery of customized medical equipment and appliances. The Contractor shall monitor the standards and take action when the subcontractor is found to be out of compliance.

Medical Marijuana: AHCCCS does not cover medical marijuana as a medical or pharmacy benefit. See AMPM Policy 320-M.

Metabolic Medical Foods: Medical foods are covered within 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. See AMPM Policy 310-GG.

Nursing Facility Services: The Contractor shall provide services in nursing facilities, including religious non-medical health care institutions, for members who require short-term convalescent care not to exceed 90 days per Contract Year. In lieu of a nursing facility, the Member may be placed in an assisted living facility or alternative residential setting, or receive Home and Community Based Services (HCBS) as defined in A.A.C. R9-22, Article 2 and A.A.C. R9-28, Article 2 that meet the provider standards described in A.A.C. R9-28, Article 5, and subject to the limitations set forth in the AMPM. See AMPM Policy 310-R.

Nursing facility services must be provided in a dually-certified Medicare/Medicaid nursing facility which includes in the per-diem rate: nursing services, basic patient care equipment and sickroom supplies, dietary services, administrative physician visits, non-customized DME, necessary maintenance and rehabilitation therapies, over-the-counter medications, social, recreational and spiritual activities, and administrative, operational medical direction services. See Paragraph 40, Responsibility for Nursing Facility Reimbursement, for further details.

Nutritional Assessments and Nutritional Therapy: Nutritional assessments are conducted as a part of the EPSDT screenings for members under age 21, and to assist members whose health status may improve with nutritional intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. 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.

Organ and Tissue Transplants, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the AMPM for members diagnosed with specified medical conditions. Services include: pre-transplant inpatient or outpatient evaluation, donor search, organ/tissue harvesting or procurement, preparation and transplantation services, and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically necessary non-experimental services are provided within limitations after the discharge from the acute care hospitalization for the transplantation. AHCCCS maintains specialty contracts with transplantation facility providers for the Contractor's use or the Contractor may select its own transplantation provider. Refer to Section D, Paragraph 55, Reinsurance. See AMPM Policy 310-DD.

Transplant Services and Immunosuppressant Medications: AHCCCS covers medically necessary transplant services and related immunosuppressant medications in accordance with Federal and State law and regulations. The Contractor shall not make payments for organ

transplants not provided for in the State Plan except as otherwise required pursuant to 42 USC 1396d(r)(5) for Individuals receiving services under EPSDT. The Contractor must follow the written standards that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high quality care to members per Sections (1903(i) and 1903(i)(1)) of the Social Security Act. Refer to the AMPM Policy 310-DD and the AHCCCS Reinsurance Policy Manual.

Orthotics: Orthotics are covered for AHCCCS members under the age of 21 as outlined in AMPM Policy 430. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply, see AMPM Policy 310-JJ:

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

Medical equipment may be rented or purchased only if other sources, which provide the items at no cost, are not available. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered for members 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 Services: The Contractor shall provide physician services to include medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

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

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

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

1. Poststabilization care services that were pre-approved by the Contractor,
2. Poststabilization care services that 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 poststabilization care services that have not been pre-approved ends when:

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

Pregnancy Terminations: 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 [42 CFR 441.202, Consolidated Appropriations Act of 2008].

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This form must be submitted to the Contractor's Medical Director and meet the requirements specified in the AMPM. The Certificate must certify that, in the physician's professional judgment, the criteria have been met. See AMPM Policy 410.

Prescription Medications: Medications, prescribed by a PCP, attending physician, dentist or other authorized clinician and dispensed by a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist, are covered subject to the requirements of AMPM Policy 310-V.

The Contractor's Drug Lists and prior authorization processes shall comply with AMPM Policy 310-V and AMPM Policy 1020. An Over-the-Counter medication may be prescribed as defined in AMPM Policy 310-V when it is equally effective and less costly than the same or similar prescription medication.

The Contractor shall make available on the Contractor's website and in electronic or paper form, the following drug list information [42 CFR 438.10(i) (1)-(2)]:

1. The Contractor's drug list(s) of medications shall include both the reference brand and generic names of each drug,
2. The tier of each covered drug shall be notated on the drug list,
3. Each drug that requires prior authorization approval shall be notated on the drug list,
4. The process for obtaining Federal and state reimbursable medications that are not included on the drug list,
5. The prior authorization form with directions for non-urgent and urgent requests, and
6. The prior authorization criteria for drugs evaluated for coverage under the Contractor's prior authorization program.

The Contractor's drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary [42 CFR 438.10(i)(3)]. See ACOM Policy 416.

The Contractor, its contracted Pharmacy Benefit Manager (PBM), and the PBM's Pharmacy Network shall comply with the following:

1. Pharmacies shall not charge patients, under the AHCCCS program, the cash price for a prescription, other than an applicable copayment, when the medication is federally and state reimbursable and the prescription is ordered by an AHCCCS Registered Prescribing Clinician.
2. Pharmacies shall not split bill the cost of a prescription claim to the Contractor's PBM for a patient under the AHCCCS Program. The Contractor's PBM's Pharmacy Network shall not allow a patient under the AHCCCS Program to pay cash for a partial prescription quantity for a federally and state reimbursable medication when the ordered drug is written by an AHCCCS Registered Prescribing Clinician.
3. Pharmacies are prohibited from auto-filling prescription medications.
4. Pharmacies shall not submit prescription claims to the contracted PBM for claims adjudication requesting reimbursement in excess of the Usual & Customary (U&C) price charged to the general public.
 - a. The sum of charges for the submitted ingredient cost plus the dispensing fee shall not exceed a pharmacy's U&C Price for the same prescription, and
 - b. The U&C submitted ingredient cost shall be the lowest amount accepted from any member of the general public who participates in the pharmacy provider's savings or discount programs including programs that require the member to enroll or pay a fee to join the program.
5. Pharmacies that purchase drugs at a Nominal Price outside of 340B or the Federal Supply Schedule shall bill their Actual Acquisition Cost of the drug to AHCCCS and the Contractor's PBM.
6. PBM Network Pharmacies, at the discretion of the pharmacy, may deliver or mail prescription medications to an AHCCCS member or to an AHCCCS registered provider's office for a specific AHCCCS member.

Medicare Part D: The Medicare Modernization Act of 2003 (MMA) created the Medicare Part D prescription drug benefit for individuals enrolled in Medicare Part A and Medicare Part B coverages. Medicare Part D drug benefit plans cover offered prescription drugs as approved by the Centers for Medicare and Medicaid Services (CMS). For full benefit dual eligible members, AHCCCS covers medically necessary, federally and state reimbursable prescription drugs that are excluded from coverage by CMS under Medicare Part D benefit plans. Contractors' coverage of CMS Medicare Part D excluded drugs, when ordered by a PCP, attending physician, dentist or other authorized prescribing clinician and dispensed by a pharmacist or a pharmacy intern acting under the direct supervision of a pharmacist in accordance with Arizona State Board of Pharmacy Rules and Regulations, are covered subject to the requirements of the AMPM Policy 310-V. Prescription drugs and therapeutic classes that are covered by a Medicare Part D drug benefit plan, but are not specifically listed in the Medicare Part D Drug List, are considered to be covered by the Medicare Part D drug benefit plan, and are *not covered* by AHCCCS. See AMPM Policy 310-V.

340B Drug Pricing Program: All federally reimbursable drugs identified in the 340B Drug Pricing Program are required to be billed and reimbursed as noted in the table below. The Contractor is required to comply with any changes to reimbursement methodology for 340B entities. See A.R.S. §36-2930.03 and A.A.C. R9-22-710 (C) for further details.

The Contractor is required to reimburse 340B entities and their employed or contracted prescribing clinicians in accordance with the payment methodology below:

1. Drugs dispensed by the 340B entity pharmacy shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price, plus a professional (dispensing) fee, and
2. Physician administered drugs shall be reimbursed at the lesser of the actual acquisition cost or the 340B ceiling price.
 - a. No professional (dispensing) fee is required; a fee payable to the physician for a covered administration procedure is permitted

340B entity hospitals, and outpatient facilities owned and operated by a 340B entity hospital, are exempt from this payment methodology.

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

Direct Acting Antiviral Medication Treatment: For AHCCCS prior authorization requirements for Title XIX and XXI members 12 years and older for coverage of direct acting antiviral medications for treatment of Hepatitis C Virus (HCV), see AMPM Policy 320-N.

Pharmacy & Therapeutics Committee: Pursuant to Executive Order 2108-06 requiring Transparency and Eliminating Undue Influence by Pharmaceutical and Medical Device Companies; AHCCCS has developed and implemented a formal Pharmacy & Therapeutics (P&T) Committee as an advisory Committee to AHCCCS. The P&T Committee is responsible for evaluating scientific evidence of the relative safety, efficacy, effectiveness, and clinical appropriateness of prescription drugs. The P&T Committee makes recommendations to AHCCCS on the development and maintenance of a statewide drug list and prior authorization criteria as appropriate. Committee members shall not participate in matters in which they have a potential conflict of interest and they shall evaluate information regarding individual drugs and therapeutic classes of drugs in an impartial manner emphasizing the best clinical evidence and cost effectiveness. Refer to ACOM Policy 111.

Pharmaceutical Rebates: The Contractor, including the Contractor's Pharmacy Benefit Manager (PBM), is prohibited from collecting and negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s) or therapeutic class.

If the Contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be excluded from such rebate agreements. For pharmacy related encounter data information see Section D, Paragraph 63, Encounter Data Reporting.

A listing of products covered under supplemental rebate agreements is available on the AHCCCS website under the Pharmacy Information section. The "preferred" products shall be available and notated on the Contractors' Drug Lists exactly as they are listed on the AHCCCS Drug List. The Contractor shall comply with AMPM Policy 310-V.

Pre-Admission Screening and Resident Review Requirements: The Contractor shall ensure members are screened using the Pre-Admission Screening and Resident Review (PASRR) prior to admission to a nursing facility as specified in AMPM Policy 680-C. The PASRR screening consists of a two-stage identification and evaluation process (Level I screening and Level II psychiatric evaluation) and is

conducted to assure appropriate placement and treatment for those identified with Mental Illness (MI) and Intellectual Disability (ID). Level I screening is required for members entering a nursing facility to determine the presence of a diagnosis or other presenting evidence that suggests the possibility of a mental illness or intellectual disability. Level II psychiatric evaluation, if indicated, is conducted by (1) DES for members believed to have an intellectual disability, or (2) the RBHA for members believed to have a mental illness. The purpose of the Level II psychiatric evaluation is to further evaluate and make a determination as to whether the member is indeed mentally ill or has an intellectual disability and to determine whether the member needs the level of care provided in a nursing facility and/or needs specialized services. 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.

The Contractor shall notify the Assistant Director of AHCCCS/DMS, by Email, when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential Fee-For-Service coverage, if the stay goes beyond the 90-day per Contract Year maximum. The notice shall be sent via e-mail to HealthPlan45DayNotice@azahcccs.gov. Notifications must include:

1. Member Name,
2. AHCCCS ID,
3. Date of Birth,
4. Name of Facility,
5. Admission Date to the Facility,
6. Date the member will reach the 90 days, and
7. Name of Contractor of enrollment.

Program to Monitor Antipsychotic Medications Prescribed for Children: The Contractor shall monitor and manage the appropriate use of antipsychotic medications prescribed for children. The Contractor shall adhere to the prior authorization requirements as outlined in AMPM Policy 310-V, including the submission of ad hoc requests as requested by AHCCCS.

Primary Care Provider Services: Primary Care Provider (PCP) services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services [42 CFR 438.208(b)(1)]. 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.

Except for annual well woman exams, behavioral health and children's dental services, and consistent with the terms of the Section 1115 Waiver demonstration, covered services must be provided by or coordinated with a Primary Care Provider.

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. Therapies provided under the home health benefit shall adhere to the requirements outlined in AMPM Policy 310-X.

- *Occupational Therapy* is covered for all members in both inpatient and outpatient settings. Outpatient occupational therapy for acute care members 21 years of age or older are subject to visit limits per Contract Year as described in the AMPM.
- *Physical Therapy* is covered for all members in both inpatient and outpatient settings. Outpatient physical therapy for members 21 years of age or older is subject to visit limits per Contract Year as described in the AMPM.
- *Speech Therapy* is covered for all members receiving inpatient hospital (or nursing facility services). Speech therapy services provided on an outpatient basis are only covered for members under the age of 21.

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.

Substance Abuse Transitional Facility: A class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem (A.A.C. R9-10-101).

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide or secure their own transportation for medically necessary services using the appropriate mode based on the needs of the member. See AMPM Policy 310-BB. 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. For information regarding Contractor reimbursement of ground ambulance and emergency care transportation when a contract does not exist between the Contractor and the transportation provider, refer to ACOM Policy 205.

Treat and Refer Services: Interaction with an individual who has accessed 911 or a similar public emergency dispatch number, but whose illness or injury does not require ambulance transport to an emergency department based on the clinical information available at that time. The interaction must include:

1. Documentation of an appropriate clinical and/or social evaluation,
2. A treatment/referral plan for accessing social, behavioral, and/or healthcare services that address the patient's immediate needs,
3. Evidence of efforts to follow-up with the patient to ascertain adherence with the treatment plan, and

4. Documentation of efforts to assess customer satisfaction with the treat and refer visit. Treat and Refer standing orders shall be consistent with medical necessity and consider patient preference when the clinical condition allows.

Triage/Screening and Evaluation of Emergency Medical Conditions: These are covered services when provided by an acute care hospital, IHS or 638 tribal facility and urgent care centers, to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine and provide 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 emergency eye care, and all medically necessary vision examinations, prescriptive lenses, frames, and treatments for conditions of the eye for all members under the age of 21.

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

Well Preventative Care: Well visits, such as, but not limited to, well woman exams, breast exams, and prostate exams are covered for members 21 years of age and older; refer to AMPM Policy 411. For members under 21 years of age, AHCCCS continues to cover medically necessary services under the EPSDT Program; refer to AMPM Policy 430.

10. SPECIAL HEALTH CARE NEEDS

AHCCCS has specified in its *Quality Assessment and Performance Improvement Strategy* certain populations with special health care needs and the mechanisms used to identify individuals with special health care needs as defined by the State [42 CFR 438.208(c)(1)].

Members with special health care needs are those members who have serious and chronic physical, developmental, and/or behavioral conditions requiring medically necessary services of a type or amount beyond that required by members generally that lasts or is expected to last one year or longer, and may require ongoing care not generally provided by a primary care provider. AHCCCS has determined that the following populations meet this definition:

1. Members with qualifying Children's Rehabilitative Services (CRS) conditions,
2. Members diagnosed with HIV/AIDS,
3. Members diagnosed with opioid use disorder, separately tracking pregnant members and members with co-occurring pain and opioid use disorder,
4. Members who are being considered for or are actively engaged in a transplant process and for up to one year post transplant,
5. Arizona Long Term Care System:
 - a. Members enrolled in the ALTCS program who are elderly and/or have a physical disability, and
 - b. Members enrolled in the ALTCS program who have a developmental disability.
6. Members who are engaged in care or services through the Arizona Early Intervention Program (AzEIP),

7. Members who are enrolled in the Comprehensive Medical and Dental Program (CMDP),
8. Members who transition out of the Comprehensive Medical and Dental Program (CMDP) up to one year post transition,
9. Members determined to have Serious Mental Illness (SMI),
10. Any child that has a CASII level of 4+,
11. Members determined to have a Seriously Emotionally Disturbed (SED) diagnosis flag in the system,
12. Substance exposed newborns and infants diagnosed with neonatal abstinence syndrome (NAS),
13. Members diagnosed with Severe Combined Immunodeficiency (SCID), and
14. Members with a diagnosis of autism or at risk for autism.

Many children with Special Health Care Needs, including children with CRS-qualifying medical conditions typically require complex care and are medically fragile. For these children, health care service delivery involves multiple clinicians, covering the entire continuum of care. In addition to a primary care provider, these children may receive services from subspecialists who manage care related to their condition(s) and coordinate with other specialty services including but not limited to behavioral health, pharmacy, medical equipment and appliances, therapies, diagnostic services, and telemedicine visits. Comprehensive care includes a multi-disciplinary team made up of subspecialists and caregivers such as pulmonologists, cardiologists, nutritionists, psychologists, and therapists. Because of the complexity of the needs of these children requiring multiple surgeries, hospitalization, and clinical care it is imperative that there be integrated health information and care coordination for the member. Services shall be provided using an integrated family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes the following elements:

1. A process for using a centralized, integrated medical record that is accessible to the Contractor and service providers consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care,
2. A process for developing and implementing a Service Plan accessible to the Contractor and service providers that is consistent with Federal and State privacy laws that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation, and
3. Collaboration with individuals, groups, providers, organizations and agencies charged with the administration, support or delivery of services for persons with special health care needs.

AHCCCS monitors quality and appropriateness of care/services for routine and special health care needs members through annual Operational Reviews of Contractors and the review of required Contractor deliverables set forth in contract, program specific performance measures, and performance improvement projects.

The Contractor shall implement mechanisms to comprehensively assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring, or transition to another AHCCCS program [42 CFR 457.1230(c), 42 CFR 438.208(c)(2) and (c)(3)(iii) - (v), and 42 CFR 438.240(b)(4), 42 CFR 441.3010(c)(3)].

The assessment mechanisms must use appropriate health care professionals with the appropriate expertise [42 CFR 438.240(c)(2) and 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)(4) and (c)(3)].

The Contractor shall ensure that members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring have an individualized physical and behavioral treatment or service plan. In addition, the Contractor shall conduct multi-disciplinary staffings for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

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 438.208(c)(4)].

The Contractor shall have a methodology to identify providers willing to provide a patient centered medical home for members with special health care needs that offers comprehensive, continuous medical care and extended access to services with the goal of obtaining maximized health outcomes.

The American Academy of Pediatrics (AAP) describes care from a medical home as:

1. Accessible,
2. Continuous,
3. Coordinated,
4. Family-centered,
5. Comprehensive,
6. Compassionate, and
7. Culturally effective.

The Contractor shall submit reports as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

11. BEHAVIORAL HEALTH SERVICES

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

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

Coordination of Care: The Contractor shall require the PCP to respond to RBHA/provider information requests pertaining to members enrolled with the Contractor within 10 business days of receiving the request. The response should include, but is not limited to, current diagnoses, medications, laboratory results, most recent PCP visit, and information about recent hospital and emergency room visits. The Contractor shall require the PCP to document or initial to signify review of member behavioral health information received from a RBHA behavioral health provider who is also treating the member. The Contractor shall ensure coordination of referrals and follow-up collaboration, as necessary, for members

identified by the behavioral health provider as needing physical health services. See AMPM Policy 541. The Contractor should consider the behavioral health needs, in addition to the primary health care needs, of members during network development to improve member access to care, care coordination, including care coordination for Medication Assisted Treatment (MAT) and to reduce duplication of services.

Court Ordered Evaluation and Court Ordered Treatment: The Contractor shall develop a collaborative process with the counties to ensure coordination of care and information sharing for timely access to pre-petition screening, Court Ordered Evaluation (COE), and Court Ordered Treatment (COT) provided. Title XIX/XXI funds shall not be used to reimburse COE services. Reimbursement for pre-petition screening and Court Ordered Evaluation (COE) services are the responsibility of the County pursuant to A.R.S. §36-545. The county's financial responsibility ends with the filing of a petition for COT. Counties maintain financial responsibility of any services provided under COE until the date and time the petition for COT is actually filed. Some counties have an agreement with AHCCCS under A.R.S. §36-545.07 to provide those services for the county. If such an agreement exists, the RBHA Contract includes those services within the scope of the RBHA's responsibilities. For additional information regarding behavioral health services refer to Title 9 Chapter 22 Articles 2 and 12. See also AMPM Policy 320-U.

The Contractor shall develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must address the processes provided in A.R.S. Title 36, Chapter 5, Article 4:

1. Involuntary evaluation/petitioning,
2. Court ordered process, including tracking the status of court orders,
3. Execution of court order, and
4. Judicial review processes.

The Contractor shall develop and make available to providers information regarding specifically where a behavioral health provider would refer an individual for a voluntary evaluation.

Emergency Services: When members present in an emergency room setting, the Contractor is responsible for payment of all emergency room services, transportation, and associated professional services as indicated by the principal diagnosis on the claim and delineated in ACOM Policy 432. When members present in an emergency room setting, the Contractor is responsible for payment of all emergency room services and transportation for all members regardless of the principal diagnosis on the emergency room and/or transportation claim.

In addition to those emergency services listed above, the Contractor is responsible for payment of the associated professional services when the principal diagnosis on the claim is physical health, as delineated in ACOM Policy 432 regarding benefit coordination and delineation of financial responsibility for AHCCCS covered physical and behavioral health services provided to AHCCCS members who are not enrolled in an integrated line of business.

EPSDT: As specified in Section D, Paragraph 9, Scope of Services, EPSDT, the Contractor must provide behavioral health screenings for members up to 21 years of age in compliance with the AHCCCS periodicity schedule. The Contractor shall ensure the initiation and coordination of behavioral health referrals when determined necessary through the screening process.

Inpatient Hospital Services: In accordance with [42 CFR 438.3(e)(2)(i) through (iii)], the Contractor may provide services in alternative inpatient settings that are licensed by ADHS/DLS, in lieu of services in an inpatient hospital.

Integration Requirements: The Contractor shall develop a readiness plan and processes for implementation of both physical health and behavioral health service provision under a fully integrated Contract, to be effective October 1, 2020. These processes must include legal requirements, operational and ongoing infrastructure, staffing resources with appropriate expertise, data system capabilities, and tools that support monitoring and oversight of the service delivery system to ensure the Contractor's capability to successfully assume direct administrative oversight of Medicaid funded behavioral health services. The Contractor shall onboard staff to assist with this readiness planning, particularly staff with behavioral health expertise.

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

Member Education: The Contractor shall be responsible for educating members in the Member Handbook and other materials to inform members how to access covered behavioral health services. Materials shall include information about behavioral health conditions that may be treated by a primary care provider (PCP) within their scope of practice.

Mental Health Parity: The Contractor shall demonstrate that services are delivered in compliance with mental health parity consistent with 42 CFR Part 457, 42 CFR Part 438, and ACOM Policy 110. The Contractor shall submit documentation which demonstrates compliance with mental health parity as promulgated under 42 CFR Part 438 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Additionally, the Contractor shall submit a Parity Analysis Deficiency Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables, identifying parity deficiencies and a plan of how the Contractor will come into compliance within the same quarter as the submission. AHCCCS may require that the mental health parity analysis is conducted in a manner consistent with the State's analysis for contracted MCOs with carved out services. The Contractor may also be required to participate with and respond to inquiries from AHCCCS and/or an AHCCCS contracted consultant regarding Contractor policies and procedures requiring review to determine compliance with mental health parity regulations.

Further, in the event that a Contract modification, amendment, novation or other legal act changes, limits, or impacts compliance with the mental health parity requirement, the Contractor agrees to conduct an additional analysis for mental health parity in advance of the execution of the Contract change. Further, the Contractor shall provide documentation of how the requirements of [42 CFR 438] are met with submission of the Contract change; and how sustained compliance shall be achieved. The Contractor shall certify compliance with mental health parity requirements before Contract changes become effective.

The Contractor may be required to cover, in addition to services covered under the State Plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K, and the Contract identifies the types and amount,

duration and scope of services consistent with the analysis of parity compliance conducted by either the State or the MCO [42 CFR 438.3(e)(1)(ii)].

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

Non-Title XIX/XXI Behavioral Health Services: Service provision for Non-Title XIX/XXI services for Contractor enrolled members is provided by the RBHAs. Non-Title XIX/XXI services include room and board, mental health services (formerly known as traditional healing), auricular acupuncture, child care, and supportive housing rent/utility subsidies and relocation services. The Contractor shall have established processes in place to refer members to the RBHA for Non-Title XIX/XXI services. The Contractor shall assist members with how to access these services and shall coordinate care for the member as appropriate. See AMPM Policy 320-T.

AHCCCS intends to require ongoing reporting from the Contractor regarding tracking of member referrals for Non-Title XIX/XXI services. This reporting is to ensure the RBHA Contractors are receiving referrals from the Title XIX/XXI Contractor for these services; that members are being connected to these referred services; and to ensure a system is in place to identify how referrals to Non-Title XIX/XXI services are initiated, documented, processed, and dispositioned. The Contractor shall submit a Non-Title XIX/XXI Services Referral Report to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables and as specified below. AHCCCS intends to utilize and validate the information provided to inform the development of an ongoing standard deliverable to monitor the referral and fulfillment of the service rendered to members.

1. A visual workflow document depicting the Contractor's referral process for members who may be eligible for Non-Title XIX/XXI services from identification of need to disposition of referral.
2. Description of the following by service type:
 - a. Strategies the Contractor utilizes to educate members and provider community of availability of services,
 - b. How the referral is submitted,
 - c. How the referral is confirmed as received by receiving entity,
 - d. How is referral monitored, recorded, and dispositioned,
 - e. Expected timeline for disposition of referrals,
 - f. Communications between the referral source, the Title XIX/XXI Contractor, and/or the RBHA Contractor, and
 - g. Tracking resolution of grievances or other member concerns.
3. A report of referral data being captured, this information may include, but is not limited to (for the period of October 1, 2018 to September 30, 2019) the following fields:
 - a. Referring Contractor Health Plan ID,
 - b. Members referred to Non-Title XIX/XXI services (including AHCCCS ID Number),
 - c. Member's behavioral health category (C=Child, G=GMH/SU, S=SMI)

- d. Member's prior Contractor or FFS Program of enrollment, if applicable (including Health Plan ID),
- e. Identify if the member was receiving Non-Title XIX/XXI services when enrolled with the prior plan of enrollment, and what those services were by service code and description,
- f. Identify each Non-Title XIX/XXI service being referred for each member by service code and description,
- g. The referral source (e.g. Title XIX/XXI Contractor [including Health Plan ID]; provider case manager),
- h. If the referral source is the Title XIX/XXI Contractor, provide the title of the individual providing the referral,
- i. Entity the member was referred to (e.g. RBHA Contractor [including Health Plan ID]; provider),
- j. Date the referral was submitted,
- k. How the referral was submitted (e.g. fax, phone call, email), and
- l. Date of referral disposition (member received service)

PCP Medication Management Services: In addition to treating physical health conditions, the Contractor shall allow PCPs to treat behavioral health conditions within their scope of practice. For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. For the antipsychotic class of medications, prior authorization may be required. For PCPs prescribing medications to treat Substance Use Disorders (SUDs), the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the Medication Assisted Treatment (MAT) model and coordinate care with the behavioral health provider. The Contractor is responsible for these services both in the prospective and prior period coverage timeframes.

Referrals: The Contractor shall develop, monitor and continually evaluate its processes for timely referral, evaluation and treatment planning for behavioral health services. The Contractor shall have identified staff members to ensure that requests for behavioral health services made by the member, family, guardian, or any health care professional are referred within one business day to ensure that the request results in the member receiving a referral to a behavioral health provider. See Paragraph 32, Appointment standards and ACOM Policy 417. A direct referral for a behavioral health assessment/evaluation may be made by the member. A direct referral for a behavioral health assessment/evaluation may be made by any health care professional in coordination with the provider case manager and PCP assigned to the member.

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

Specific Requirements for Behavioral Health Services for members in legal custody of the Department of Child Safety (DCS): The Contractor shall ensure timely care coordination with the Regional Behavioral Health Authorities (RBHAs) for members receiving behavioral health services.

Transfer of Care: When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or Contractor that the member should be transferred to a behavioral health provider for evaluation and/or continued medication management services, the Contractor will require and ensure that the PCP or Contractor coordinates the transfer of care. All affected subcontracts shall include this provision. The Contractor shall establish policies and procedures for the transition of members who are referred to the RBHA for ongoing treatment. The Contractor shall ensure that PCPs maintain continuity of care for these members. Refer to AMPM Policy 510 and 520. The policies and procedures must address, at a minimum, the following:

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

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

12. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals, including but not limited to, ACOM, AMPM and Reporting Guides are hereby incorporated by reference into this Contract. Guides and manuals are available on the AHCCCS website. Refer to ACOM Policy 100 and AMPM Policy 100 for an overview of the principles of service delivery; an outline of the ACOM and AMPM layout; and processes for policy development. The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to the AHCCCS guidelines, policies, and manuals. The Contractor is responsible for complying with all requirements set forth in these sources as well as with any updates. In addition, linkages to AHCCCS rules, statutes and other resources are available through the AHCCCS website. Upon adoption by AHCCCS, updates will be available on the AHCCCS website.

13. MEDICAID SCHOOL BASED CLAIMING PROGRAM

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

Individualized Education Program (IEP) as medically necessary for the child to obtain a public school education. See AMPM Policy 710.

Medicaid School Based (MSB) services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSB approved alternative setting. Currently, services include: audiology, therapies (OT, PT and speech/language), behavioral health evaluation and counseling, nursing and attendant care (health aid services provided in the classroom), and specialized transportation to and from school on days when the child receives an AHCCCS-covered MSB service. See AMPM Policy 320-O for provisions regarding behavioral health assessment and treatment/service planning.

The Contractor's evaluations and determinations, about whether services are medically necessary, should 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 Contractors and its providers shall coordinate with schools and school districts that provide MSB services to the Contractor's enrolled members. Services should not be duplicative. Contractor care managers, and provider case managers working with children who have special needs, shall 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 shall be used to enhance the services provided to members.

14. PEDIATRIC IMMUNIZATIONS AND THE VACCINES FOR CHILDREN PROGRAM

Through the Vaccine for Children Program (VFC), the Federal and State governments purchase, and make available to providers at no cost, vaccines for AHCCCS children under age 19. 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/, Quality Improvement Management for guidance. Any provider, licensed by the State to administer immunizations, may register with Arizona Department of Health Services (ADHS) as a VFC provider and receive these free vaccines. The Contractor shall not reimburse providers for the administration of the vaccines in excess of the maximum allowable as set by CMS. The Contractor shall comply with all VFC requirements and monitor Contracted providers to ensure that providers are registered as VFC providers when acting as Primary Care Providers (PCPs) for members under the age of 19 years.

Due to low numbers of children in their panels, providers in certain Geographic Service Areas may choose not to provide vaccinations. Whenever possible, members shall be assigned to VFC registered providers within the same or a nearby community. When that is not possible, the Contractor shall develop processes to ensure vaccinations are available through a VFC enrolled provider or through the appropriate County Health Department. In all instances, the vaccines are to be provided through the VFC program. The Contractor shall develop processes to pay the administration fee to whoever administers the vaccine regardless of their contract status with the Contractor.

Arizona State law requires the reporting of all immunizations given to children under the age of 19. Immunizations must be reported at least monthly to the ADHS Immunization Registry. Reported

immunizations are held in a central database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. The Contractor shall educate its provider network about these reporting requirements and the use of this resource.

15. STAFFING REQUIREMENTS

The Contractor shall have in place the organization, operational, managerial and administrative systems capable of fulfilling all Contract requirements. For 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 No 12549 or under guidelines implementing Executive Order 12549f [42 CFR 438.610(a) and (b), 42 CFR 1001.1901(b), 42 CFR 1003.102(a)(2)]. The Contractor is obligated to screen employees and subcontractors to determine whether they have been excluded from participation in Federal health care programs as outlined in Section D, Paragraph 60, Corporate Compliance.

The Contractor shall employ sufficient staff and utilize appropriate resources to achieve Contractual compliance. The Contractor's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with Contractual and AHCCCS policy requirements. If the Contractor does not achieve the desired outcomes or maintain compliance with Contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS as outlined in Section D, Paragraph 70, Administrative Actions of the Contract.

The Contractor shall have local staff available 24 hours per day, seven days per week to work with AHCCCS and/or other State agencies, such as Arizona Department of Health Services (ADHS)/Public Health Licensing or the Arizona Department of Emergency and Military Affairs on urgent issue resolutions. Urgent issue resolutions include Immediate Jeopardies (IJ), fires, or other public emergency situations. These staff shall have access to information necessary to identify members who may be at risk and their current health/service status, the ability to initiate new placements/services, and have the ability to perform status checks at affected facilities and perform ongoing monitoring, if necessary. Additionally, the Contractor shall have processes in place to assure limited member disruption of care/services in the case of an emergency; examples include but are not limited to mechanisms for service authorization and/or pharmacy overrides and transportation to support evacuation efforts. The Contractor shall provide the contact information for these staff, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. AHCCCS must be notified and provided back up contact information when the primary contact individual will be unavailable.

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

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

An individual staff member is limited to occupying a maximum of two Key Staff positions listed below, unless contract specifies otherwise or prior approval is obtained by AHCCCS/DHCM. When submitting its functional organizational chart, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, the Contractor must document, for each Key Staff position, the portion of time allocated to each Medicaid contract as well as all other lines of business.

The Contractor shall inform AHCCCS/DHCM, in writing as specified in Section F, Attachment F3, Contractor Chart of Deliverables, when an employee leaves one of the **Key Staff** positions listed below. The Contractor shall include the name of the interim contact person with the notification. Unless otherwise approved by AHCCCS, an individual staff member is limited to occupying an interim position for no longer than six months from the date of notification submitted to AHCCCS. The name and resume of the permanent employee is to be submitted as soon as the new hire has taken place along with a revised Organization Chart complete with Key Staff.

The Contractor shall inform AHCCCS/DHCM, in writing as specified in Section F, Attachment F3, Contractor Chart of Deliverables when any of the following contact information for an individual holding a Key Staff position changes: the individual's name, the individual's telephone number, the individual's email address, or the individual's location.

AHCCCS has the discretion to review all submitted Key Staff positions and reserves the right to direct Contractor actions regarding staffing decisions it deems are in the best interest of the State. AHCCCS will not permit any Contractor staff to hold positions which may present a conflict of interest.

At a minimum, the following staff is required:

Key Staff Positions:

1. **Administrator/Chief Executive Officer (CEO)** who is located in Arizona, and must directly oversee the entire operation of the Contractor on a day-to-day basis, including actively directing and prioritizing work and operations of the organization, regardless of where that work is performed or the site of operations. The Contractor's Administrator/CEO is accountable to AHCCCS for compliance with the requirements and obligations under this Contract.
2. **Medical Director/Chief Medical Officer (CMO)** who is located in Arizona and an Arizona-licensed physician in good standing. The Medical Director shall actively provide oversight and management of the clinical, Quality Management and Medical Management components of the Contractor.
3. **Chief Financial Officer (CFO)** who is responsible for oversight of the budget and accounting systems and financial reporting requirements. This must be a full-time position dedicated solely to CMDP and to meeting the requirements of this Contract.
4. **Pharmacy Coordinator/Pharmacy Director** who is an Arizona licensed pharmacist or physician in good standing, who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or a subcontractor of the Contractor.
5. **Dental Director** who is located in Arizona, is an Arizona licensed general or pediatric dentist in good standing and who is responsible for leading and coordinating the dental activities of the Contractor including review and denial of dental services, provider consultation, utilization review, and

participation in tracking and trending of quality of care issues as related to dental services. The Dental Director may be an employee or a subcontractor of the Contractor but may not be from the Contractor's delegated dental subcontractor.

6. **Corporate Compliance Officer** who is located in Arizona and who implements and oversees the Contractor's Compliance Program. The Corporate Compliance Officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS Office of Inspector General. See Section D, Paragraph 60, Corporate Compliance for more information.
7. **Dispute and Appeal Manager** who is located in Arizona, is responsible for managing and adjudicating member grievances and appeals, and provider claim disputes, arising under the Grievance and Appeal System and who is responsible for forwarding all requests for hearing to AHCCCS Office of Administrative Legal Services (OALS) with the required information. Any staff reporting to this position who manage and adjudicate disputes and appeals must also be located in Arizona. See Section D, Paragraph 25, Grievance and Appeal System.
8. **Continuity of Operations and Recovery Coordinator** who is located in Arizona, and is responsible for the coordination and implementation of the Contractor's Continuity of Operations and Recovery Plan, and training and testing of the Plan, as outlined in ACOM Policy 104.
9. **Contract Compliance Officer** who is located in Arizona and who serves as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer include, but are not limited to, coordination of the tracking and submission of all Contract deliverables, fielding and coordinating responses to AHCCCS inquiries, coordinating the preparation and execution of Contract requirements such as Operational Reviews (ORs), random and periodic audits and ad hoc visits.
10. **Quality Management Manager** who is located in Arizona, and an Arizona-licensed registered nurse, physician or physician's assistant in good standing 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 Manager must have experience in quality management and quality improvement. Quality Management must have sufficient local staffing who are licensed clinical or behavioral health professionals to meet the requirements of the quality management program. Staff must report directly to the Quality Management Manager.

The primary functions of the Quality Management Manager position are:

- a. Ensure individual and systemic quality of care,
- b. Conduct comprehensive quality-of-care investigations,
- c. Conduct onsite quality management visits/reviews,
- d. Conduct Care Needed Today/Immediate Jeopardy investigations,
- e. Integrate quality throughout the organization,
- f. Implement process improvement, and
- g. Resolve, track and trend quality of care grievances.

11. **Performance/Quality Improvement Manager** who is located in Arizona who is a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Physicians, or comparable education and experience in health plan data and outcomes measurement. The Performance/Quality Improvement Manager is responsible for quality improvement activities and for staff conducting the quality improvement work. Staff reporting to this position must be appropriate to meet the AHCCCS quality improvement Contractual and policy requirements and must be located in Arizona.

The primary functions of the Performance/Quality Improvement Manager are:

- a. Focus organizational efforts on improving quality improvement performance measures,
 - b. Develop and implement performance improvement projects,
 - c. Utilize data to develop intervention strategies to improve outcomes, and
 - d. Report quality improvement/performance outcomes.
12. **Credentialing Coordinator** who is located in Arizona and who has appropriate education and/or experience to effectively complete all requirements of the position. The primary functions of the Credentialing Coordinator are:
- a. Serve as the single point of contact to AHCCCS for credentialing-related questions and concerns,
 - b. Responsible for timely and accurate completion of all credentialing-related deliverables,
 - c. Ensure all credentialing requirements, including timeframes, are adhered to by the Contractor,
 - d. Provide a detailed, transparent description of the credentialing process to providers and serve as the single point of contact for the Contractor to address provider questions about the credentialing process.
13. **Maternal Child Health MCH/EPSTD Coordinator** who is located in Arizona and is an Arizona licensed nurse, physician, or physician's assistant in good standing; or has a Master's degree in health services, public health, or health care administration or other related field and/or a CPHQ or CHCQM certification. Staff reporting to this position must be appropriate to meet the AHCCCS MCH/EPSTD Contractual and policy requirements, and quality and performance measure goals, and must be located in Arizona. MCH/EPSTD staff must either report directly to the MCH/EPSTD Coordinator or the MCH/EPSTD Coordinator must have the ability to ensure that AHCCCS MCH/EPSTD requirements are met.

The primary functions of the MCH/EPSTD Coordinator are:

- a. Ensure receipt of EPSTD services,
 - b. Ensure receipt of maternal and postpartum care,
 - c. Promote family planning services,
 - d. Promote preventive health strategies,
 - e. Promote access to oral health care services,
 - f. Identify and coordinate assistance for identified member needs, and
 - g. Interface with community partners.
14. **Member Advocate** who is located in Arizona and who is experienced in working with individuals including members with special healthcare needs, families, youth, advocates and key stakeholders.

This position also serves as an advocate on behalf of members with qualifying CRS diagnoses and their family members. Communicate and disseminate information to members and families to identify concerns and remove barriers that affect service delivery or member satisfaction.

15. **Medical Management Manager** who is located in Arizona and is a registered nurse, physician or physician's assistant in good standing. This position manages all medical management requirements under AHCCCS policies, State regulations and Contract, including but not limited to: application of appropriate medical necessity criteria, concurrent review, discharge planning, care coordination, disease management, and prior authorization functions. Sufficient local staff reporting to this position must be in place to meet medical management requirements.
16. **Behavioral Health Coordinator** who is a behavioral health professional as described in Health Services Rule, A.A.C. R9-10-101, and is located in Arizona. The Behavioral Health Coordinator shall ensure AHCCCS behavioral health requirements are met, including but not limited to: coordination of behavioral health care and physical health care between all providers, review network to reduce out of state placements, active involvement in out of state placements.
17. **Transition Coordinator** who is a health care professional or who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all member transition issues, responsibilities and activities. The Transition Coordinator shall ensure safe, timely, and orderly member transitions. Refer to ACOM Policy 402.
18. **Network Administrator** who is located in Arizona and who manages and oversees network development, network sufficiency and network reporting functions. This position ensures network adequacy and appointment access, develops network resources in response to identified unmet needs, and ensures a member's choice of providers.
19. **Member Services Manager** who is located in Arizona and who coordinates communication with members, coordinates issues with appropriate areas within the organization, resolves member inquiries/problems and meets standards for resolution, telephone abandonment rates and telephone hold times.
20. **Provider Services Manager** who is located in Arizona and coordinates communications between the Contractor and providers. This position ensures that providers receive prompt resolution to their problems and inquiries and appropriate education about participation in the AHCCCS Program. Sufficient local staffing under this position must be in place to ensure providers receive assistance and appropriate and prompt responses. See Section D, Paragraph 28, Network Management.
21. **Claims Administrator** who shall ensure prompt and accurate provider claims processing. Sufficient staffing under this position must be in place to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.

The primary functions of the Claims Administrator are:

- a. Develop and implement claims processing systems capable of paying claims in accordance with State and Federal requirements,
- b. Develop processes for cost avoidance,
- c. Ensure minimization of claims recoupments,

- d. Ensure claims processing timelines are met, and
 - e. Meet AHCCCS encounter reporting requirements.
22. **Encounter Manager** who shall ensure AHCCCS encounter reporting requirements are met. Sufficient staffing under this position must be in place to ensure timely and accurate processing and submission of encounter data and reports to AHCCCS.
23. **Provider Claims Educator** who is located in Arizona and who facilitates the exchange of information between the grievances, claims processing, and provider relations systems.

The primary functions of the Provider Claims Educator are:

- a. Educate contracted and non-contracted providers (professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer,
 - b. Educate contracted and non-contracted providers on available Contractor resources such as provider manuals, website, fee schedules, etc.,
 - c. Interface with the Contractor's call center to compile, analyze, and disseminate information from provider calls,
 - d. Identify trends and guide the development and implementation of strategies to improve provider satisfaction, and
 - e. Frequently communicate with providers, including conducting on-site visits, to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices.
24. **Information Systems (IS) Administrator** who is responsible for information system management including coordination of the technical aspects of application infrastructure, server and storage needs, reliability and survivability of all data and data exchange elements. Sufficient staffing reporting to this position must be in place to ensure timely and accurate information systems management to meet system and data exchange requirements.
25. **Management Services Agreement Administrator** who is responsible for oversight of the Management Services Agreement (MSA) subcontractor and who is the Contractor's Key Contact for AHCCCS coordination and who is not employed by the MSA. This position is only required when the Contractor operates under a subcontract with an MSA.
26. **Cultural Competency Coordinator** who is responsible for implementation and oversight of the Contractor's Cultural Competency Program and the Cultural Competency Plan.
27. **Communications Administrator** who is responsible for media inquiries, public relations, policy development, implementation and oversight of all social networking and marketing activities.
28. **Transplant Coordinator** who is an Arizona licensed registered nurse in good standing and who is responsible for the timely review and authorization of transplant services in accordance with AHCCCS policy and State regulations. Refer to AMPM Policy 310-DD.

Additional Required Staff:

29. **Prior Authorization staff** to authorize health care services. This staff shall include but is not limited to Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. The staff will work under the direction of an Arizona-licensed physician.
30. **Concurrent Review staff** who are located in Arizona and who conducts inpatient medical necessity reviews. This staff shall include but is not limited to Arizona-licensed nurses and/or licensed behavioral health professionals in good standing. The staff will work under the direction of an Arizona-licensed physician.
31. **Member Services staff** to enable members to receive prompt resolution of their inquiries/problems.
32. **Care Management staff** who are located in Arizona and who provide care coordination for members with special health care needs.

The Contractor must submit the following items as specified in Section F, Attachment F3, Contractor Chart of Deliverables:

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

The Contractor is responsible for maintaining a significant local presence within the State of Arizona. Positions performing functions related to this Contract must have a direct reporting relationship to the local Administrator/Chief Executive Officer (CEO). The local CEO shall have the authority to direct, implement and prioritize work to ensure compliance with Contract requirements. The local CEO shall have the authority and ability to prioritize and direct work performed by Contractor staff and work performed under this Contract through a management service agreement or through a delegated agreement.

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 Contract.

The Contractor shall provide initial and ongoing staff training that includes an overview of AHCCCS, AHCCCS Policy and Procedure Manuals, Contract requirements and State and Federal requirements

specific to individual job functions. The Contractor shall ensure that all staff members having contact with members or providers receive initial and ongoing training with regard to the appropriate identification and handling of quality of care/service concerns.

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

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

Preventing Suicide Among AHCCCS Members: The Contractor shall require its staff who have direct contact with members (e.g. provider case managers and Contractor care managers, customer/member service staff) to be trained in *SafeTalk* or other nationally recognized suicide risk identification training.

16. WRITTEN POLICIES AND PROCEDURES

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

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

17. MEMBER INFORMATION

In addition to compliance with other pertinent Federal laws and regulations, the Contractor shall ensure its member communications comply with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act [45 CFR Part 92, 42 CFR Part 438], and related State requirements including ACOM Policy 404, ACOM Policy 406 and ACOM Policy 433. The Contractor shall ensure that it takes reasonable steps to provide meaningful access to each individual with Limited English Proficiency eligible to be served or likely to be encountered in its health programs and activities. As part of this obligation, the Contractor shall identify the prevalent non-English languages spoken by members in its service area and develop and implement an effective written language access plan as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with Limited English Proficiency [45 CFR 92.201(c)]. For significant communications and publications, the Contractor shall

comply with the nondiscrimination notice provisions in [45 CFR 92.8]. In addition to the general requirements set forth in Section D, Paragraph 17, Member Information, the Contractor shall implement all other activities necessary to comport with Federal and State requirements.

The Contractor shall provide members the Contractor's toll free and TTY/TDY telephone numbers for customer service which shall be available during normal business hours. In addition, the Contractor shall consider providing members access to a toll free TTY/TDY nurse triage line telephone number which shall be available 24 hours a day, 7 days a week.

All informational materials prepared by the Contractor shall be approved by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 404 and ACOM Policy 406 for further information and requirements for member communications.

The Contractor shall make interpretation services available to its members free of charge including: written translation of vital materials in prevalent non-English languages in its service area, availability of oral interpretation services in all languages, and use of auxiliary aids such as TTY/TDY and American Sign Language [42 CFR 438.10(d)(4)].

The Contractor shall notify its members of the following upon request and at no cost:

1. That oral interpretation is available for any language,
2. That written translation is available in each of the prevalent non-English languages in the Contractor's service area,
3. That auxiliary aids and services are available for members with disabilities, and
4. How members may access the services above [42 CFR 438.10(d)(5)].

All written materials to members must be written in easily understood language, use font size of at least 12 points, and be available in alternative formats and through provision of auxiliary aids and services that take into account the special needs of members with disabilities or Limited English Proficiency. All written materials must also include large print taglines and information (in font size of at least 18 point) explaining how to request auxiliary aids and services, including the provision of materials in alternative formats [42 CFR 438.10(d)(6)].

The Contractor shall make its written materials that are critical to obtaining services (also known as vital materials) available in the prevalent non-English language spoken for each LEP population in the Contractor's service area [42 CFR 438.10(d)(3)]. These written materials must also be made available in alternate formats upon request at no cost. Auxiliary aids and services must also be made available upon request and at no cost. Additionally, the materials shall include taglines in the prevalent non-English languages in Arizona and include large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services to understand the information with the Contractor's toll free and TTY/TDY telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials.

Vital materials include, at a minimum, the following:

1. Member Handbooks,
2. Provider Directories,
3. Consent forms,

4. Appeal and Grievance Notices, and
5. Denial and Termination Notices.

When there are program changes, notification shall be provided to members at least 30 days before implementation [42 CFR 438.10(g)(4)].

For consistency in the information provided to members, the Contractor is required to utilize the AHCCCS-developed definitions for managed care terminology [42 CFR 438.10(c)(i)]. Refer to ACOM Policy 406.

Social Networking Activities: Should the Contractor engage in Social Networking Activities, the Contractor shall adhere to the requirements for Social Networking as described in ACOM Policy 425 and submit deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Member Identification Cards): The Contractor is responsible for the production, distribution and cost of AHCCCS Member Identification (ID) Cards and the AHCCCS Notice of Privacy Practices in accordance with ACOM Policy 433. The Contractor shall submit Member ID Cards for AHCCCS approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Member Handbook and Provider Directory: The Contractor shall provide the following information to each member/representative or household within 12 business days of receipt of notification of the enrollment date.

1. A **Member Handbook** which serves as a summary of benefits and coverage. The Contractor is required to use the State developed model Member Handbook (refer to ACOM Policy 406). The content of the Member Handbook must include information that enables the member to understand how to effectively use the managed care program and at a minimum, shall include the information provided in ACOM Policy 406 [42 CFR 438.10(g)(1), 42 CFR 438.10(g)(2), 42 CFR 438.10(c)(4)(ii)].

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

The Contractor has the option of providing the Member Handbook in hard copy format with the new member packet, or providing the member written notification of how the Member Handbook information is available to the member on the Contractor's website, via electronic mail or via postal mailing [42 CFR 438.10(g)(3)(i)–(iv)]. Should the Contractor elect not to provide the Member Handbook in hard copy format with the member packet, the following provisions apply:

- a. The member notification must be approved in accordance with ACOM Policy 406, and
- b. The written notification must give the member the option to obtain a printed version of the Member Handbook.

2. A **Provider Directory**, which at a minimum, includes those items listed in ACOM Policy 406 [42 CFR 438.10].

The Contractor has the option of providing the Provider Directory in hard copy format or providing written notification of how the Provider Directory information is available on the Contractor's

website, via electronic mail, or via postal mailing as described in ACOM Policy 406. The written notification shall be sent to members within 12 business days of receipt of notification of the enrollment date. The Provider Directory must be made available on the Contractor's website in a machine readable file and format as specified by the Secretary [42 CFR 438.10(h)(4)].

The Contractor must give written notice about termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

The Contractor shall have information available for potential-members as described in ACOM Policy 404 and ACOM Policy 406 [42 CFR 438.10(f)(4)].

MCH and EPSDT Member Outreach: The Contractor shall conduct written and other member educational outreach related to MCH and EPSDT as delineated in AMPM Chapter 400 and AMPM Exhibit 400-3.

Member Newsletter: The Contractor must develop and distribute, at a minimum, two member newsletters during the Contract Year. Member Newsletters must be developed in accordance with ACOM Policy 404.

Member Rights: The Contractor shall, on an annual basis, inform all members of their right to request the below information [42 CFR 438.10(g)(2)(ix), 42 CFR 438.100(a)(1) and (2)]. This information may be sent in a separate written communication or included with other written information such as in a Member Newsletter:

1. An updated Member Handbook at no cost to the member, and
2. The Provider Directory as described in ACOM Policy 406.

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 [42 CFR 438.100 et. seq.].

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)].

Website Requirements: The Contractor shall develop and maintain a website that is focused, informational, user-friendly, functional, and provides the information as required in ACOM Policy 404 and submit deliverables as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

As required by [42 CFR 438.10(c)(3)], AHCCCS provides a direct URL website hyperlink to the below information to members via the AHCCCS website. The Contractor shall provide notification to AHCCCS when there is a change in a URL for this information as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

1. Contractor's main Arizona Medicaid website,
2. Contractor's Member Handbook, and
3. Contractor's Formulary.

18. SURVEYS

The Contractor may be required to perform surveys at AHCCCS' request. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool. The final survey tool shall be approved in advance by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The results and the analysis of the results shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Survey results are to be reported separately by Title XIX and Title XXI categories and in aggregate. The Contractor shall utilize member survey findings to improve care for Title XIX and Title XXI members.

As specified in Section F, Attachment F3, Contractor Chart of Deliverables, the Contractor is required to perform periodic surveys of its membership, as outlined in ACOM Policy 424, in order to verify that members have received services that have been paid for by the Contractor and to identify potential service/claim fraud [42 CFR 455.20, 42 CFR 433.116]. The Contractor, or its subcontractor if the Contractor has delegated its responsibilities for coverage of services and payment of claims, shall perform these surveys [42 CFR 438.608(a)(5)].

For non-AHCCCS required surveys, the Contractor shall provide notification as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The notification must include a project scope statement, project timeline and a copy of the survey. Survey results are to be reported separately by Title XIX and Title XXI categories and in aggregate. The Contractor shall utilize member survey findings to improve care for Title XIX and Title XXI members. The results and analysis of the results of any Contractor initiated surveys shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Surveys performed by the Contractor to evaluate Plan satisfaction for previous members (exit surveys), are subject to the above notification requirement for non-AHCCCS required surveys and are not subject to AHCCCS Marketing Committee approval.

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

The Contractor shall participate in the delivery and/or results review of member surveys as requested by AHCCCS. Surveys may include Home and Community Based (HCBS) Member Experience surveys, HEDIS Experience of Care (Consumer Assessment of Healthcare Providers and Systems–CAHPS) surveys, and/or any other tool that AHCCCS determines will benefit quality improvement efforts. While not included as an official performance measure, survey findings or performance rates for survey questions may result in regulatory action including, but not limited to, the Contractor being required to develop a Corrective Action Plan (CAP) and/or participate in technical assistance or AHCCCS-led workgroups to improve any areas of concern noted by AHCCCS. Failure to effectively develop or implement AHCCCS-approved CAPs and drive improvement may result in additional regulatory action by AHCCCS. The Contractor shall submit the Member Survey Notification and Results to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

19. CULTURAL COMPETENCY

The Contractor shall participate in AHCCCS' efforts to promote, and shall implement a program that promotes, the delivery of services in a culturally competent manner to all members, including those

with Limited English Proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity and meets the requirements of ACOM Policy 405 [42 CFR 438.206(c)(2)].

The Contractor shall develop and implement a Cultural Competency Plan which meets the requirements of ACOM Policy 405. An annual assessment of the effectiveness of the Cultural Competency Plan, along with any modifications to the Plan, must be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

20. MEDICAL RECORDS

The member's medical record shall be maintained by the provider who generates the record. Medical records include those maintained by Primary Care Providers (PCPs) or other providers, including but not limited to, medical records kept in placement settings such as nursing facilities, assisted living facilities and other home and community based providers.

The Contractor shall ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member. The Contractor shall have written policies guaranteeing each member's right to request and receive a copy of his or her medical records, and to request that the medical record be amended or corrected [45 CFR Part 160, 164, 42 CFR 438.100(a)(1), 42 CFR 438.100(b)(2)(vi)]. The Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

The Contractor is responsible for ensuring that a medical record (hard copy or electronic) is established when information is received about a member. If the provider has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of actually establishing a medical record, but must be associated with the member's medical record as soon as one is established.

Medical records shall be maintained in a detailed and comprehensive manner, which conforms to professional standards, complies with records retention requirements, and permits effective medical review and audit processes, and which facilitates an adequate system for follow-up treatment.

The Contractor shall have written policies and procedures for the maintenance of medical records to ensure those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information and which comply with AMPM Policy 940 and AMPM Policy 550. The Contractor shall ensure that providers maintain and share a member health record in accordance with professional standards [42 CFR 438.208(b)(5)].

The Contractor shall have written policies and procedures to ensure that MSICs have an integrated electronic medical record for each member that is maintained and available for the multi-specialty treatment team and community providers. An integrated electronic medical record shall contain all information necessary to facilitate the coordination and quality of care delivered by multiple providers in multiple locations at varying times.

For care coordination purposes, medical records must be shared with other care providers, such as the multi-specialty interdisciplinary team.

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. The Contractor shall comply with medical record review requirements as outlined in AMPM Policy 940. The Contractor shall comply with record retention requirements as outlined in Section D, Paragraph 61 Record Retention.

AHCCCS is not required to obtain written approval from a member, before requesting the member's medical record from the PCP or any other organization or agency. The Contractor may obtain a copy of a member's medical records without written approval of the member, if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCS shall be afforded access to all members' medical records whether electronic or hard copy within 20 working days of receipt of request or more quickly if necessary.

21. RESERVED

22. QUALITY MANAGEMENT AND PERFORMANCE IMPROVEMENT

General Requirements: 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 (QM/PI) processes. The Contractor shall execute processes to monitor, analyze, plan, implement, evaluate, and report QM/PI activities, as specified in the AMPM [42 CFR 457.1240(b), 42 CFR 457.1240(f), 42 CFR 457.1201(n)(2), 42 CFR 438.330(a)(1) and (e), 42 CFR 438.330(a)(3), 42 CFR 438.330(b), 42 CFR 438.330(e)(1), 42 CFR 438.330(e)(2)]. Refer to Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall undergo annual, external independent reviews of the quality of, timeliness of, and access to services covered under the Contract [42 CFR 457.1250(a), 42 CFR 457.1240(f), 42 CFR 457.1201(n)(2), 42 CFR 438.320, 42 CFR 438.350]. AHCCCS will utilize an External Quality Review Organization (EQRO) for purposes of independent review of its Contractors and related AHCCCS oversight. External quality reviews will be conducted by an EQRO [42 CFR 438.358]. Direct engagement at the Contractor level may occur, at the discretion or invitation of AHCCCS.

The Contractor shall ensure that the QM/PI Unit within the organizational structure is separate and distinct from any other units or departments such as Medical Management or Contractor Care Management. The Contractor is expected to integrate QM/PI processes, such as tracking and trending of issues, throughout all areas of the organization, with ultimate responsibility for QM/PI residing within the Quality Management Unit.

QM/PI positions performing work functions related to the Contract shall have a direct reporting relationship to the local Chief Medical Officer (CMO)/Medical Director and the local Chief Executive Officer (CEO). The local CMO and CEO shall have the ability to direct, implement, and prioritize interventions resulting from QM/PI activities and investigations. Contractor staff, including Administrative Services Subcontractors' staff which perform functions under this Contract related to QM/PI, shall have the work directed and prioritized by the Contractor's local CMO and CEO.

The Contractor shall maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including

administrative and clinical integration of health care service delivery. Integration strategies and activities shall focus on improving individual health outcomes, enhancing care coordination including care coordination for Medication Assisted Treatment (MAT), and increasing member satisfaction.

The Contractor's QM/PI Programs, at a minimum, shall comply with the requirements outlined in AMPM, ACOM, State and Federal Requirements, and this Section.

Quality Management/Performance Improvement Program: The Contractor shall have an ongoing QM/PI Program for the services it furnishes to members, regardless of payor source or eligibility category [42 CFR 457.1240(b), 42 CFR 438.330(a)(1), 42 CFR 438.330(a)(3)].

The Contractor's QM/PI program shall be designed to achieve and sustain, through ongoing measurements and intervention, significant improvement in the areas of clinical care and nonclinical care which is expected to have a favorable effect on health outcomes and member satisfaction, as specified in AMPM Chapter 900 [42 CFR 328.330(a)(1), 42 CFR 438.330(b)(1-2)].

The Contractor shall:

1. Measure and report to the State, its performance, using standard measures required by the State or as required by Centers for Medicare and Medicaid Services (CMS) [42 CFR 438.330(c)(1)(i), 42 CFR 438.330(c)(2)(i)],
2. Submit specified data to the State that enables the State to measure the Contractor's performance using standardized measures, as defined by the State [42 CFR 438.330(c)(1)(i), 42 CFR 438.330(c)(2)(ii)], or
3. Perform a combination of the above activities [42 CFR 438.330(c)(2)(iii)].

The Contractor's QM/PI Program shall include, but is not limited to:

1. Implementation, monitoring, evaluation, and compliance with applicable requirements in the ACOM and AMPM,
2. Provision of quality care and services to eligible members, regardless of payor source or eligibility category,
3. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as specified in Contract [42 CFR 457.1240(b), 42 CFR 438.330(b)(4), and 42 CFR 438.340],
4. Demonstration of improvement in the quality of care and services provided to members through established QM/PI processes,
5. Analysis of the effectiveness of implemented interventions, to include targeted interventions, to address the unique needs of populations and subpopulations served [42 CFR 438.330(e)(2)],
6. Attendance and/or participation in applicable community initiatives, events, and/or activities as well as implementation of specific interventions to address overarching community concerns (including chronic disease management, behavioral health, justice population, opioid and substance use, suicide, and Social Determinants of Health (SDOH) including, but not limited to, homelessness, employment/community engagement, etc.),
7. Written policies regarding member rights and responsibilities [42 CFR 438.100(b)(1)],
8. Protection and confidentiality of medical records and any other personal health/enrollment information that identifies a particular member, or subset of members, in accordance with Federal and State privacy requirements, AMPM, and the Medical Records Contract section [42 CFR 438.224],

9. Compliance with requirements to assure member rights and responsibilities conform with AHCCCS policies on Title XIX/XXI Notice and Appeal Requirements, Special Assistance for Persons Determined to have a Serious Mental Illness (SMI), Notice and Appeal Requirements (SMI and Non-SMI), Member Grievance Resolution Process, and AMPM [42 CFR 457.1220, 42 CFR 438.100(a)(2), 42 CFR 438-228(a), 42 CFR 438.400(a), 42 CFR 438.402(a)]. The Contractor shall also comply with any other applicable Federal and State laws (such as Title VI of the Civil Rights Act of 1964), including other laws regarding privacy and confidentiality [42 CFR 457.1220, 42 CFR 438.100(d)],
10. Development and maintenance of mechanisms to solicit feedback and recommendations from key stakeholders, subcontractors, members, and family members to:
 - a. Monitor service quality, and
 - b. Develop strategies to improve member outcomes and quality improvement activities related to quality of care and system performance.
11. Employment of sufficient, knowledgeable, and qualified local staff and utilization of appropriate resources to achieve Contractual compliance. The Contractor's resource allocation must be adequate to achieve quality outcomes. Staffing adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS Policy requirements,
12. Local staff available 24 hours per day, seven days per week, to work with AHCCCS and/or other State agencies on urgent issue resolutions, such as Arizona Department of Health Services (ADHS)/Bureau of Medical Facilities. Urgent issue resolutions include Immediate Jeopardies (IJ), fires, or other public emergency situations. These staff shall have:
 - a. Access to information necessary to identify members who may be at risk, including the identified members' current health/service status,
 - b. The ability to initiate new placements/services,
 - c. The ability to perform status checks at affected facilities, and
 - d. Perform ongoing monitoring, if necessary.

The Contractor shall supply AHCCCS/DHCM, Quality Management with the contact information for these staff, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. At a minimum the contact information shall include a current 24/7 telephone number. The AHCCCS QM Manager must be notified and provided with back up contact information when the primary contact person will be unavailable,

13. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credentialing for all provider types that shall comply with the requirements outlined in AMPM, ACOM, State and Federal requirements, and this section [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b)],
14. Tracking and trending of member and provider issues, which includes, but is not limited to, investigation and analysis of quality of care issues, related to: abuse, neglect, exploitation, suicide attempts, substance use disorders/opioid-related concerns, alleged human rights violations, and unexpected deaths. The Contractor shall comply with requirements, as specified in AMPM Policy 960,
15. Opioid Drug Utilization Review management in accordance with the Federal Opioid Legislation Support Act P.L 115-271 which includes the following:
 - a. Implementation of opioid safety edits by the Pharmacy Benefits Manager (PBM) at the Point-of-Sale,
 - b. Monitoring of member utilization when the cumulative current utilization of opioid(s) is a Morphine Daily Equivalent Dose of greater than 90,
 - c. Monitoring of members with concurrent utilization of an opioid(s) in conjunction with a benzodiazepine(s) and/or an antipsychotic(s),

- d. Monitoring of antipsychotic prescribing for children,
 - e. Monitoring of fraud, waste, and abuse by enrolled members, pharmacies and prescribing clinicians, and
 - f. Reporting of Opioid Drug Utilization Review management activities for 15. a. through e. above as specified in Section F, Attachment F3, Contractor Chart of Deliverables.
16. Submission of Inter-Rater Reliability (IRR) metrics and evidence of completed IRR activities, as specified in Section F, Attachment F1, Contractor Chart of Deliverables, for each of the following areas, at a minimum: triage, case leveling, and corrective actions,
 17. Submission of any cases involving Medicaid fraud, waste, or abuse reported to the AHCCCS Office of the Inspector General. See Section D, Paragraph 58, Corporate Compliance,
 18. Requirement for any ADHS licensed or certified provider to submit to the Contractor their most recent ADHS licensure review, copies of substantiated complaints, and other pertinent information that is available and considered to be public information from oversight agencies. The Contractor shall monitor contracted providers for compliance with quality management measures including supervisory visits conducted by a Registered Nurse when a home health aide is providing services,
 19. Monitoring of services and service sites, as outlined in AMPM Policy 910. The Contractor shall submit a Contractor Monitoring Summary, as specified in Section F, Attachment F3, Contractor Chart of Deliverables,
 20. QM/PI program monitoring and evaluation activities, which include:
 - a. Peer Review and QM/PI Committees that meet at least quarterly and are chaired by the Contractor's local Chief Medical Officer/Medical Director, and
 - b. Other subcommittee(s) under the QM Committee, as required, or as a need is identified. AHCCCS reserves the right to be in attendance as a silent witness to requested Peer Review Committee Meetings.
 21. Requirements for its QM Committee to proactively and regularly review member grievance and appeal data to identify:
 - a. Outlier members who have filed multiple complaints, grievances, or appeals regarding services, or against the Contractor, or
 - b. Who contact governmental entities for assistance, including contact to AHCCCS for the purposes of assigning a care coordinator to assist the member in navigating the health care system.
 22. Collection and submission of performance measure data, including any required by the State or CMS [42 CFR 457.1201(n)(2), 42 CFR 457.1240(b), 42 CFR 438.330(a)(2), 42 CFR 438.330(b)(2), 42 CFR 438.330(c)],
 23. Mechanisms to detect both underutilization and overutilization of services [42 CFR 457.1240(b), 42 CFR 457.1240(f), 42 CFR 457.1201(n)(2), 42 CFR 438.330(b)(3)],
 24. Implementation of processes to assess, plan, implement, and evaluate QM/PI activities related to the care and services provided to members, in conformance with AMPM requirements[42 CFR 438.330(a)(1), (b)(1) and (b)(2)],
 25. Performance measurement and performance improvement projects, as specified in this section, AMPM Policies 910, 970, and 980 [42 CFR 457.1240(b), 42 CFR 438.330(a)(2), 42 CFR 438.330(b)(1), 42 CFR 438.330(c), 42 CFR 438.330(d), 42 CFR 438.330(a)(2)],
 26. Routine, and ad hoc, dissemination of subcontractor and provider quality improvement related information including performance metrics, dashboard indicators, and member outcomes to the State and key stakeholders, inclusive of members and family members,
 27. A written QM/PI Program Annual Plan in accordance with 42 CFR 438.330, AMPM Policy 920, and Section F, Attachment F3, Contractor Chart of Deliverables,

Timely, accurate, and complete submission of QM/PI Program deliverables that address strategies and performance for program activities, as specified in this section, AMPM, and Section F, Attachment F3, Contractor Chart of Deliverables.

Health Care-Acquired Conditions and Other Provider-Preventable Conditions: Federal regulation prohibits payment for Provider-Preventable Conditions that meet the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). OPPC refers to a condition occurring in any health care setting and that meets the following criteria [42 CFR 434.6(a)(12)(i), 42 CFR 438.3(g), 42 CFR 447.26(a), 42 CFR 447.26(b), 42 CFR 447.26(c)]:

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

If an HCAC or OPPC is identified, the Contractor must conduct a Quality of Care (QOC) investigation, as outlined in AMPM Chapter 900, and report the occurrence to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.3(g), 42 CFR 434.6(a)(12)(ii), 42 CFR 447.26(d)].

Credentialing: The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee [42 CFR 457.1230(a), 42 CFR 438.206(b)(6)]. The Contractor shall refer to the AMPM Chapter 900 and Section F, Attachment F3, Contractor Chart of Deliverables for reporting requirements.

The Contractor shall comply with uniform provisional credentialing, initial credentialing, re-credentialing and organizational credentialing for all provider types as follows [42 CFR 457.1208, 42 CFR 457.1233(a), 42 CFR 438.206(b)(6), 42 CFR 438.12(a)(2), 42 CFR 438.214(b)]:

1. Document provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the Contractor or have seen 25 or more of the Contractor's members [42 CFR 438.206(b)(1-2)],
2. Demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's local Chief Medical Officer/Medical Director,
3. Comply with requirements as specified in AMPM Policy 950 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables,
4. Not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, and
5. Not employ or contract with providers excluded from participation in Federal health care programs [42 CFR 457.1233(a), 42 CFR 438.214].

Credential Verification Organization Contract: The Arizona Association of Health Plans (AzAHP) has established a Contract with a Credential Verification Organization (CVO) that is responsible for:

1. Receiving completed applications, attestations and primary source verification documents, and
2. Conducting annual CVO entity site visits to ensure compliance with AHCCCS requirements.

The AHCCCS Contractor must utilize the contracted CVO as part of its credentialing and re-credentialing process, regardless of membership in the AzAHP. This requirement eases the administrative burden for providers that contract with AHCCCS Contractors which often results in duplicative submission of information used for credentialing purposes. The Contractor shall follow the AHCCCS re-credentialing timelines for providers that submit their credentialing data and forms to the AzAHP CVO.

The Contractor is responsible for completing the credentialing process. The Contractor shall continue to include utilization, performance, compliance, and quality of care documentation, as specified in the AMPM, to complete the credentialing or re-credentialing files that are brought to the Credentialing Committee for a decision. In addition, the Contractor shall also meet AMPM Policy 950 requirements for provisional credentialing.

Credentialing Timelines: The Contractor is required to process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing a Contractor shall calculate and report to AHCCCS as outlined in AMPM Policy 950. The Contractor shall ensure that recredentialing is completed within 36 months of the previous credentialing approval. The Contractor shall notify providers of a credentialing decision (approved or denied) within 30 days of Committee review.

The Contractor shall ensure that they have a process in place to monitor occurrences which may have jeopardized the validity of the credentialing process, at a minimum, on an annual basis. The Contractor shall report the credentialing information with regard to all credentialing applications, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Accreditation: The Contractor is required to inform AHCCCS/DHCM, Quality Improvement Team as to whether it has been accredited by a private independent accrediting entity. If the Contractor has received accreditation by a private independent accrediting entity, the Contractor shall provide AHCCCS a copy of its most recent accreditation review, including the following [42 CFR 457.1240(c), 42 CFR 438.332(a) and [42 CFR 438.332(b)(1)-(3)]:

1. Its accreditation status, survey type, and level (as applicable),
2. Recommended actions or improvements, Corrective Action Plans (CAPs), and summaries of findings, and
3. The expiration date of the accreditation.

This information shall be made available on the AHCCCS website [42 CFR 438.332(c)(1)]. Should the Contractor renew or lose its accreditation, the Contractor shall provide AHCCCS written notification (in the case of losing its accreditation) or a copy of the renewal certificate, as applicable, within 15 calendar days of notification or receipt from the accrediting entity.

Incident, Accident, and Death Reporting: The Contractor shall develop and implement policies and procedures that require individual and organizational providers to report to the Contractor, the Regulator, and other appropriate authorities, Incident, Accident and Death (IAD) Reports (to include

abuse, neglect, injury, access to care issues, exploitation, suicide attempts, substance use disorders/opioid-related concerns, high profile cases, Health Care-Acquired Conditions, Other Provider-Preventable Conditions, alleged human rights violations, and member deaths), in conformance with AMPM Chapter 900. IAD Reports must be submitted in accordance with requirements established by AHCCCS and as specified in Attachment F3, Contractor Chart of Deliverables.

Quality of Care Concerns and Investigations: The Contractor shall establish and implement mechanisms to assess the quality and appropriateness of care provided to members, including members with special health care needs, [42 CFR 457.1230(c), 42 CFR 438.208(c)(4), 42 CFR 438.330(a)(1), 42 CFR 438.330(b)(4)]. The Contractor shall assess incidents for potential Quality of Care (QOC) concerns and develop a process that delineates between non-AHCCCS reportable events and AHCCCS-reportable events (which includes incidents of: Health Care-Acquired Conditions, Other Provider-Preventable Conditions, abuse, neglect, exploitation, injuries, high profile cases, suicide attempts, substance use disorders/opioid-related concerns, alleged human rights violations, and unexpected death). The Contractor shall develop a process to report incidents to AHCCCS/DHCM, Quality Management Team and as specified in Attachment F3, Contractor Chart of Deliverables.

The Contractor shall develop and implement policies and procedures that analyze quality of care issues through identifying the issue, initial assessment of the severity of the issue, and prioritization of action(s) needed to resolve immediate care needs when appropriate. The Contractor shall establish a process to ensure that all staff and providers are trained on how to refer suspected quality of care issues to quality management. This training must be provided during new employee orientation (within 30 days of hire) and annually, thereafter.

The Contractor shall monitor contracted providers for compliance with Quality Management metrics, as well as member health and safety; Clinical Quality Management staff shall lead all monitoring and investigative efforts. The Contractor shall establish mechanisms to track and trend member and provider issues. The Contractor must comply with requirements, as specified in Contract and AMPM Policy 960.

Subcontractor Monitoring: The Contractor shall develop and submit a Subcontractor Performance Monitoring Plan as a component of its QM/PI Program Plan, to include, at a minimum, the following quality management functions:

1. Peer Review processes,
2. Incident, Accident, Death (IAD) report timely completion and submission,
3. Quality of Care (QOC) Concerns and investigations,
4. AHCCCS required Performance Measures,
5. Performance Improvement Projects, and
6. Provisional, initial, organizational, and re-credentialing processes and requirements.

The Contractor shall conduct an annual Operational Review (OR) audit of subcontracted provider services and service sites, and assess each provider's performance on satisfying established quality management and performance measures standards. AHCCCS will accept the AzAHP review process to meet this audit requirement. A Corrective Action Plan (CAP) shall be developed and implemented when provider monitoring activities reveal poor performance, as follows:

1. When performance falls below the minimum performance level, or

2. Shows a statistically significant decline from previous period performance.

Provider Quality Monitoring: Provider Quality Monitoring functions include but are not limited to the service site assessments of all providers as outlined in AMPM Policy 910. The Contractor shall conduct comprehensive onsite quality audits of each location where members receive services.

The Contractor shall ensure:

1. Instances where concerns are identified, corrective actions are implemented in order to bring the provider into compliance,
2. Any potential QOCs are immediately (within 24 hours) referred to the QOC triage team for review,
3. Utilization of standardized monitoring tools by provider type (utilizing AHCCCS-developed tools when available), and
4. Inter-Rater Reliability (IRR) of quality monitoring processes with documented testing and results of individuals completing provider quality monitoring activities.

Performance Improvement Projects: The Contractor shall implement Performance Improvement Projects (PIPs) designed to achieve and sustain significant improvement in the areas of clinical and non-clinical care, through ongoing measurements and interventions, as specified in AMPM Chapter 900, and involve the following [42 CFR 457.1240(b), 42 CFR 438.330(d) (i)-(iv)]:

1. Measurement of performance using objective quality indicators,
2. Implementation of interventions to achieve improvement in access to and quality of care,
3. Evaluation of the effectiveness of the interventions based on measures collected as part of the PIP, and
4. Planning and initiation of PIP activities for increasing or sustaining improvement.

PIPs are mandated by AHCCCS; however, the Contractor shall also identify and implement additional PIPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the Contractor. If the Contractor holds AHCCCS Contracts for more than one line of business, the Contractor shall submit separate reports for each line of business that contain rates and results specific to the line of business for which the submission pertains. In addition, the Contractor shall ensure the inclusion of subpopulation data and disparities analysis within its reporting, with the identification of targeted interventions to be implemented specific to findings.

The Contractor shall report the status and results of each PIP to AHCCCS, no less than once per year and as requested, using the AHCCCS Performance Improvement Project (PIP) Reporting Template included in AMPM Policy 980 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Performance for each PIP shall be evaluated minimally on an annual basis, or more frequently, so information related to the Contractor's performance can be reviewed and evaluated, with interventions revised accordingly [42 CFR 457.1240(b), 42 CFR 438.330(d)(1), 42 CFR 438.330(d)(3)].

Performance Measures: The Contractor shall comply with AHCCCS QM/PI requirements to improve the care, coordination, and services provided to AHCCCS members as demonstrated through quality metrics and performance measure reporting. Technical specifications for performance measures are based on the CMS Core Measure Sets methodologies. AHCCCS may utilize other methodology sources, such as National Committee for Quality Assurance (NCQA) Health Exchange Data and Information System

(HEDIS®) or develop methodologies for measurement that are reflective of the Arizona system of care delivery model. As measure sets are updated, performance measures required by AHCCCS may also be updated to reflect the changes.

Performance Measure calculations shall be reflective of the applicable Contract Year [i.e. Contract Year Ending (CYE) 2020: 10/1/2019 through 9/30/2020]. The Contractor shall calculate, analyze, and report rates specific to line of business and applicable populations (i.e. the Contractor shall separately calculate, analyze, and report performance measures for its Title XIX and Title XXI populations). In addition, the Contractor shall analyze performance measure data specific to applicable subpopulations [i.e. Children's Rehabilitative Services (CRS) designated members]. The Contractor shall conduct routine monitoring and implement population/subpopulation specific targeted interventions, meant to ameliorate or eliminate identified disparities, which are based evaluation and analysis of previous performance.

The Contractor shall also analyze and report results by placement (e.g. HCBS vs. nursing facility), system of care delivery model, Geographic Service Areas (GSA) or County, applicable member designations, and/or other applicable demographic factors. The Contractor's performance measure monitoring, inclusive of measurable goals/objectives, rates, analysis, and newly implemented or revised interventions shall be reported to AHCCCS in accordance to this section; Section F, Attachment F3, Contractor Chart of Deliverables; and as required by AHCCCS. Contractor performance measure monitoring results shall be reported to AHCCCS in conjunction with its Performance Measure Monitoring Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall report in alignment with the requirements found in AMPM Policy 910, 920, and 970.

The Contractor is responsible for collecting valid and reliable data in accordance with associated measure specifications, as well as technical guidance and instructions provided by AHCCCS and/or an EQRO conducting validation activities. The Contractor shall also ensure qualified staff and personnel are utilized in the data collection and reporting process. Responsibility for validation and oversight of performance measure data collection and rate reporting in alignment with AHCCCS requirements remain with the Contractor, despite utilization of a vendor or subcontractor to conduct performance measure calculations or hybrid reviews on its behalf. The Contractor shall comply with all manuals, documents, and guides referenced within this section to improve performance for all applicable performance measures.

Hybrid Performance Measures: AHCCCS may utilize hybrid or other methodologies for collecting and reporting performance measure rates, as allowed by CMS Core Measure Sets, the NCQA for selected HEDIS® measures, as allowed by other entities for nationally recognized measure sets, or as determined by AHCCCS. The Contractor shall participate in hybrid immunization audits, at intervals specified by AHCCCS, to assess the immunization status of members at 24 months of age and by 13 years of age. The Contractor shall also participate in hybrid performance measure reviews/audits for any and all other measures identified by AHCCCS, at intervals specified by AHCCCS. If records are missing for more than five percent (5%) of the Contractor's final sample, the Contractor is subject to sanctions by AHCCCS. An EQRO may conduct a study to validate the Contractor's collection process, collected data, and/or reported rates.

The number of records that each Contractor collects will be based on CMS Core measure specifications, EQRO, or other sampling guidelines and instructions provided by AHCCCS. The number of records that each Contractor collects may be affected by the Contractor's previous performance rate for the

associated measure. The Contractor shall comply with and implement the hybrid methodology data collection as directed by AHCCCS.

Hybrid Data Collection Procedures: When requested by AHCCCS, the Contractor shall submit data for standardized Performance Measures and/or PIPs within specified timelines and according to AHCCCS procedures for collecting and reporting the data. The Contractor shall collect data from medical records, Electronic Health Records (EHRs), or through other AHCCCS approved mechanisms in accordance with the technical specifications and/or methodology identified by AHCCCS. Data shall be reported utilizing a standardized format for each hybrid measure, with allowable supporting documentation submitted, in accordance with AHCCCS provided instructions. Data collected for Performance Measures and/or PIPs must be returned by the Contractor in a standardized format and in accordance with instructions provided by AHCCCS on or before the due date specified.

The Contractor must also ensure that data collected by multiple parties/individuals for Performance Measures and PIP reporting is consistent and comparable through an implemented inter-rater reliability process, as outlined in AMPM Policy 970. Failure to follow the data collection and reporting instructions that accompany the data request may result in regulatory actions including, but not limited to, sanctions imposed on the Contractor.

If an extension of time is needed to complete a report, the Contractor may submit a formal request via email communication before the deliverable due date to the AHCCCS/DHCM, Operations Compliance Officer and Quality Improvement Team Manager, in accordance with AMPM Policy 920 requirements.

CMS-416: The EPSDT Participation and Preventive Dental Services performance measures utilize methodology established within the CMS Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report, which can be found on the AHCCCS website.

AHCCCS uses the national CMS-416 methodology to generate the EPSDT Participation and Preventive Dental Services rates. The aggregate rates for Title XIX and Title XXI (KidsCare) are generated one time per year and reported to CMS within specified timeframes. AHCCCS may require the Contractor to implement a corrective action plan or participate in mandatory workgroup activities when statistically significant declines in the Title XIX and Title XXI (KidsCare) aggregate rates are identified.

Maternal Health: The Contractor must monitor rates and implement interventions to improve or sustain rates for low/very low birth weight deliveries, utilization of Long Acting Reversible Contraceptives (LARC), prenatal, and postpartum visits. The Contractor must implement processes to monitor and evaluate cesarean section and elective inductions rates prior to 39 weeks gestation, and implement interventions to decrease the incidence of occurrence. Contractor EPSDT and Adult monitoring results shall also be reported to AHCCCS in conjunction with its EPSDT and Adult Monitoring Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Quality Improvement Performance Requirements: The Contractor shall monitor and report all CMS Children's Core Set measures, as applicable, and may be required to monitor and report select NCQA HEDIS® or other AHCCCS-required measures, as mandated by AHCCCS, for the applicable Contract Year. The Contractor shall utilize the appropriate measure specifications, to include the appropriate measure steward and version/year, as directed by AHCCCS. The Contractor shall perform in accordance with

established standards, as outlined in this section. Contractor performance that does not meet established standards may be subject to regulatory action.

The Contractor shall implement a process for internally monitoring and reporting Performance Measure rates, utilizing a standard or adopted methodology, as defined and determined by AHCCCS, for each required Performance Measure. The Contractor shall evaluate performance, based on unique population/line of business and applicable subpopulations, utilizing a Contract Year Ending (CYE) timeframe. The Contractor shall conduct separate reporting for Title XIX and Title XXI (KidsCare) populations (the Contractor must analyze the population each year and determine if there is an appropriate denominator for reporting and analysis). The Contractor shall have a mechanism for its QM/PI Committee to report the Contractor's performance on an ongoing basis to its CEO, stakeholders, and other key staff. Contractor calculated rates that have been validated by the EQRO are the official rates utilized for determination of Contractor compliance with performance requirements. AHCCCS reserves the right to calculate and report rates, in lieu of Contractor calculated rates, which may be utilized as the official rates when determining Contractor compliance with performance measure requirements.

Contractor performance is evaluated annually using the official rates described in the preceding paragraph. These rates are considered the official measurements for each Performance Measure. Official rates will be compared with the MPS specified in the Contract in effect during the measurement period. Contractors/AHCCCS will utilize methodologies that are reflective of specifications in place or identified for the measurement period. For instance, performance measure data will be based on the associated measure stewards published technical specifications applicable for the measurement year or as directed by AHCCCS at the time of review. The Contractor is responsible for monitoring and reporting to the AHCCCS/DHCM, Quality Improvement (QI) Manager the status of, and any discrepancies identified in encounters received by AHCCCS including paid, denied and pended for purposes of Performance Measure monitoring prior to the official rate calculations being conducted.

The Contractor must meet and sustain, as well as ensure that each subcontractor meets and sustains, the AHCCCS stated Minimum Performance Standards (MPS) for each applicable population/eligibility category (i.e. Title XIX and/or Title XXI – KidsCare Program) for each required performance measure [42 CFR 438.330(b)(1)(2) and (d)(1)]. It is equally important that, in addition to meeting the contractual MPS, the Contractor continually improve performance measure outcomes from year to year. If a Contractor does not achieve standards per AHCCCS Official reporting, the Contractor will be required to submit a Corrective Action Plan (CAP) and may be subject to regulatory action, which may include a sanction, for each deficient measure as outlined within AMPM Policy 970.

The Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Minimum Performance Standards (MPS) or other established standard as identified by AHCCCS. AHCCCS will require the Contractor to implement a Corrective Action Plan (CAP) for measures that are below the MPS/established standard. AHCCCS may require the implementation of a CAP for measures that show a statistically significant decrease in its rate even if it meets or exceeds the MPS/established standard. AHCCCS may also require the Contractor to conduct a chart audit for validation of any performance measure that falls below the MPS/established standard. AHCCCS may impose sanctions on the Contractor, if it does not show statistically significant improvement in its official rates. Sanctions may also be imposed for statistically significant declines of official rates, even if they meet or exceed the MPS/established standard; for any rate that does not meet the AHCCCS MPS/established standard; or a rate that has a significant impact to the aggregate rate for the State. AHCCCS may require the

Contractor to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. In addition, AHCCCS may require the Contractor to implement a CAP or participate in mandatory workgroup activities when statistically significant declines in the aggregate rate(s) are identified.

The Contractor shall monitor and report all Centers for Medicare and Medicaid Services (CMS) Core Set measures and may be required to monitor and report select NCQA HEDIS® or other AHCCCS-required measures, as mandated by AHCCCS, for the applicable Contract Year. The Contractor is to refer to Section F, Attachment F4, Performance Measures table that are inclusive of required performance measures and associated standards in place at the time the Contract was made effective. The Contractor is required to monitor and report all measures included within the applicable CMS Core Measure Set for the reporting period at the time of its publication, despite their inclusion within the referenced Performance Measures tables.

Quality Improvement Corrective Action Plans: An evidence-based corrective action plan (CAP) inclusive of elements outlined in AMPM Policy 920 must be received by AHCCCS within 30 days of the notification from AHCCCS of the deficiency(s). Proposed CAPs must be approved by AHCCCS prior to implementation and CAP updates shall be submitted at intervals specified by AHCCCS. In addition, AHCCCS may conduct one or more follow-up desktop or on-site reviews to verify compliance with a CAP. Contractors shall implement an evidence-based corrective action plan (CAP) inclusive of elements outlined in AMPM Policy 920 within 30 days of notification from AHCCCS of a quality improvement (QI) related deficiency(s). The Contractor shall also identify and implement additional CAPs based on self-identified opportunities for improvement, as supported by root cause analysis, external/internal data, surveillance of trends, or other information available to the Contractor. Self-implemented CAPs and associated CAP updates shall be submitted upon AHCCCS request.

If an extension of time is needed to complete a report, the Contractor may submit a formal request via email communication before the deliverable due date to the AHCCCS/DHCM, Operations Compliance Officer and Quality Improvement Team Manager, in accordance with AMPM Policy 920 requirements.

Member Satisfaction Surveys: AHCCCS or the Contractor may conduct surveys of a representative sample of the Contractor's membership and providers. The Contractor shall, as requested by AHCCCS, participate in member satisfaction surveys in accordance with Statewide Consumer Survey protocol [42 CFR 438.340(a), 42 CFR 438.340(b)(4)]. AHCCCS may provide the survey tool or require the Contractor to develop the survey tool which shall be approved in advance by AHCCCS and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The results of the surveys may become public information and available to all interested parties on the AHCCCS website. The Contractor may be required to participate in workgroups and other efforts that are initiated based on the survey results. The Contractor may participate in or conduct additional surveys based upon findings from the previously conducted member satisfaction survey, as approved by AHCCCS, as part of designing its quality improvement or Corrective Action Plan (CAP) activities.

While not included as an official performance measure, survey findings or performance rates for survey questions may result in regulatory action including, but not limited to, the Contractor being required to develop a CAP to improve any areas of concern noted by AHCCCS. Failure to effectively develop or implement AHCCCS-approved CAPs and drive improvement may result in additional regulatory action.

Engaging Members through Technology Executive Summary: The Contractor shall engage its membership through web based applications, which may include mobile device technologies. The Contractor shall identify web/mobile-based applications utilized in its outward facing communication with members. The Contractor shall also identify subpopulations that can benefit from web/mobile based applications used to assist members with self-management of health care needs (e.g. chronic conditions, pregnancy, SDOH resources, or other health related topics the Contractor considers to be most beneficial to members), implementing and evaluating targeted Engaging Members through Technology (EMTT) related activities specific to these areas. The Contractor shall submit an EMTT Executive Summary, in report format and as a component of the Contractor's QM/PI Program Plan submission, as specified in AMPM Policy 920 and Section F, Attachment F3, Contractor Chart of Deliverables.

Targeted Investments): AHCCCS' Targeted Investments (TI) program outlines requirements that providers agree to implement to support and enable their ability to offer improved integration of physical and behavioral health services for members. These requirements, identified as core components, are found at www.azahcccs.gov/PlansProviders/TargetedInvestments/. The Contractor shall consider alignment with these core components when developing and implementing strategies to support integration efforts.

23. MEDICAL MANAGEMENT

The Contractor shall ensure an integrated Medical Management (MM) process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from preventive care to hospice care).

The Contractor shall have a process to report MM data and management activities through a MM Contractor MM Committee. The Contractor's MM Committee shall utilize the plan, do, study, act (PDSA) cycle to analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings back to the MM Committee for review and ongoing process improvement. The Contractor shall assess, monitor, and report medical decisions quarterly through the Contractor's MM Committee to assure compliance with timeliness, language, Notice of Adverse Benefit Determination intent and that the decisions comply with all Contractor coverage criteria.

The Contractor shall maintain a written MM Plan and Work Plan that address the monitoring of MM activities. See AMPM Policy 1010. The Contractor shall develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the Contractor shall develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement must be reported in the annual MM Plan, Evaluation, and Work Plan submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall implement processes to assess, plan, implement, evaluate and as mandated, report MM monitoring activities as specified in AMPM Chapter 1000 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall evaluate Medical Management (MM) activities, as specified in the AMPM Chapter 1000, including:

1. Utilization Data Analysis and Data Management [42 CFR 438.330(b)(3)],
2. Concurrent Review [42 CFR 438.208(b)(2)(i)],
3. AMPM Policy for Discharge Planning [42 CFR 438.208],
4. Prior authorization and Service Authorization [42 CFR 438.210(b)(2)],
5. Inter-rater Reliability [42 CFR 438.210(b)(2)(i)],
6. Retrospective Review [42 CFR 438.208(b)(2)(i)],
7. Clinical Practice Guidelines [42 CFR 438.236],
8. New Medical Technologies and New Uses of Existing Technologies,
9. Contractor Care Management and Coordination [42 CFR 438.208],
10. Disease/Chronic Care Management [42 CFR 438.3(s)], and
11. Drug Utilization Review.

The Contractor shall disseminate practice guidelines to all affected providers and to members and potential members upon request [42 CFR 438.236(c)].

The Contractor shall ensure that each member has a designated individual or entity that is primarily responsible for coordinating services for the member. The Contractor shall have procedures to ensure that each member has an assigned primary care provider that provides care appropriate to the member's needs. The Contractor is required to provide the member with information on how to contact their designated individual or entity [42 CFR 438.208(b)(1)].

The Contractor shall make a best effort to conduct an initial screening of each member's needs as outlined in AMPM Policy 910 [42 CFR 438.208(b)(2)(iv)(3)]. The Contractor shall share with the State or other contracted entities serving the member, the results of any identification and assessment of the member's needs to prevent duplication of services and activities [42 CFR 438.208(b)(4)].

The Contractor shall have procedures to coordinate the services provided for members between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)].

The Contractor shall have procedures to coordinate the services provided for members between services provided by the Contractor and services received from other AHCCCS Contractors, from FFS Medicaid, or from the community and social support providers [42 CFR 438.208(b)(2)(i)(ii),(iii),(iv)].

The Contractor shall ensure the provision of care management to assist members who may or may not have a chronic disease but have physical or behavioral health needs or risks that need immediate attention. This care coordination shall assure members get the services they need to prevent or reduce an adverse health outcome. Care management should be short term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention.

The Contractor shall employ care managers to perform Contractor care management functions as required in AMPM Chapters 500 and 1000. Contractor care managers should have expertise in member self-management approaches, member advocacy, navigating complex systems and communicating with a wide spectrum of professional and lay persons including family members, physicians, specialists and other health care professionals. The Contractor shall coordinate care with other AHCCCS Contractors

and PCPs that deliver services to Title XIX/XXI members [42 CFR 438.208(b)(3-4)]. The Contractor shall coordinate care with other AHCCCS Contractors and PCPs that deliver services to Title XIX/XXI members [42 CFR 438.208(b)(3-4)].

The Contractor shall ensure that Contractor care managers are trained on Social Determinants of Health (SDOH) issues and shall have training requirements in place to educate Contractor staff and providers regarding SDOH support addressing the socioeconomic needs of members.

The Contractor shall establish care coordination and Service Plan processes for members designated as having a CRS condition as specified in AMPM Policy 560.

High Need/High Cost: The Contractor shall identify, monitor, and implement interventions for addressing the appropriate and timely to improve care provided to members with high needs and/or high costs who have physical and/or behavioral health needs. The Contractor shall conduct, at a minimum, monthly interdisciplinary team meetings to review and monitor the care provided to the members and to make recommendations for clinical interventions or alternative treatments. The Contractor shall report as specified in Section F, Attachment F3, Contractor Chart of Deliverables. See AMPM Policy 1020.

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

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

Collaboration with Tribal Nations and Providers: The Contractor shall consult with each Tribal Nation within the Contractor's assigned Geographic Service Area(s) (GSAs) to ensure availability of appropriate and accessible services.

24. TELEPHONE PERFORMANCE STANDARDS

The Contractor shall meet and maintain established telephone performance standards to ensure member and provider satisfaction as specified in ACOM Policy 435. The Contractor shall report on compliance with these standards as specified in Section F, Attachment F3, Contractor Chart of Deliverables and ACOM Policy 435. All reported data is subject to validation through periodic audits and/or Operational Reviews.

25. GRIEVANCE AND APPEAL SYSTEM

The Contractor shall have in place a written Grievance and Appeal System process for members, subcontractors, and providers, which defines their rights regarding disputed matters with the Contractor [42 CFR 438.402(a) and 42 CFR 438.228(a)]. The Contractor's Grievance and Appeal System for members includes a grievance process (the procedures for addressing member grievances), an appeals process and access to the State's fair hearing process as outlined in Section F, Attachment F1, Member Grievance and Appeal System Standards.

The Contractor's dispute process for subcontractors and non-contracted providers includes a claim dispute process and access to the State's fair hearing process as outlined in Section F, Attachment F2, Provider Claim Dispute Standards. The Contractor shall remain responsible for compliance with all requirements set forth in Section F, Attachment F1, Member Grievance and Appeal System Standards, Section F, Attachment F2, Provider Claim Dispute Standards, and [42 CFR Part 438 Subpart F].

Information to members must meet cultural competency and Limited English Proficiency requirements as specified in Section D, Paragraph 17, Member Information and Section D, Paragraph 19, Cultural Competency.

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

The Contractor may delegate the Grievance and Appeal System process to Administrative Services Subcontractors, however, the Contractor shall 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. However, the Contractor is not permitted to delegate the Grievance and Appeal System requirements to its providers.

The Contractor shall also ensure that it timely provides written information to both members and providers, which clearly explains the Grievance and Appeal System requirements. This information must include a description of:

1. The right to a State fair hearing, the method for obtaining a State fair hearing,
2. The Rules that govern representation at the hearing,
3. The right to file grievances, appeals and claim disputes,
4. The requirements and timeframes for filing grievances, appeals and claim disputes,
5. The availability of assistance in the filing process,
6. The toll-free numbers that the member can use to file a grievance or appeal by phone,
7. That benefits will continue when requested by the member in an appeal or State fair hearing request concerning certain actions which are timely filed,
8. That the member may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the member, and
9. That a provider may file an appeal on behalf of a member with the member's written consent.

The future enrollment of a Contractor's member to another Contractor and/or the member's subsequent loss of AHCCCS eligibility are not valid reasons to deny or limit a member's service authorization request submitted to the Contractor during the time period in which the member was enrolled with that Contractor. Contractors shall not take the position during the grievance and appeals process that a former member's subsequent enrollment with another Contractor or that member's subsequent loss of AHCCCS eligibility are valid reasons for the Prior Contractor to deny or dismiss an appeal of the adverse benefit determination if the member submitted the service authorization request to the Prior Contractor during a period of enrollment with the Prior Contractor. The Prior Contractor is required to substantiate that the denial or reduction of the service authorization request is based upon medical necessity, the exclusion of the service from the scope of AHCCCS covered services, and/or cost effectiveness. If the authorization decision of the Prior Contractor is overturned on appeal, the Prior Contractor is financially responsible for coverage of those services notwithstanding the member's subsequent enrollment with a different Contractor or the member's subsequent loss of AHCCCS eligibility.

The Contractor shall provide reports on the Grievance and Appeal System as required in the AHCCCS Grievance and Appeal System Reporting Guide and Section F, Attachment F3, Contractor Chart of Deliverables.

26. NETWORK DEVELOPMENT

The Contractor shall develop, maintain and monitor a comprehensive provider network that is diverse and supports the needs of AHCCCS members. The Contractor's network shall be supported by written agreements which are sufficient to provide all covered services to AHCCCS members including those with Limited English Proficiency or physical or cognitive disabilities [42 CFR 438.206(b)(1)]. The Contractor shall ensure covered services are accessible in terms of location and hours of operation as required by AHCCCS Network requirements. The Contractor shall ensure its membership has access to providers at least equal to community.

Regardless of the setting, the Contractor shall develop and implement organizational structures and procedures that promote collaboration and consultation among multi-specialty treatment team members and community providers.

The Contractor's shall ensure access to:

1. Community-based providers including physicians, preventive, primary care, family planning, dental, , laboratory, x-ray, therapy services, and other specialty providers through a network of community-based providers in accordance with network standards and which maximize member choice and ensure timely access to covered services [42 CFR 438.206(b)(7)],
2. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State, and
3. Community-based, family support providers in urban, suburban and rural areas of the State.

There shall be sufficient providers for the provision of all covered services, including emergency medical care on a 24-hour-a-day, seven-days-a-week basis [42 CFR 438.206 (c)(1)(iii)]. 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 is required to have available non-emergent after-hours physician or primary care services within its network.

The Contractor is expected to design a network that provides a geographically convenient flow of patients among network providers to maximize member choice. The Contractor shall allow each member to choose his or her network provider to the extent possible and appropriate [42 CFR 457.1201(j), 42 CFR 438.3(l)]. Services shall be accessible to members in terms of timeliness, amount, duration and scope as those are available to beneficiaries under Fee-For-Service Medicaid [42 CFR 438.210(a)(2)]. The Contractor shall ensure its provider network provides physical access, accessible equipment, reasonable accommodations, culturally competent communications, for all members including those with physical or cognitive disabilities [42 CFR 438.206(c)(3)]. The Contractor may request an exception to these network standards; it shall submit such a request for AHCCCS approval as specified in ACOM Policy 436 and Section F, Attachment F3, Contractor Chart of Deliverables.

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 its provider networks to maximize the availability of community based primary care and specialty care access, including specialists that treat individuals with qualifying medical conditions under A.A.C. R9-22-1303 to ensure, to ensure a reduction in: 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.

For members with special health care needs, including members with CRS conditions who could benefit from a multi-disciplinary approach, covered services shall be delivered through a combination of established Multi-Specialty Interdisciplinary Clinics (MSICs), Field Clinics, Virtual Clinics, and in community settings.

With regard to procedure code T1015 and its application in the MSIC, the MCO shall not make payments for T1015 unless:

1. It is billed by an MSIC, and
2. For a CRS or former CRS member

The MSIC may include all services provided to a member on a single date of service on one claim form or multiple claim forms. If multiple claim forms, the MSIC NPI must be used as the rendering provider on each claim. A single MSIC is eligible for only one T1015 code payment per day.

The use of procedure code T1015 and its application to FQHCs/RHCs remains unchanged.

In the absence of a contract with the MSIC, the Contractor must allow members to utilize the MSIC, and the Contractor shall reimburse the MSIC at the AHCCCS MSIC fee schedule.

Arizona Early Intervention Program: The Contractor shall comply with the requirements of the Arizona Early Intervention Program (AzEIP). The AzEIP is implemented through the coordinated activities of the ADES, ADHS, Arizona State Schools for the Deaf and Blind (ASDB), AHCCCS, and ADE. The AzEIP Program is governed by the Individuals with Disabilities Act (IDEA), Part C (P.L.105-17). AzEIP, through Federal regulation, is stipulated as the payor of last resort to Medicaid, and is prohibited from supplanting another entitlement program, including Medicaid. The Contractor must pay all AHCCCS registered Arizona Early Intervention Program (AzEIP) providers, regardless of their contract status with the Contractor, when

Service Plans identify and meet the requirement for medically necessary EPSDT covered services. Refer to AMPM Policy 430. AHCCCS has developed an AzEIP Speech Therapy Fee Schedule and rates incorporating one procedure code, along with related modifiers, settings, and group sizes. The Contractor shall utilize this methodology and these rates for payment for the speech therapy procedure when provided to an AHCCCS member who is a child identified in the AHCCCS system as an AzEIP recipient.

Centers of Excellence: The Contractor shall promote Centers of Excellence which implement evidence based practices and track outcomes for members with specialized healthcare needs. See Section D, Paragraph 75, Value-Based Purchasing.

Network Development and Management Plan: The Contractor shall develop and maintain a Network Development and Management Plan (NDMP) to demonstrate that it maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area and which ensures the provision of covered services [42 CFR 438.207(b)(1) and 42 CFR 438.207(b)(2)]. The submission of the NDMP to AHCCCS is an assurance of the adequacy and sufficiency of the Contractor's provider network. The NDMP shall be evaluated, updated annually and submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The NDMP must include the requirements outlined in ACOM Policy 415.

The Contractor shall continually assess network sufficiency and capacity using multiple data sources to monitor appointment standards, member grievances, appeals, quality data, quality improvement data, utilization of services, member satisfaction surveys, and demographic data requirements. The Contractor shall also develop non-financial incentive programs to increase participation in its provider network when feasible [42 CFR 438.604(a)(5), 42 CFR 438.606, 42 CFR 438.207(b), 42 CFR 438.206].

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

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)(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)(2)]. 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)]. 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 employ or contract with providers who are 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)].

The Contractor is also encouraged to develop non-financial incentive programs to increase participation in its provider network.

Graduate Medical Education (GME) Residency Training Programs: 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 GME Residency Training Program or training site, the Contractor may not remove members from that program in such a manner so 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.

Telehealth: Telehealth is defined as healthcare services delivered via teledentistry, telemedicine (synchronous and remote patient monitoring), or asynchronous (store and forward) technologies. The Contractor shall promote the use of telehealth to support an adequate provider network. Telehealth shall not replace provider choice and/or member preference for physical delivery of services. The Contractor shall be responsible for the oversight, administration, and implementation of telehealth services in compliance with State and Federal laws and the requirements of this Contract and all incorporated references. The Contractor shall ensure that telehealth is available and utilized, when appropriate, to ensure geographic accessibility of services to members. The Contractor shall be responsible for developing and expanding the use and availability of telehealth services, when indicated and appropriate. See AMPM Policy 320-I.

27. PROVIDER AFFILIATION TRANSMISSION

The Contractor must submit information regarding its preferred provider network in the format described in the AHCCCS Provider Affiliation Transmission (PAT) User Manual, which can be found on the AHCCCS website. The PAT shall be submitted as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

28. NETWORK MANAGEMENT

The Contractor shall have written policies and procedures on how the Contractor will [42 CFR 438.12(a)(2), 42 CFR 438.214(a)]:

1. Communicate with the network regarding Contractual and/or program changes and requirements,
2. 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,
3. Evaluate the quality of services delivered by the network,
4. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the Contracted service area,
5. 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,
6. Process provisional credentials,
7. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling,
8. Provide training for its providers and maintain records of such training,
9. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate, and

10. Ensure that provider calls are acknowledged within three business days of receipt; resolved and 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/DHCM, and shall be monitored through Operational Reviews.

The Contractor shall monitor providers to demonstrate compliance with all applicable network requirements in this Contract.

Provider Forums: The Contractor shall hold a Provider Forum no less than semi-annually. The forum must be chaired by the Contractor's Administrator/CEO or designee. The purpose of the forum is to improve communication between the Contractor and its providers. The forum shall be open to all providers including dental providers. The Provider Forum shall not be the only venue for the Contractor to communicate and participate in the issues affecting the provider network. Provider Forum meeting agendas and minutes must be made available to AHCCCS upon request. The Contractor shall report information discussed during these Forums to Executive Management within the organization.

Material Change to the Provider Network: The Contractor is responsible for evaluating all provider network changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's provider network. These changes could include, but would not be limited to, changes in services, covered benefits, geographic service areas, composition of or payments to its provider network, or eligibility of a new population. Material changes to the provider network must be approved in advance by AHCCCS. The Contractor must submit the required documentation as outlined in ACOM Policy 439 and Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.604(a)(5), 42 CFR 438.606, 42 CFR 438.207(b)(c), 42 CFR 438.206].

See Section D, Paragraph 42, regarding material changes by the Contractor that may impact business operations.

See Section D, Paragraph 53, Capitation Adjustments regarding material changes by the Contractor that may impact capitation rates.

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

Provider/Network Changes Report: The Contractor shall comply with ACOM Policy 415 and submit the Provider/Network Changes Due to Rates Report as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

29. PRIMARY CARE PROVIDER STANDARDS

The Contractor shall include in its provider network a sufficient number of Primary Care Providers (PCPs) to meet the requirements of this Contract [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 the PCP. The

Contractor shall adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. AHCCCS shall inform the Contractor when a PCP has a panel of more than 1800 AHCCCS members (i.e. 1800 report), to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis.

The Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP who serves as a coordinator in referring the member for specialty medical services and that the Contractor's data regarding PCP assignments is current. The Contractor is encouraged to develop a methodology to assign members to those providers participating in Value-Based purchasing initiatives who have demonstrated high value services or improved outcomes. 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 provide information to the member on how to contact the member's assigned PCP [42 CFR 438.208(b)(1)].

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 ensure that primary care services are available and accessible in the communities in which members would access routine health care services. In addition, the Contractor shall have a network of specialty providers available to provide care and services in the community in addition to those specialty and multi-disciplinary services that are available through the MSIC, thereby maximizing member choice.

The Contractor shall offer members freedom of choice within its network in selecting a PCP consistent with [42 CFR 438.6(m), 438.52(d), 438.14(b)(3)] 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 days of the Contractor's receipt of notification of assignment by AHCCCS. See ACOM Policy 404 and ACOM Policy 406 for member information requirements.

At a minimum, the Contractor shall hold the PCP responsible for the following activities:

1. Supervising, coordinating and providing care to each assigned member (except for well woman exams children's dental services when provided without a PCP referral,
2. Initiating of referrals for medically necessary specialty care,
3. Maintaining continuity of care for each assigned member,
4. 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,
5. Utilizing the AHCCCS approved EPSDT Tracking form,
6. 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,
7. If serving children, for enrolling as a Vaccines for Children (VFC) provider, and

8. Check the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) when prescribing controlled medications in accordance with A.R.S §36-2606.

See also requirements outlined in AMPM Policy 510.

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.

30. MATERNITY CARE PROVIDER REQUIREMENTS

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

1. Arizona licensed allopathic and/or osteopathic physicians who are Obstetricians or general practice/family practice providers who provide maternity care services,
2. Physician Assistants,
3. Nurse Practitioners,
4. Certified Nurse Midwives, and
5. Licensed Midwives.

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

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

31. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

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

1. Use of referral forms clearly identifying the Contractor,

2. A 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,
3. 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,
4. Referral to Medicare,
5. Women shall have direct access to in-network gynecological providers, including physicians, physician assistants and nurse practitioners within the scope of their practice [42 CFR 438.206(b)(2)], and
6. 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.

The Contractor must allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

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

1. Clinical laboratory services,
2. Physical therapy services,
3. Occupational therapy services,
4. Outpatient speech-language pathology services,
5. Radiology and certain other imaging services,
6. Radiation therapy services and supplies,
7. Medical equipment, including appliances and supplies,
8. Parenteral and enteral nutrients, equipment and supplies,
9. Prosthetics, orthotics and prosthetic devices and supplies,
10. Home health services,
11. Outpatient prescription drugs, and
12. Inpatient and outpatient hospital services.

32. APPOINTMENT STANDARDS

The Contractor shall actively monitor and track provider compliance with appointment availability standards as required in AMPM Policy 1020 and ACOM Policy 417 [42 CFR 438.206(c)(1)]. The Contractor shall ensure that providers offer a range of appointment availability, per appointment timeliness standards, for intakes, initial services and ongoing services based upon the clinical need of the member. The exclusive use of same-day only appointment scheduling, and/or open access, is prohibited within the Contractor's network. The Contractor is required to conduct regular reviews of the availability of providers and report this information as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation, end of life care or hospice 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.

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

If the Contractor's 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)].

For medically necessary non-emergent transportation, the Contractor shall schedule transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment. 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 regarding appointment time requirements. The Contractor must develop a corrective action plan when appointment standards are not met. In addition, the Contractor must develop a corrective action plan in conjunction with the provider when appropriate [42 CFR 438.206(c)(1)(iv)(v) and (vi)]. Appointment standards shall be included in the Contractor's Provider Manual. The Contractor is encouraged to include the standards in the provider subcontracts.

33. FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

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

To ensure compliance with the requirement of [42 USC 1396 b (m)(2)(A)(ix)] that the Contractor's payments, in aggregate, will not be less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC or FQHC Look-Alike, the Contractor shall pay the unique PPS rates to FQHCs/RHCs and FQHC Look-Alikes

for PPS-eligible visits. Reimbursement of case management, behavioral health group therapy, and telehealth and telemedicine services provided by a FQHC or RHC shall be in accordance with AMPM Policy 670. For services not eligible for PPS reimbursement, the Contractor shall negotiate rates of payment with FQHCs/RHCs and FQHC Look-Alikes for non-pharmacy services that are comparable to the rates paid to providers that provide similar services.

The Contractor shall be required to submit member information for members for each FQHC/RHC/FQHC Look-Alike as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS will perform periodic audits of the member information submitted. Refer to the AHCCCS Financial Reporting Guide for further guidance. The FQHCs/RHCs and FQHC Look-Alike registered with AHCCCS are listed on the AHCCCS website.

See Section D, Paragraph 9, Scope of Services, *Prescription Medications* for information related to 340B Drug Pricing.

34. PROVIDER MANUAL

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

35. PROVIDER ENROLLMENT/TERMINATION

The Contractor shall ensure that all of its subcontractors register with AHCCCS as an approved service provider (i.e. AHCCCS registered provider) consistent with provider disclosure, screening, and enrollment requirements [42 CFR 438.608(b), 42 CFR 455.100-106, 42 CFR 455.400-470]. This includes, but may not be limited to, the Contractor ensuring that all subcontractors provide to AHCCCS their identifying information such as name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

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

The National Provider Identifier (NPI), for all providers eligible for an NPI, is required on all claim submissions from providers and subsequent encounters from MCO's to AHCCCS. The Contractor shall work with providers to obtain the NPI. AHCCCS reserves the right to withhold all payments for services where a provider who is eligible for enrollment with AHCCCS has not become an AHCCCS registered provider. AHCCCS further reserves the right to recoup or recover all payments made to such a provider who was eligible for enrollment with AHCCCS but has not become an AHCCCS registered provider.

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.

AHCCCS will screen and enroll, and periodically revalidate all of the Contractor's subcontracted providers as Medicaid providers as required by [42 CFR 438.602(b)(1)].

36. SUBCONTRACTS

The Contractor shall be held fully liable for the performance of all Contract requirements. Subject to limitations as outlined in this Contract, any function required to be provided by the Contractor pursuant to this Contract may be subcontracted to a qualified individual or organization [42 CFR 438.6]. Notwithstanding any relationship(s) the Contractor may have with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract [42 CFR 438.230(b)(1), 42 CFR 438.3(k)].

The Contractor shall oversee, and is accountable for, any functions and responsibilities that it delegates to any subcontractor [42 CFR 438.230(a)]. All such subcontracts must be in writing [42 CFR 438.6(l)].

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

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

The Contractor shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this Contract [42 CFR 434.6(c)].

The Contractor may not employ or contract with providers who are 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)].

The Contractor shall require subcontracted providers to adhere to the requirements of the Arizona Opioid Epidemic Act SB1001, Laws 2018. First Special Session.

Minimum Subcontract Provisions: All subcontracts must reference and require compliance with the Minimum Subcontract Provisions (MSPs). See the AHCCCS Minimum Subcontract Provisions on the AHCCCS website.

In addition, each subcontract must contain the following:

1. Subcontractor activities and obligations, and related reporting responsibilities [42 CFR 438.230(c)(1)(i), 42 CFR 438.3(k)],
2. A provision requiring subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with Contract obligations [42 CFR 438.230(c)(1)(ii), 42 CFR 438.3(k)],

3. A provision that requires the subcontractor to comply with all applicable Medicaid laws, regulations, including applicable sub regulatory guidance and Contract provisions [42 CFR 438.230(c)(2), 42 CFR 438.3(k)],
4. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor,
5. Identification of the name and address of the subcontractor,
6. Identification of the population, to include patient capacity, to be covered by the subcontractor,
7. The amount, duration and scope of services to be provided, and for which compensation will be paid,
8. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation,
9. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability,
10. The specific duties of the subcontractor relating to coordination of care for all members,
11. 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,
12. A description of the subcontractor's patient, medical, dental and cost record keeping system,
13. Specification that the subcontractor shall cooperate with quality management programs, and comply with the utilization control and review procedures specified in [42 CFR Part 456], as specified in the AMPM,
14. A provision stating that a Change in Contractor Organizational Structure of an Administrative Services Subcontractor shall require a contract amendment and prior approval of AHCCCS,
15. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population,
16. 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,
17. A provision that the subcontractor must obtain any necessary authorization from the Contractor or AHCCCS for services provided to eligible and/or enrolled members,
18. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract,
19. 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,
20. A provision for revocation of the delegation of activities or obligations, or specifies other remedies in instances where AHCCCS or the Contractor determines that the subcontractor has not performed satisfactorily [42 CFR 438.230(c)(1)(iii), 42 CFR 438.3(k)],
21. 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,
22. 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 member [42 CFR 438.210(e)],
23. A provision that the State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's Contract with the State [42 CFR 438.230],
24. A provision that the subcontractor will make available, for purposes of an audit, evaluation, or inspection under Paragraph (c)(3)(i) of 42 CFR 438.230, its premises, physical facilities, equipment,

books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees [42 CFR 438.230], and

25. A provision that the right to audit under Paragraph (c)(3)(i) of 42 CFR 438.230 will exist through 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later [42 CFR 438.230].

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

The Contractor shall not delegate the quality of care investigations processes or onsite quality of care visits to Administrative Services Subcontractors or providers.

Provider Agreements: The Contractor shall not include covenant-not-to-compete requirements in its provider agreements. Furthermore, the Contractor shall not prohibit a provider from providing 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. In addition, the Contractor shall require subcontracted providers to adhere to the requirements outlined in AMPM Chapter 600.

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

In all contracts with network providers, the Contractor must comply with any additional provider selection requirements established by the State [42 CFR 438.12(a)(2), 42 CFR 438.214(e)].

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

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

Administrative Services Subcontracts: All Administrative Services Subcontracts entered into by the Contractor require prior review and written approval by AHCCCS, and shall incorporate by reference the applicable terms and conditions of this Contract. Proposed Administrative Services Subcontracts shall be submitted as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS will not permit one organization to own or manage more than one contract within the same program in the same GSA. The Contractor's Administrator/CEO must retain the authority to direct and prioritize any delegated contract requirements.

The Contractor shall not delegate the quality of care investigations processes or onsite quality of care visits to Administrative Services Subcontractors or providers.

Before entering into an Administrative Services 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 Administrative Services Subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the Administrative Services Subcontractor's performance is inadequate.

In order to determine adequate performance, the Contractor shall monitor the Administrative Services Subcontractor's performance on an ongoing basis and subject it to formal review at least annually or more frequently if requested by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the Administrative Services Subcontractor in order to establish a corrective action plan [42 CFR 438.230(b)]. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion. Additionally, if at any time during the period of the Administrative Services Subcontract the subcontractor is found to be in non-compliance, the Contractor shall notify AHCCCS and comply with ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor must submit an annual Administrative Services Subcontractor Evaluation Report as specified in ACOM Policy 438 and Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall require Administrative Services Subcontractors to adhere to screening and disclosure requirements as described in Section D, Paragraph 60, Corporate Compliance.

A change to a subcontract due to a Change in Contractor Organizational Structure of an Administrative Services Subcontractor requires prior approval of AHCCCS, as outlined in ACOM Policy 438.

Management Services Agreement and Cost Allocation Plan: If the Contractor has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS/DHCM in accordance with ACOM Policy 438. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or cost allocations made.

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

The performance of management service subcontractors must be evaluated and included in the Annual Subcontractor Assignment and Evaluation Report required by Section D, Paragraph 36, Subcontracts and Section F, Attachment F3, Contractor Chart of Deliverables and as outlined in ACOM Policy 438.

Pharmacy Benefit Manager Subcontracts Pass-Through Pharmacy Benefit Manager Pricing Model and Discrete Administrative Fee: The Contractor shall amend the subcontract between the Contractor and its Pharmacy Benefit Manager (PBM) to reflect a pass-through pricing model, in which the Contractor reimburses the PBM in the exact amount of actual payments of incurred pharmacy claims made to pharmacies. The PBM may charge a discrete administrative fee to the Contractor. This expense shall be

reported by the Contractor as an administrative expense to AHCCCS and shall not be included in the encounter amount. The discrete administrative fee shall be reported to AHCCCS in the quarterly financial reporting packages as directed in the AHCCCS Financial Reporting Guide. See Section F, Attachment F3, Contractor Chart of Deliverables. Contractor pharmacy encounters must be submitted in accordance with the requirements in Section D, Paragraph 61, Encounter Data Reporting. The Contractor shall submit the PBM subcontract to AHCCCS in order to demonstrate that it is in compliance with the above provisions as stated in Section F, Attachment F3, Contractor Chart of Deliverables.

PBM Reimbursement Provisions: The Contractor shall include specific content below in Pharmacy Benefit Manager (PBM) subcontracts for reimbursement:

Brand Name Drugs: The Contractor's contract with the PBM shall provide a Guaranteed Brand Drug Discount Rate and require the reimbursement of brand name medications, in aggregate, at a minimum, to be the following:

1. *84-Day Supply or Less:* The lesser of Average Wholesale Price (AWP) less 18% or the Usual & Customary price, and
2. *Greater than an 84-Day Supply:* The lesser of AWP less 19.50% or the Usual & Customary price.

The Guaranteed Discount Rate shall be calculated quarterly to ensure the PBM is meeting the brand name drug reimbursement guarantee for branded legend and Over-the-Counter branded drugs.

Generic Drugs: The Contractor's contract with the PBM shall require the reimbursement of generic drugs to be guaranteed, in aggregate, at AWP less 84% for all Days Supplies dispensed. The calculation of the aggregate guarantee shall include all generic drugs, including single source, multisource and Over-the-Counter generic drugs and generic drug claims reimbursed at Usual & Customary pricing. All generic drugs shall be reimbursed to network pharmacies at the lesser of the Maximum Allowable Cost (MAC), AWP less 18%, or Usual & Customary pricing.

The Generic Drug Guarantee shall be calculated twice annually in accordance with the following schedule: January 1 through June 30 and July 1 through December 31.

Specialty and Biosimilar Drugs: The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate for Specialty and Biosimilar Drugs and require the reimbursement of these drugs to be, in aggregate, at a minimum, to be the lesser of AWP less 18.25%, MAC (if applicable) or the Usual & Customary price.

Mail Order Prescriptions Services: The Contractor's contract with the PBM shall provide a Guaranteed Discount Rate for Mail Order Prescriptions Services and require the reimbursement of these drugs to be, in aggregate, at a minimum, to be the lesser of AWP less 24% or the Usual & Customary price. This is applicable to Contractors providing mail order services when the pharmacy is owned or under the same umbrella of companies as the PBM. This does not apply to the retail networks.

PBM - Rebate Payment: AHCCCS suggests that the Contractor include the content below in PBM subcontracts for reimbursement when the PBM is paying a flat fee rebate, a percentage rebate, or a market share rebate to the Contractor for prescription utilization:

1. Rebate guarantees based on a minimum flat rate fee, a percentage or market share rebate shall be compared, in total, to the collected rebates by the PBM. The PBM shall provide the Contractor with

- the minimum flat rate rebate, the percentage rebate, the market share rebate, or 100% of the collected rebates, whichever is greater for all prescription utilization,
2. The PBM subcontract should include a clause that allows for an annual review of the contract for rate setting, adjustments to market conditions, and to ensure network adequacy,
 3. The PBM subcontract should include language that allows the Contractor to terminate the PBM subcontract without cause and without penalty,
 4. The PBM subcontract should include language requiring the PBM to monitor generic drug pricing with specific timelines and report back to the Contractor on the monitoring to ensure that adjustments are made to the pricing when drug pricing increases or erodes. The language should include a specific response time for pricing resolution when inquiries are brought to the attention of the PBM by the Contractor or Network Pharmacy, and
 5. The PBM subcontract should consider language with performance guarantees that address adherence to the AHCCCS Drug List Preferred Agents for the AHCCCS Supplemental Rebate Classes Preferred Agents.

37. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

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

General Claims Processing Requirements: Claims submission deadlines shall be calculated from the claim end date of service, inpatient claim date of discharge or the effective date of eligibility posting, whichever is later as stated in A.R.S. §36-2904. Additionally, unless a subcontract specifies otherwise, the Contractor shall ensure that for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)(5) and (6), 42 CFR 447.46, Sections 1932(f) and 1902(a)(37)(A) of the Social Security Act].

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

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
2. Multiple Procedure/Surgical Reductions, and
3. Global Day E & M Bundling standards.

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

1. Benefit Package Variations,
2. Timeliness Standards,
3. Data Accuracy,
4. Adherence to AHCCCS Policy,
5. Provider Qualifications,
6. Member Eligibility and Enrollment, and
7. Over-Utilization Standards.

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

1. The reason(s) for denials and adjustments,
2. A detailed explanation/description of all denials, payments and adjustments,
3. The amount billed,
4. The amount paid,
5. Application of COB and copays, and
6. Provider rights for claim disputes.

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

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT. See Section D, Paragraph 62, Systems and Data Exchange Requirements, for specific standards related to remittance advice and EFT payment.

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

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

The Contractor is required to reimburse AHCCCS registered providers that are county departments of health for adult immunization services at the AHCCCS fee schedule in the absence of a Contract or negotiated rate.

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

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

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

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

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

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

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

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

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

Claims Processing Related Reporting: The Contractor shall submit to AHCCCS a Claims Dashboard in conformance with the AHCCCS Claims Dashboard Reporting and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

1. Verification that provider contracts are loaded correctly, and
2. Accuracy of payments against provider contract terms.

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

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

Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services: The Contractor shall comply with ACOM Policy 432, regarding benefit coordination and delineation of financial responsibility for AHCCCS covered physical and behavioral health services provided to AHCCCS members who are not enrolled in an integrated line of business.

38. 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 to utilize the specialty contract if such action is determined to be in the best interest of the State; however, in no case shall reimbursement exceeding that payable under the relevant AHCCCS specialty contract be considered in capitation rate development or risk sharing arrangements, including reinsurance.

During the term of specialty contracts, AHCCCS may act as an intermediary between the Contractor and specialty Contractors to enhance the cost effectiveness of service delivery, medical management and

adjudication of claims related to such payments provided under specialty contracts shall remain the responsibility of the Contractor.

AHCCCS has specialty contracts, including but not limited to, transplant services, anti-hemophilic 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.

See Section D, Paragraph 55, Reinsurance for more information.

39. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

In the absence of a contract between the Contractor and a hospital providing otherwise, the Contractor shall reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. §36-2904 and §36-2905.01, 36-2905.03, and 9 A.A.C. 22, Article 7, sets forth requirements for: reimbursement of the majority of inpatient hospital services using the APR-DRG payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81, reimbursement of limited inpatient hospital services using per diem rates described in A.A.C. R9-22-712.61; reimbursement of inpatient services provided by non-contracted hospitals in Pima and Maricopa counties at 95% of the amounts otherwise payable for inpatient services; and reimbursement of inpatient behavioral health services provided by non-contracted behavioral health inpatient facilities (in any county) at 90% of the AHCCCS Fee-For-Service rates.

The Contractor may conduct prepayment, concurrent and post-payment medical reviews of all hospital claims including outlier claims. Erroneously paid claims may be subject to recoupment. If the Contractor fails to identify lack of medical necessity through prepayment and/or concurrent medical review, lack of medical necessity shall not constitute a basis for recoupment of paid hospital claims, including outlier claims, unless the Contractor identifies the lack of medical necessity through a post-payment medical review of information that the Contractor could not have discovered during a prepayment and/or concurrent medical review through the exercise of due diligence. The Contractor shall comply with Section D, Paragraph 37, Claims Payment/Health Information System.

For information on Differential Adjusted Payments see Paragraph 51, *Compensation*.

40. RESPONSIBILITY FOR NURSING FACILITY REIMBURSEMENT

The Contractor shall provide medically necessary nursing facility services as outlined in Section D, Paragraph 9, Scope of Services. The Contractor shall also provide medically necessary nursing facility services for any enrolled member who has a pending ALTCS application who is currently residing in a nursing facility and is eligible for services provided under this Contract. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days per Contract Year of nursing facility coverage, the Contractor is only responsible for nursing facility reimbursement during the time the member is enrolled with the Contractor as shown in the PMMIS. Nursing facility services covered by another liable party (including Medicare) while the member is enrolled with the Contractor, shall be applied to the 90 day per Contract Year limitation.

The Contractor shall not deny nursing facility services when the member's eligibility, including prior period coverage, had not been posted at the time of admission. In such situations the Contractor shall impose reasonable authorization requirements. There is no ALTCS enrollment, including prior period coverage, which occurs concurrently with AHCCCS acute enrollment.

The Contractor shall notify the Assistant Director of AHCCCS/DMS, when a member has been residing in a nursing facility, alternative residential facility or receiving home and community based services for 45 days as specified in Section D, Paragraph 9, Scope of Services, under the heading *Nursing Facility services*. This will allow AHCCCS time to follow-up on the status of the ALTCS application and to consider potential Fee-For-Service coverage if the stay goes beyond the 90 day per Contract Year maximum.

For information on Differential Adjusted Payments see Section D, Paragraph 51, *Compensation*.

41. PHYSICIAN INCENTIVES

Physician Incentives

The Contractor must ensure compliance with all applicable physician incentive requirements, including but not limited to [Section 1903 (m)(2)(A)(x) of the Social Security Act, 42 CFR 438.10(f)(3), 42 CFR 438.3(i), 42 CFR 422.208(c)(1)-(2) and 42 CFR 422.210]. These regulations, in part prohibit Contractors from operating any physician incentive plan that directly or indirectly makes payments to a physician or physician group as an inducement to limit or reduce medically necessary services to a member.

The Contractor shall not enter into contractual arrangements that place providers at substantial financial risk as defined in [42 CFR 422.208], unless prior written approval of the contractual arrangement is received by AHCCCS. For those proposed contractual arrangements which meet the definition of substantial financial risk, the following must be submitted to the AHCCCS for review and approval as specified in Section F, Attachment F3, Contractor Chart of Deliverables [42 CFR 438.6(g)]:

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

Upon request from CMS or AHCCCS, the Contractor shall promptly disclose all requested information regarding its physician incentive plans. In addition, the Contractor shall provide the information specified in [42 CFR 422.210] to any member who requests it.

Any Contractor-selected and/or developed physician incentive that meets the requirements of [42 CFR 417.479] must be approved by AHCCCS prior to implementation as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

AHCCCS shall review the Value-Based Purchasing (VBP) deliverables required under Section D, Paragraph 74, Value-Based Purchasing.

42. MATERIAL CHANGE TO BUSINESS OPERATIONS

The Contractor is responsible for evaluating all operational changes, including unexpected or significant changes, and determining whether those changes are material changes to the Contractor's business operations [42 CFR 438.207(c)]. All material changes to business operations must be approved in advance by AHCCCS.

The Contractor must submit the request for approval of a material change to business operations as outlined in ACOM Policy 439 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. A material change to business operations is defined as any change in overall business operations (e.g. policy, process, protocol such as prior authorization or retrospective review) that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as described in this Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.

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

See Section D, Paragraph 28, regarding material changes by the Contractor that may impact the provider network.

See Section D, Paragraph 62, for additional submission requirements regarding system changes and upgrades.

43. RESERVED

44. RESERVED

45. RESERVED

46. ACCUMULATED FUND DEFICIT

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

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

47. ADVANCES, EQUITY DISTRIBUTIONS, AND LOANS

The Contractor shall not, without the prior approval of AHCCCS, make any advances, equity distributions, loans or loan guarantees, including, but not limited to those to related parties or affiliates including another fund or line of business within its organization. The Contractor shall not, without prior approval of AHCCCS, make individual or cumulative loans, loan guarantees, or advances to providers equal to or in excess of \$50,000 per Provider Tax Identification Number (TIN) within a contract year. The Contractor is required to report all repayment of advances, equity distributions, loans, loan guarantees, or investments as specified in Section F, Attachment F3, Contractor Chart of Deliverables and ACOM Policy 418. All requests for prior approval are to be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Refer to ACOM Policy 418 for further information.

48. FINANCIAL VIABILITY STANDARDS

The Contractor must comply with the AHCCCS-established financial viability standards or any revisions or modifications of the standards, in conformance with the AHCCCS Financial Reporting Guide. On a quarterly basis, AHCCCS will review the following ratios with the purpose of monitoring the financial health of the Contractor: current ratio; medical loss ratio; and the administrative cost percentage [42 CFR 438.116 (a) and (b)]. Additional information regarding the Equity per Member requirement may be found in ACOM Policy 305.

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 loss and administrative ratio results. However, if a critical combination of the Financial Viability Standards is not met, additional monitoring, such as monthly reporting, may be required.

Financial Viability Standards:

Current Ratio Current assets less due from affiliates divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%).

Standard: At least 1.00

Other Assets deemed restricted by AHCCCS are excluded from this ratio. See the AHCCCS Financial Reporting Guide for more information.

Performance Guidelines:

Medical Loss Ratio Incurred claims plus expenditures for activities that improve health care quality, divided by premium revenue less Federal, State, and local taxes and licensing and regulatory fees. For additional information see the AHCCCS Financial Reporting Guide.

Standard: At least 85%

Administrative Cost Percentage Total administrative expenditures – administrative expenditures for activities that improve health care quality included in the Medical Loss Ratio above, divided by premium revenue less Federal, State, and local taxes and licensing and regulatory fees. For additional information see the AHCCCS Financial Reporting Guide.

Standard: No more than 15%

Medical Loss Ratio: The Contractor shall submit a Medical Loss Ratio (MLR) Report in compliance with [42 CFR 438.8], as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Any retroactive changes to capitation rates after the Contract Year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to AHCCCS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by AHCCCS. For additional information see the AHCCCS Financial Reporting Guide.

The Contractor shall comply with all financial reporting requirements contained in Section F, Attachment F3, Contractor Chart of Deliverables and the AHCCCS Financial Reporting Guide. The required reports are subject to change during the contract Term and are summarized in Section F, Attachment F3, Contractor Chart of Deliverables.

The Contractor must submit unaudited financial information, including financial statements, in an Excel file through SharePoint via the Financial Reporting Package, and a flat file through the FTP server, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor must utilize both the AHCCCS prepared Excel template and the flat file specifications as specified in the AHCCCS Financial Reporting Guide.

49. RESERVED

50. CHANGE IN CONTRACTOR ORGANIZATIONAL STRUCTURE

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

51. COMPENSATION

The method of compensation under this Contract will be Prior Period Coverage (PPC) capitation, prospective capitation, and reinsurance, as described and defined within this Contract, special provisions for payment as described in Section D, Paragraph 51, and appropriate laws, regulations and policies [42 CFR 438.6(b)(1)]. Final capitation rates are identified and developed, and payment is made in accordance with 42 CFR 438.3(c) [42 CFR 457.1201(c)]. Capitation payments may only be made by the State and retained by the Contractor for Medicaid-eligible members [42 CFR 438.3(c)(2)].

Capitation rates are developed by AHCCCS according to the applicable provisions of 42 CFR Part 438 and applicable Actuarial Standards of Practice, and following generally accepted actuarial principles and practices. AHCCCS provides the following data to its actuaries to establish rates for the purposes of rebasing and/or updating the capitation rates:

1. Utilization and unit cost data derived from fully adjudicated and approved encounters, as well as individual encounter level detail as needed,
2. Both audited and unaudited financial statements [42 CFR 438.3(m)] reported by Contractors,
3. Market basket inflation trends,
4. AHCCCS Fee-For-Service schedule pricing adjustments, if applicable,
5. Historical and projected enrollment by risk group,
6. Programmatic or Medicaid covered service changes that affect reimbursement,
7. Additional administrative requirements for the Contractor, and
8. Additional administrative requirements for the Contractor that affect reimbursement.

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

1. Reinsurance (as described in Section D, Paragraph 55, Reinsurance),
2. Age/Gender,
3. Medicare enrollment,
4. Geographic Service Area adjustments,
5. Risk sharing arrangements for specific populations, and
6. Member specific statistics, e.g. member acuity, member choice, member diagnosis, etc.

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 or the Arizona Medicaid Section 1115 Demonstration Waiver Special Terms and Conditions approved by CMS; however those services are not included in the data provided to actuaries for setting capitation rates [42 CFR 438.6(e)] (Section 1903(i) and 1903(i)(17) of the Social Security Act). Graduate Medical Education payments (GME) are not included in the capitation rates but paid out separately consistent with the terms of Arizona's State Plan. Likewise, because AHCCCS does not delegate any of its responsibilities for administering Electronic Health Record (EHR) incentive payments to the Contractor, EHR payments are also excluded from the capitation rates and are paid out separately by AHCCCS pursuant to Section 4201 of the HITECH Act, 42 USC 1396b(t), and [42 CFR 495.300 et seq].

In instances in which AHCCCS has specialty contracts or legislation/policy limits the allowable reimbursement for certain services or pharmaceuticals, 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.

Capitation rate development will not include costs for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

The Contractor will be denied payment for newly enrolled members when, and for so long as, payment for those members is denied by CMS under [42 CFR 438.730(e), 42 CFR 438.726(b), 42 CFR 438.700(b)(1) - (6), 42 CFR 438.730(e)(1)(i), 42 CFR 438.730(e)(1)(ii), Section 1903(m)(5)(B)(ii) of the Social Security Act].

The Contractor shall not provide any case management services to CMDP members that are covered under Contract via the Interagency Service Agreement between DCS and AHCCCS. AHCCCS shall recoup capitation payments, or withhold future capitation payments, for any duplicative case management services provided by CMDP and DCS.

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

The Contractors will not receive PPC capitation for newborns of members who are enrolled at the time of delivery. There is no PPC capitation for members enrolled with the Contractor who are initially found eligible for AHCCCS through Hospital Presumptive Eligibility. These members will receive coverage of services during the PPC period through AHCCCS Fee-For-Service.

Reconciliation of Costs to Reimbursement: AHCCCS will reconcile the Contractor's total medical cost expenses (prospective and PPC) to total capitation paid (prospective and PPC) to the Contractor. Refer to ACOM Policy 329 for further details. For CYE20, this reconciliation will limit the Contractor's profits and losses as follows:

Profit	MCO Share	State Share	Max MCO Profit	Cumulative MCO Profit
<= 6%	100%	0%	6%	6%

Loss	MCO Share	State Share	Max MCO Loss	Cumulative MCO Loss
<= 2%	100%	0%	2%	2%

Premium Tax: A.R.S. §36-2905 and A.R.S. §36-2944.01 require that the Contractor report and pay premium tax quarterly to ADOI based on Title XIX/XXI payments received from AHCCCS during the quarter being reported. Capitation payments, reinsurance payment, reconciling payments/recoupments, supplemental payments, cost settlements, and health insurance provider fee payments, will have the Premium Tax included in the payments/recoupments. Premium tax report(s) shall be due to DHCM as specified in Section F, Attachment F3, Contractor Chart of Deliverables. See ACOM Policy 304.

Differential Adjusted Payments: AHCCCS has introduced multiple Differential Adjusted Fee Schedules to distinguish providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. Federal regulation mandates that these payments be prior-approved by CMS before the Differential Adjusted Payments (DAP) shall be implemented. AHCCCS will notify the Contractor when CMS approves each of these DAPs. AHCCCS may amend the DAP components effective October 1, 2020, including but not limited to, the qualifications, rate adjustments, and/or providers eligible for the increases. The Contractor will support the Rate Differential in accordance with [42 CFR 438.6(c)(1)(iii)(B)]. The DAP effective October 1, 2019 require that the Contractor shall adjust payments for specified providers and provider types as listed below, in addition to any AHCCCS fee for service rate changes adopted by the Contractor, to the qualified providers. This DAP increase to rates should be included on all payments made to qualified providers (including sub-capitation and block payment arrangements). These DAP payments are described in the Public Notices and Opportunities for Public Comment – Rates and Supplemental Payment - DAP public notice documents "AHCCCS Differential Adjusted Payment (DAP) Activity CYE 2020 Final Public Notice, Originally Posted April 30, 2019, and Revised May 21, 2019", as well as described in any fee for service rate public notices that are applicable to the same time period posted to the AHCCCS website:

https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/rates/FinalNoticeOfPublicInformationDifferentialAdjustedPaymentsEffectiveOctober_1_2019-September_30_2020_DatesOfService.pdf

DAP rates apply to the following qualified providers:

1. Nursing Facility (Provider Type 22)
2. Hospital subject to APR-DRG Reimbursement (Provider Type 02)
3. Critical Access Hospital (Provider Type 02)
4. Other Hospitals and Inpatient Facilities (Psychiatric Hospitals with the exception of public hospitals, Provider Type 71, Subacute Facilities (1- 16 Beds), Provider Type B5, Rehabilitation
5. Integrated Clinic
6. Behavioral Health Outpatient Clinics and Integrated Clinics (Provider Type 77), and Integrated Clinics (Provider Type IC)
7. Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31)
8. Dental Providers (Provider Types D1, D2, D3, D4, 07, 54)
9. Home and Community Based Services Providers (Provider Types A3, FI, IC, 23, 39, 40, 46, 77, and 95)

AHCCCS will provide a reference file that will contain the qualified DAP providers, or a provider file for individual provider flags, for applicable DAP categories. In addition, AHCCCS will post listings of qualified providers by DAP category on the AHCCCS Fee-For-Service Fee Schedules - Differential Adjusted Payments - "Qualifying Provider" webpage on the AHCCCS website:

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

The Contractor shall utilize these files along with information described in the DAP public notice on the AHCCCS website to increase the rates that the Contractor would otherwise pay by the appropriate percentage for contracted and non-contracted providers. For contracted providers, the DAP category is reflected as an increase in the provider contracted rates. For non-contracted providers not reimbursed at a provider specific rate, the applicable AHCCCS MCO fee schedule (also supplied as a reference file extract) shall be used as the default base rate to which the applicable increase or increase percentages shall be applied for the qualified providers. For non-contracted providers reimbursed at a provider specific rate, the AHCCCS supplied rates are reflective of the % increase.

Federally Qualified Health Centers: For CYE 20, for Federally Qualified Health Centers (FQHCs) registered with AHCCCS who demonstrate attainment of the Minimum Performance Standard (MPS) for one or more of the selected clinical quality measures shown below, the Contractor is required to increase the rates that the Contractor would otherwise pay by 0.5%, 1.0% or 1.5%, on all FQHC visits that are payable at the AHCCCS all-inclusive per visit Prospective Payment System (PPS) rates.

Criteria: "Demonstrated attainment" means the FQHC has submitted to AHCCCS a copy of its 2017 Uniform Data Set (UDS) Report containing statistics that meet or exceed the MPS for the selected measures.

An FQHC whose patient population is greater than 20% homeless/transient or greater than 50% uninsured is qualified for up to a 1.5% Differential Adjusted Payment increase for attainment of each MPS for each Clinical Quality Measure below:

- Colorectal Cancer Screening requires a MPS increase over prior year according to the table below to qualify for a 0.5% Differential Adjusted Payment increase

If Prior Year performance measure is:	And increase over prior year is greater than:
At or below 15.0%	0.5% point
15.0 - below 30.0%	1.0% point
30.0 - below 40.0%	1.5% points
40.0 - below 65.0%	2.5% points

AND/OR

- Diabetes Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year requires a MPS decrease from prior year at or greater than 1.5% to qualify for a 0.5% Differential Adjusted Payment increase

AND/OR

- Patients with Hypertension Controlled (BP <140/90) requires a MPS increase over prior year according to the table below to qualify for a 0.5% Differential Adjusted Payment increase

Prior year performance:	And increase over prior year is greater than:
At or below 40.0%	0.5% point
40.0 - below 50.0%	1.0% point
50.0 - below 61.2%	2.5% points

An FQHC whose patient population is greater than 50% uninsured is qualified for up to a 1.5% Differential Adjusted Payment increase for attainment of each MPS for each Clinical Quality Measure below:

- Colorectal Cancer Screening requires a MPS greater than 65% to qualify for a 0.5% Differential Adjusted Payment increase

If Prior Year performance measure is:	And increase over prior year is greater than:
At or below 15.0%	0.5% point
15.0 - below 30.0%	1.0% point
30.0 - below 45.0%	2.0% points
45.0 - below 65.0%	2.5% points

AND/OR

- Diabetes Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year requires a MPS less than 41% to qualify for a 0.5% Differential Adjusted Payment increase

AND/OR

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents requires a MPS greater than 55% to qualify for a 0.5% Differential Adjusted Payment increase

Prior year performance:	And increase over prior year is greater than:
At or below 15.0%	0.5% point
15.0 - below 30.0%	1.0% point
30.0 - below 45.0%	2.0% points
45.0 - below 55.0%	2.5% points

All other FQHC are qualified for up to a 1.5% Differential Adjusted Payment increase for attainment of each MPS for each Clinical Quality Measure below:

- Colorectal Cancer Screening requires a MPS greater than 65% to qualify for a 0.5% Differential Adjusted Payment increase

AND/OR

- Diabetes Hemoglobin A1c Poor Control (Diabetic Patients with HbA1c > 9%) or No Test During Year requires a MPS less than 41% to qualify for a 0.5% Differential Adjusted Payment increase

AND/OR

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents requires a MPS greater than 55% to qualify for a 0.5% Differential Adjusted Payment increase

State Only Transplants Option 1 and Option 2: The Contractor will be paid as a lump-sum payment, from State Only funding, an administrative component for those member months the member is enrolled with the Contractor. For Option 1 members the Contractor will be paid the administrative component up to a 12-month continuous period of extended eligibility. For Option 2 members the administrative component will be paid for the period of time the transplant is scheduled or performed. All medically necessary covered services will be reimbursed 100% with no deductible through Reinsurance payments based on adjudicated encounters. Delivery supplemental payments will not apply to women who deliver during the 12 month continuous period of extended eligibility specified as Option 1.

52. PAYMENTS TO CONTRACTOR

Subject to the availability of funds, AHCCCS shall make payments to the Contractor in accordance with the terms of this Contract provided that the Contractor’s performance is in compliance with the terms and conditions of this Contract. Payment must comply with requirements of A.R.S. Title 36. 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 or 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. Except for adjustments made to correct errors in payment, and as otherwise specified in this

Contract, any savings remaining to the Contractor as a result of favorable claims experience and efficiencies in service delivery at the end of the Contract term may be kept by the Contractor.

All funds received by 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 third-party liabilities, the only source of payment to Contractor for the services provided hereunder is from funds under the control of AHCCCS. An error discovered by AHCCCS or any of the applicable oversight entities, with or without an audit, in the amount of fees paid to Contractor, with or without audit, will be subject to adjustment or repayment by AHCCCS via a recoupment from future payment(s) to the Contractor, or by making an additional payment to the Contractor. When the Contractor identifies an overpayment, AHCCCS must be notified and reimbursed within 30 days of identification [42 CFR 438.608(c)(3)].

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.

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

53. CAPITATION ADJUSTMENTS

Rate Adjustments: The rates set forth in Section B shall not be subject to renegotiation during the term of the Contract.

Rates are based on public or private payment rates for comparable services for comparable populations, consistent with actuarially sound principles as defined at 42 CFR 457.10 [42 CFR 457.1203(a)]. Capitation rates may be modified during the term of the Contract when changes to provisions in the Contract require adjustment to maintain actuarially sound rates. In addition, AHCCCS, at its sole discretion, may adjust capitation rates to address fundamental changes in circumstances such as:

1. Program changes,
2. Legislative requirements,
3. Updated encounter experience,
4. Rate setting assumptions, and
5. CMS Mandates.

If a capitation rate adjustment is determined necessary, the adjustment and assumptions may be discussed with the Contractor prior to modifying capitation rates. The Contractor may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review.

The Contractor is responsible for notifying AHCCCS of program and/or expenditure changes initiated by the Contractor during the Contract term 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:

1. Death of a member,
2. Inmate of public institution,
3. Duplicate capitation to the same Contractor,
4. Adjustment based on change in member's Contract type, or
5. Child was not eligible for CMDP as described in A.R.S. §8-512.

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

Inmate of a Public Institution Reporting: Several Counties are submitting daily files of all inmates entering their jail and all inmates released. AHCCCS will match these files against the database of active AHCCCS members. AHCCCS members who become incarcerated will be disenrolled from their Contractor and placed in a "no-pay" status for the duration of their incarceration. Upon release from jail, the member will be re-enrolled with their previous Contractor unless that plan is no longer available to the member. If the plan the member was enrolled in prior to incarceration is no longer available, the member will be auto-assigned using the current enrollment rules. The Contractor will see the "IE" code for ineligible associated with the disenrollment. A member is eligible for covered services until the effective date of the member's "no-pay" status.

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

Notifications must include:

1. AHCCCS ID,
2. Name,
3. Date of Birth (DOB),
4. When incarcerated, and
5. Where incarcerated.

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

54. MEMBER BILLING AND LIABILITY FOR PAYMENT

AHCCCS registered providers may charge AHCCCS members for services which are excluded from AHCCCS coverage, which are provided in excess of AHCCCS limits, or as otherwise described in A.A.C R9-28-701.10 (2).

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

1. The Contractor's or any subcontractor's debts in the event of Contractor's or the subcontractor's insolvency, [42 CFR 438.106(a), Section 1932(b)(6) of the Social Security Act], and
2. Covered services provided to the member except as permitted under A.A.C. R9-28-701.10(2) [42 CFR 438.106(b)(1) and (2), 42 CFR 438.3(k), 42 CFR 438.230, Section 1932(b)(6) of the Social Security Act].

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 [42 CFR 438.106(c), 42 CFR 438.3(k), 42 CFR 438.230, Section 1932(b)(6) of the Social Security Act].

55. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCS to the Contractor for the partial reimbursement of covered medical services for the Contract Year as described in this paragraph. The reinsurance Contract Year is the year beginning on October 1 and ending on September 30. Reinsurance is paid for services incurred for a member beyond an annual deductible level. AHCCCS is self-insured for the reinsurance program which is characterized by an initial deductible level and a subsequent coinsurance percentage. The coinsurance percentage 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 to the reinsurance deductibles would have a corresponding impact on capitation rates. Refer to the AHCCCS Reinsurance Policy Manual for further details on the Reinsurance Program.

AHCCCS will reimburse a Contractor for costs incurred in excess of the applicable deductible level and subject to coinsurance percentages and Medicare/Third Party Liability (TPL) payment, less any applicable quick pay discounts, slow payment penalties and interest. PPC and prospective expenses are included under the reinsurance program. For reimbursement of reinsurance encounters in subcapitated arrangements, see the AHCCCS Reinsurance Policy Manual.

The table below represents deductible and coinsurance levels. See specific case types below for coverage details.

Reinsurance Case Types	Deductible	Coinsurance
Regular Reinsurance	\$35,000	75%
Catastrophic Reinsurance	N/A	85%
Transplant and Other Case Types	See specific paragraphs below	See specific paragraphs below

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

Regular Reinsurance: Regular reinsurance covers partial reimbursement of covered inpatient facility medical services. Reinsurance reimbursement is based upon the lesser of the AHCCCS transplant contract amount or the Contractor's paid amount, subject to coinsurance percentages. Inpatient services are those services provided in acute care hospitals (provider type 02) and accredited psychiatric hospitals (provider type 71) only. Same-day admit-and-discharge services do not qualify for reinsurance. Regular reinsurance covers the inpatient provider types listed above, but does not cover services provided by any other inpatient provider type, including but not limited to residential treatment centers and subacute facilities. See the AHCCCS Reinsurance Policy Manual for additional details.

In certain situations as outlined in the AHCCCS Reinsurance Policy Manual, per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any Contract Year shall be eligible for reinsurance coverage. The Skilled Nursing Facility stay must be the first continuous Skilled Nursing Facility stay post inpatient discharge. A second admission to the Skilled Nursing Facility is not eligible for reinsurance unless there is an additional Inpatient stay directly preceding the second admission.

Encounter Submission and Payments for Reinsurance: Contractors are reimbursed for reinsurance claims by submitting encounters that associate to a reinsurance case. All reinsurance associated encounters, except as provided below for "Disputed Matters" must reach an adjudicated/approved status within 15 months from the end date of service, or date of eligibility posting, whichever is later. For all reinsurance case types, for services or pharmaceuticals, in the instances in which AHCCCS has specialty contracts or legislation/policy limiting 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.

Encounters for claims which cross over reinsurance Contract Years will not be eligible for reinsurance. The association of an encounter to a reinsurance case does not automatically qualify the encounter for reinsurance reimbursement.

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

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 and reach adjudicated status within 15 months of end date of service to receive adjusted reinsurance benefits. See AHCCCS Reinsurance Policy Manual for further details. The Contractor should refer to Section D, Paragraph 63, Encounter Data Reporting, for encounter reporting requirements.

Catastrophic Reinsurance: The Catastrophic Reinsurance program encompasses members receiving certain biological drugs as well as those members who are diagnosed with Hemophilia, Von Willebrand's Disease, or Gaucher's Disease, as follows:

Biological Drugs: Catastrophic reinsurance is available to cover the cost of certain biological drugs when medically necessary. Refer to the AHCCCS Reinsurance Processing Manual for a complete list of the approved biological drugs.

When a biosimilar (generic equivalent) of a biologic drug is available, and AHCCCS has determined that the biosimilar is more cost effective than the brand name biologic product, AHCCCS will reimburse 85% of the lesser of the biologic drug or its biosimilar equivalent for reinsurance purposes unless the biosimilar equivalent is contraindicated for a specific member. If the AHCCCS Pharmacy & Therapeutics (P&T) Committee mandates the utilization of only the brand name biologic drug rather than biosimilar, AHCCCS will reimburse 85% of the amount of the branded biologic drug.

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

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

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

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

Transplants Reinsurance: This program covers members who are eligible to receive AHCCCS covered major organ and tissue transplants. Refer to the AMPM Policy 310-DD and the AHCCCS Reinsurance Policy Manual for covered services and types of organ and tissue transplants. The Contractor must notify AHCCCS/, Medical Management Supervisor 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 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 Management Supervisor. Depending on the unique circumstances of each approved out-of-state transplant, AHCCCS Finance/Reinsurance may consider, on a case-by-case basis, the Contractor's reinsurance coverage at 85% of the Contractor's paid amount for comparable case/component rates. If no prior approval is obtained, and the Contractor incurs costs at the out-of-state facility, those costs are not eligible for either transplant or regular reinsurance.

Payment of Transplant Reinsurance Cases: Reinsurance coverage for transplants received at an AHCCCS contracted facility is paid at the lesser of 85% of the AHCCCS Contract amount for the transplant services rendered or 85% of the Contractor's paid amount. Transplant contracts include per diem rates for inpatient follow-up care post-transplant (day 11+ for kidneys and day 61+ for all other transplants). Reinsurance for follow-up care follows the regular reinsurance reimbursement, including a deductible requirement. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS Contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS Contracted transplant rates may be found on the AHCCCS website.

Reinsurance payments are linked to transplant encounter submissions. The Contractor is required to submit all supporting encounters for transplant services and additional documentation as identified in the AHCCCS Reinsurance Policy Manual.. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must equal the amounts on the required documentation submitted to AHCCCS. Timeliness for each component payment will be calculated based on the latest adjudication date for the complete set of encounters related to the component. Clean claims must be received no later than 15 months from the end date of service for each particular transplant stage. Refer to the AHCCCS Reinsurance Policy Manual for the appropriate billing of transplant services.

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

1. The individual has been determined ineligible due to excess income, and
2. The individual was on the transplant waitlist before AHCCCS eligibility expired.

Reinsurance coverage for State Only Option 1 and Option 2 members (as described in Section D, Paragraph 3, Eligibility Categories) for transplants received at an AHCCCS Contracted facility is paid at the lesser of 1) 85% of the AHCCCS Contract amount for the transplantation services rendered less the transplant share of cost, or 2) 85% of the Contractor paid amount, less the transplant share of cost. For transplants received at a facility not contracted with AHCCCS, payment is made at the lesser of 100% of the lowest AHCCCS contracted amount for the transplant services rendered less the transplant share of cost, or 85% of the Contractor paid amount, less the transplant share of cost. All Option 1 and Option 2 transplants are subject to the terms regarding out of state transplants set forth above and in the AHCCCS Reinsurance Policy Manual. The AHCCCS contracted transplant rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCS/DHCM, Medical Management as specified in the AMPM Chapter 300, Policy 310 Attachments A and B.

Option 1: Extended eligibility is for one twelve-month continuous period of time. During that time, the member is eligible for all AHCCCS covered services including transplant as long as they

continue to remain on the transplant waiting list. All medically necessary covered services provided to Option 1 members, unrelated to the transplant, shall be eligible for reimbursement, with no deductible, at 100% of the Contractor's paid amount based on adjudicated encounters. If determined medically ineligible for a transplant at any time during the period, eligibility for AHCCCS covered services will terminate at the end of the calendar month in which the determination is made.

Option 2: Extended eligibility covers transplant services only. At the time that the transplant is scheduled to be performed, the transplant candidate will reapply and will be re-enrolled with her/her previous Contractor to receive all covered transplant services.

Other Catastrophic Reinsurance: For all reinsurance case types other than transplants, the Contractor is reimbursed 100% for all medically necessary covered expenses provided in a reinsurance Contract Year, after the Contractor paid amount in the reinsurance case reaches \$1,000,000. It is the responsibility of the Contractor to notify the AHCCCS/DHCM, Reinsurance Supervisor, once a reinsurance case reaches \$1,000,000. Failure to notify AHCCCS or failure to adjudicate encounters appropriately within 15 months from the end date or service will disqualify the related encounters for 100% reimbursement consideration.

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

Failure to submit the Notice of Decision and the encounters within the applicable timeframes specified above will result in the denial of reinsurance.

Reinsurance Audits: AHCCCS may perform medical audits on reinsurance cases. Terms of the audit process will be disclosed prior to implementation of the audits providing the Contractor with appropriate advance notice.

56. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

AHCCCS is the payor of last resort unless specifically prohibited by applicable State or Federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall take reasonable measures to identify potentially legally liable third party sources. Refer to ACOM Policy 434.

If the Contractor discovers the probable existence of a liable third party that is not known to AHCCCS, or identifies any change in coverage, the Contractor must report the information within 10 days of discovery via the TPL Leads File or the TPL Referral Web Portal, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 70, Administrative Actions.

AHCCCS will provide the Contractor with a file of all other coverage information, for the purpose of updating the Contractor's files, as described in the AHCCCS Technical Interface Guidelines (TIG).

The Contractor shall coordinate benefits in accordance with [42 CFR 433.135 et seq.], A.R.S. §36-2903, and A.A.C. Title 9, Chapter 28, Article 9, so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the Federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this Contract. The two methods used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The Contractor shall use these methods as described in A.A.C. Title 9, Chapter 28, Article 9, Federal and State law, and ACOM Policy 434. For Contractor cost sharing responsibilities for members covered by both Medicare and Medicaid see ACOM Policy 201 [42 CFR 433 Subpart D, 42 CFR 447.20].

The Contractor shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There are limited circumstances when cost avoidance is prohibited and the Contractor must apply post-payment recovery processes as described further below.

Cost Avoidance: For purposes of cost avoidance, establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established, the Contractor must adjudicate the claim. The Contractor must then utilize post-payment recovery which is described in further detail below. If AHCCCS determines that the Contractor is not actively engaged in cost avoidance activities, the Contractor shall be subject to sanctions.

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

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

Medicare Fee-for-Service Crossover Claims Payment Coordination: AHCCCS delegates to Contractors coordination of benefits payment activities with legally liable third parties, including Medicare. For dual eligible members, the Contractor shall coordinate Medicare Fee-For-Service (FFS) crossover claims payment activities with the Medicare Benefits Coordination and Recovery Center (BCRC) in accordance with [42 CFR 438.3(t)].

The Contractor shall be registered with the BCRC as a trading partner to electronically process Medicare FFS crossover claims. An Attachment to the existing AHCCCS Medicare FFS Coordination of Benefits Agreement (COBA) shall be executed by Contractors to register as a BCRC trading partner. Upon completion of the registration process, the BCRC shall issue each Contractor a unique COB ID number upon completion of BCRC readiness review activities.

Upon completion of BCRC readiness review activities, the Contractor shall coordinate with BCRC regarding the electronic exchange and transmission of necessary BCRC-provided data files and file

layouts, including eligibility and claim data files to coordinate payment of Medicare FFS crossover claims only.

Further information and resources for Contractors regarding the Medicare FFS cross-over claims process and BCRC requirements are available on the BCRC webpage: www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html

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

Members Covered by both Medicare and Medicaid (Duals): See Section D, Paragraph 58, Medicare Services and Cost Sharing.

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

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

1. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
2. Services covered by third party liability that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

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

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

Other Third Party Liability Recoveries: The Contractor shall identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. 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:

1. Motor Vehicle Cases,

2. Other Casualty Cases,
3. Tort feasons,
4. Restitution Recoveries, and
5. Worker's Compensation Cases.

Upon identification of a potentially liable third party for any of the above situations, the Contractor shall, within 10 business days, report the potentially liable third party to AHCCCS' TPL Contractor for determination of a mass tort, total plan case, or joint case, specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 70, Administrative Actions. A mass tort case is a case where multiple plaintiffs or a class of plaintiffs have filed a lawsuit against the same tort feason(s) to recover damages arising from the same or similar set of circumstances (e.g. class action lawsuits) regardless of whether any reinsurance or Fee-For-Service payments are involved. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Contractor; no reinsurance or Fee-For-Service payments are involved. By contrast, a "joint" case is one where Fee-For-Service payments and/or reinsurance payments are involved. The Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

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

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

Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCS or AHCCCS' authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. Failure to report these cases prior to negotiating a settlement amount may result in one of the remedies specified in Section D, Paragraph 70, Administrative Actions.

The Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS-approved casualty recovery Settlement Notification Form (see ACOM Policy 434), within 10 business days from the settlement date or in an AHCCCS-approved monthly file, as specified in Section F, Attachment F3, Contractor Chart of Deliverables. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 70, Administrative Actions.

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

responding to requests from AHCCCS or AHCCCS' TPL contractor to provide a list of claims related to the joint or mass tort case within 10 business days of the request. The Contractor will be responsible for their prorated share of the contingency fee. The Contractor's share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Contractor.

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

Title XXI (KidsCare) and Breast and Cervical Cancer Treatment Program: Eligibility for KidsCare and Breast and Cervical Cancer Treatment Program (BCCTP) benefits require that the applicant/member not be enrolled with any other creditable health insurance plan. If the Contractor becomes aware of any such coverage, the Contractor shall notify AHCCCS immediately. AHCCCS will determine if the other insurance meets the creditable coverage definition in A.R.S. §36-2982(G).

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

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

57. COPAYMENTS

The Contractor is required to comply with A.A.C. R9-22-711, ACOM Policy 431, and other direction by AHCCCS. Those populations exempt from copayments or subject to non-mandatory (also known as nominal or optional) copayments may not be denied services for the inability to pay the copayment [42 CFR 438.108]. However, for those populations subject to mandatory copayments services may be denied for the inability to pay the copayment. Members with a CRS qualifying condition are currently exempt from mandatory and optional copayments.

58. MEDICARE SERVICES AND COST SHARING

Medicare Services: Dual eligible members shall have choice of all providers in the Contractor's network. The Contractor shall coordinate Medicare services based on a dual eligible member's coverage choices through either Original Medicare or a State-contracted Medicare Advantage Dual Eligible Special Needs Plan with prescription drug coverage (a Medicare Advantage Part C D-SNP that covers Medicare Parts A, B and D services).

Medicare covered Part B preventive services available to dual eligible members at little or no cost include, but are not limited to (subject to specific terms and requirements of each): annual alcohol misuse screenings for adults, biennial bone mass measurements, annual cardiovascular disease behavioral health therapy visit, cervical and vaginal cancer screenings, chronic care management

services for members having two or more chronic conditions expected to last at least one year, colorectal cancer screenings, annual primary care depression screening, diabetes screenings and self-management training, appropriate vaccinations (influenza, pneumococcal, hepatitis B), hepatitis C screening, HIV screening, glaucoma testing, lung cancer screening, medical nutrition therapy services, obesity screening and counseling, prostate cancer screenings, sexually transmitted infection screenings and counseling, smoking and tobacco use cessation counseling, initial "Welcome to Medicare" preventive visit in first 12 months of program enrollment, and annual wellness visit.

Medicare Cost Sharing: The Contractor must pay Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Contractor's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. The Contractor must limit their cost sharing responsibility according to A.A.C. R9-29-301 and A.A.C. R9-29-302 and as further outlined in ACOM Policy 201. Refer to Section D, Paragraph 9, Scope of Services, *Prescription Medications*, coverage of Medicare Part D medications.

In Original Medicare, a dual eligible member may access Medicare services from any provider participating in Medicare. Dual eligible members who choose to obtain Medicare-covered services from a "non-participating" Medicare provider may be required to pay for the entire charge at the time of service, which may be greater than the Medicare-approved amount. Dual eligible members are to be encouraged to obtain Medicare covered services from participating Medicare providers that accept "assignment," the Medicare-approved amount as payment in full for Medicare covered services.

For a dual eligible member enrolled in a State-contracted Medicare Advantage D-SNP for Medicare covered services, the dual eligible member must follow the D-SNP's rules as approved by CMS, including but not limited to those governing use of the plan's provider network in obtaining covered services.

When a dual eligible member is in a medical institution and that stay is funded by Medicaid for a full calendar month, the dual eligible member is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to CMS, the Contractor must, notify AHCCCS pursuant to ACOM Policy 201 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

59. RESERVED

60. CORPORATE COMPLIANCE

Corporate Compliance Program: The requirements of 42 CFR 438.608 are imposed on the Contractor and the Contractor shall ensure compliance with these provisions. The Contractor shall have a mandatory Corporate Compliance Program that is designed to guard against fraud, waste, and abuse and is supported by other administrative procedures including a Corporate Compliance Plan. The Contractor shall appoint a Corporate Compliance Officer in accordance with Section D, Paragraph 15, Staffing Requirements. The Contractor's written Corporate Compliance Plan must adhere to Contract and ACOM Policy 103, and must be submitted to AHCCCS/OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

The Corporate Compliance Program shall be designed to prevent, detect and report fraud, waste, or abuse. The Corporate 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 rules, regulations, guidelines, and standards,
2. The Corporate Compliance Officer must be an onsite management official who reports directly to the Contactor's CEO and Board of Directors, if applicable. The Corporate Compliance Officer must be responsible for developing and implementing policies, procedures and practices designed to ensure compliance with the requirements of the Contract,
3. Effective lines of communication between the Corporate Compliance Officer and the Contractor's employees,
4. Enforcement of standards through well-publicized disciplinary guidelines,
5. Establishment and implementation of procedures that include provision for the prompt referral of any potential fraud, waste, or abuse to AHCCCS/OIG,
6. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly to reduce the potential for recurrence, ongoing compliance with requirements under the Contract, and external monitoring and auditing of subcontractors, and
7. Submission of an External Audit Plan/Schedule, and Executive Summary of all individual provider audits to AHCCCS/OIG as specified in ACOM Policy 103 and Section F, Attachment F3, Contractor Chart of Deliverables.
8. The establishment of a Regulatory Compliance Committee involving the Board of Directors and the Contractor's senior management level charged with overseeing the Contractor's compliance program and its compliance with the requirements of the Contract,
9. Compliance with the requirements of Section 6032 Deficit Reduction Act of 2005 (DRA) [Section 1902(a)(68) of the Social Security Act, 42 CFR 438.608(a)(6)]. As a condition for receiving payments, the Contractor shall establish written policies, and shall ensure adequate training and ongoing education for, all of its employees (including management), members, and of any subcontractors and/or agents of the Contractor regarding the following:
 - a. Detailed information about the Federal False Claims Act,
 - b. The administrative remedies for false claims and statements,
 - c. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and
 - d. The whistleblower protections under such laws.
10. Establishment of a system for training and education for the Corporate Compliance Officer, the Contractor's senior management, all staff and new hires on the Federal and State standards and requirements under the Contract, including the items in number 9 above. All training shall be conducted in such a manner that can be verified by AHCCCS,
11. Notification to AHCCCS/DHCM, Data Analysis and Research, as specified in Section F, Attachment F3, Contractor Chart of Deliverables of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions,
12. Reporting to AHCCCS of description of transactions between the Contractor and a party in interest as defined in Section 1318(b) of the Social Security Act, including the following transactions as specified in Section F, Attachment F3, Contractor Chart of Deliverables [Section 1903(m)(4)(B) of the Social Security Act]:
 - a. Any sale or exchange, or leasing of any property between the organization and such a party,

- b. Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment, and
- c. Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported regarding an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

The Contractor shall make the information reported available to its members upon reasonable request.

Reporting Alleged Fraud Waste, or Abuse of the AHCCCS Program: In accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and ACOM Policy 103, the Contractor, its subcontractors and providers are required to notify the AHCCCS Office of Inspector General (AHCCCS/OIG) regarding all allegations of fraud, waste or abuse involving the AHCCCS Program as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor shall promptly notify AHCCCS when it receives information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member [42 CFR 438.608(a)(3)]. The Contractor shall not conduct any investigation or review of the allegations of fraud, waste, or abuse involving the AHCCCS Program. Notification to AHCCCS/OIG shall be in accordance with ACOM Policy 103 and as specified in Section F, Attachment F3, Contractor Chart of Deliverables. The Contractor must also report to AHCCCS, as specified in Section F, Attachment F3, Contractor Chart of Deliverables, any credentialing denials including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with [42 CFR 455.14], AHCCCS/OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation [42 CFR 455.17, 42 CFR 455.1(a)(1)].

The Contractor agrees to permit and cooperate with any onsite review. A review by the AHCCCS/OIG may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS. The Contractor agrees to provide documents, including original documents, to AHCCCS/OIG upon request and at no cost. The AHCCCS/OIG shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 30 calendar days from the date of the AHCCCS/OIG request.

Once the Contractor has referred a case of alleged fraud, waste, or abuse to AHCCCS/OIG, the Contractor shall take no action to recoup or otherwise offset any suspected overpayments. In the event that AHCCCS/OIG, either through a criminal restitution order, civil monetary penalty or assessment, a global civil settlement or judgment, or any other form of civil action, including recovery of an overpayment, receives a monetary recovery from an entity/individual, the entirety of such monetary recovery belongs exclusively to AHCCCS and the Contractor has no claim to any portion of this recovery. The Contractor hereby assigns to AHCCCS each, every, any and all of its rights to recover overpayments due to fraud, waste or abuse including any and all monetary recoveries in connection with, related to, or otherwise arising out the overpayment(s).

In the event that the Contractor has recovered an overpayment, the Contractor must notify AHCCCS/OIG as specified in Section F, Attachment F3, Contractor Chart of Deliverables. AHCCCS/OIG will notify the Contractor when the investigation concludes. If it is determined by AHCCCS/OIG to not be

a fraud, waste, or abuse case, the Contractor shall adhere to the applicable AHCCCS policy manuals for disposition.

Disclosure Information: The Contractor shall submit all disclosure Information requested in ACOM Policy 103 and its attachments, and as required by federal and state law, including but not limited to the following: Disclosure of Ownership or Control Interest; fiscal agents; business transactions; persons convicted of crimes as delineated in regulation, ACOM Policy 103, and in Section F, Attachment F3, Contractor Chart of Deliverables; and creditors [42 CFR 455, Subpart B, 42 CFR 455.436, 42 CFR 438.608(c), 42 CFR 455.436, SMDL 08-003 and 09-001, Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act]. Disclosures shall be made in accordance with ACOM Policy 103, as directed by regulation, and upon request from AHCCCS or CMS [42 CFR 455, Subpart B].

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

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. 45 days prior to the effective date of commencement of operations for a change in Contractor Organizational Structure. Refer to ACOM Policy 317 for more information,
5. Within 35 days after any change, and
6. Upon request by AHCCCS.

The Contractor shall immediately notify AHCCCS/OIG of any person who has been excluded through these checks as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

1. The Contractor is controlled by a sanctioned individual under Section 1128(b)(8) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(1), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09],
2. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in Section 1128(b)(8)(B) of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09],
3. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual or entity that is, or is affiliated with a person/entity that is, debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation (FAR) or from participating in non-procurement activities under regulation issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(a), 42 CFR 431.55(h), Section 1903(i)(2) of the

Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549],

4. The Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act [42 CFR 438.808(a), 42 CFR 438.808(b)(2), 42 CFR 438.610(b), 42 CFR 431.55(h), Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09], and
5. The Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following:
 - a. Any individual or entity that is, or was affiliated with a person/entity that is excluded from participation in any Federal health care programs [42 CFR 438.808, 42 CFR 438.610, Section 1903(i)(2) of the Social Security Act, 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, SMDL 1/16/09, Executive Order No. 12549].
 - b. Any entity that would provide those services through an excluded individual or entity excluded from participation in any Federal healthcare program [42 CFR 438.808, 42 CFR 438.610, Section 1903(i)(2) of the Social Security Act, 42 CFR 431.55(h), 42 CFR 1001.1901(c), 42 CFR 1002.3(b)(3), SMDL 6/12/08, and SMDL 1/16/09].

Should AHCCCS learn that the Contractor has a prohibited relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1128 or 1128A of the Social Security Act, AHCCCS may not renew or extend the existing agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliation [42 CFR 438.610(d)(3), 42 CFR 438.610(b)].

The Contractor shall require Fiscal Agents and Administrative Services Subcontractors to adhere to the requirements outlined above regarding disclosure Information requested in ACOM Policy 103 and its attachments, and as required by federal and state law, including but not limited to the following: Disclosure of Ownership or Control Interest; fiscal agents; business transactions; persons convicted of crimes [42 CFR 455, Subpart B, 42 CFR 455.436, 42 CFR 438.608(c), 42 CFR 455.436, SMDL 09-001, Sections 1124(a)(2)(A) and 1903(m)(2)(A)(viii) of the Social Security Act]. Administrative Services Subcontractors shall disclose to AHCCCS/OIG the identity of any excluded person [42 CFR 438.604(a)(6), 42 CFR 438.606, 42 CFR 455.104, 42 CFR 438.230, 42 CFR 438.608(c)(2)]. Refer to ACOM Policy 103 and its attachments.

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

The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, XX, or XXI pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had

reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person) (Sections 1903(i) and 1903(i)(2)(B)) of the Social Security Act).

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

Termination of Provider From Contractor Network of Providers: The Contractor shall ensure, for itself and require of any subcontractor(s), that any provider of services or person terminated from participation in the AHCCCS Medicaid Program, other XIX programs, Title XVIII or XXI programs, shall be terminated from participating with Contractor as a provider in any of Contractor's network of providers who render services to individuals eligible to receive medical assistance pursuant to Title XIX.

61. RECORD 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 shall make available, at all reasonable times during the term of this Contract, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government. The Contractor shall be responsible for any costs associated with the 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 unless a longer period of time is required by law.

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

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

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

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

If this Contract is completely or partially terminated, records shall be retained as described above.

62. SYSTEMS AND DATA EXCHANGE REQUIREMENTS

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

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

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

Contractor Data Exchange: Before a Contractor may exchange data with AHCCCS, certain agreements, authorizations and control documents are required, including the completion and submission of the EDI Trading Partner Agreement in order to exchange data with AHCCCS.

With the completion of required documents as outlined in the AHCCCS Encounter Manual, each Contractor is assigned a Transmission Submitter Number (TSN) for encounter submissions. The Contractor may elect to obtain additional TSNs based upon processing or tracking needs.

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

The Contractor is required to provide an attestation that any data transmitted is accurate, complete, and truthful, to the best of the Contractor's Chief Executive Officer, Chief Financial Officer or designee's knowledge under penalty of perjury [42 CFR 438.606] as outlined by AHCCCS in the HIPAA Transaction Companion Guides and Trading Partner Agreements [42 CFR 438.606, 42 CFR 457.1201(o), 42 CFR 457.1201(n)(2)].

Neither the State of Arizona nor AHCCCS shall be responsible for any incorrect or delayed payment to the Contractor's subcontractors resulting from error, omission, deletion, or erroneous input data caused by the Contractor in the submission of AHCCCS claims.

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

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

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

The Contractor shall develop and maintain a HIPAA compliant claims processing and payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2903 and §36-2904 and A.A.C. R9-28-701.10. The system must be adaptable to updates in order to support future AHCCCS claims related policy requirements on a timely basis as needed.

On a recurring basis, monthly based on adjudication date, AHCCCS shall provide the Contractor an electronic file of claims and encounter data for members enrolled with the Contractor who have received services that adjudicated from another contractor or through AHCCCS FFS for purposes of member care coordination. Data sharing will comply with Federal privacy regulations.

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

1. Receive 85% of total claims (e.g. professional, institutional and dental), with a minimum 60% requirement by form type, based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs) electronically,
2. Produce and distribute 75% of remittances electronically, and
3. Provide 85% of claims payments via EFT.

AHCCCS intends to increase the percentage requirements over the term of the Contract.

System Changes and Upgrades: The costs of software changes are included in administrative costs paid to the Contractor. There is no separate payment for software changes. A PMMIS systems contact will be assigned to the Contractor after Contract award.

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

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

Data Security: The Contractor is required to have a security audit performed by an independent third party on an annual basis. The annual audit report must be submitted to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

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

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

Health Information Exchange (HIE): The Contractor is required to join the membership organization, Arizona Health Current which is a non-profit organization established for the purpose of education and policy setting for Health Information Technology (IT). As a participant of The Network, the Contractor shall be identified by The Network as a "data user" and is expected to become a "data supplier" over time, as required by AHCCCS.

To further the integration of technology based solutions and the promotion of interoperability of electronic health records within the system of care, AHCCCS will increase opportunities for providers and Contractors to utilize technological functions for processes that are necessary to meet Medicaid requirements. Expanding the adoption and use of health information technology may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative overhead, and decreasing the number of adverse events resulting from medical errors. The Contractor is expected to collect data from providers in standardized formats to the extent feasible and will actively participate in offering information and providing provider support and education to further expand provider adoption and use of health information technology. It is AHCCCS' expectation that the Contractor review operational processes to reduce provider hassle factors by implementing technological solutions for those providers utilizing electronic health records and to incentivize providers to implement and meaningfully use health information technology as a standard of doing business with the AHCCCS program. AHCCCS also anticipates establishing minimum standards, goals and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. AHCCCS anticipates accelerating statewide Health Information Exchange (HIE) participation for all Medicaid providers and Contractors by:

1. Requiring that behavioral health and physical health providers use The Network for secure sharing of clinical information between physical and behavioral health providers,
2. Administering an HIE onboarding program for high volume Medicaid hospitals, Federally Qualified Health Centers, Rural Health Clinics, Look-a-Like clinics and other eligible groups of Medicaid providers,
3. Supporting the acceleration of electronic prescribing by Arizona Medicaid providers,
4. Joining the State level HIE for governance, policy making, and information technology service offerings, and
5. Identifying Value-Based purchasing opportunities that link with a provider's adoption and use of Health Information Technology (HIT).

The Contractor shall encourage providers that are participating in the Medicaid EHRS Incentive Program (i.e. eligible hospitals and eligible professionals) to continue to move through the Promoting Interoperability continuum, accelerate the participation of other provider types in their network, and participate in planning activities that will result in improved care coordination and health care delivery for members.

The Contractor is expected to collaborate with AHCCCS and a qualifying HIE Organization to target efforts to specific areas where HIT and HIE can bring significant change and progress including efforts focused on:

1. Coordinating the secure sharing of clinical health information between providers,
2. Identifying additional partnerships for integrated care among other health care delivery participants,
3. Identifying and implementing strategies for high need/high cost members,
4. Coordination of care for members who are enrolled in the American Indian Health Program (AIHP),
5. Coordination of care for members who are transitioning between AHCCCS and Qualified Health Plans,
6. Coordination of care for AHCCCS eligible and enrolled members involved in transitioning in or out of the Justice system,
7. Care coordination,
8. Pharmacy management,
9. Quality improvement activities and reporting as identified by the Contractor or AHCCCS, and
10. Other activities as identified by AHCCCS and that are allowed under the Permitted Use Policy of the Qualifying HIE Organization.

63. ENCOUNTER DATA REPORTING

Complete accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to pay reinsurance benefits, set Fee-For-Service and capitation rates, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. Furthermore, increased emphasis on encounter data is highlighted in the Medicaid Managed Care Regulations published on May 6, 2016. The Contractor shall submit encounter data to AHCCCS for all services for which the Contractor incurred a 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 [42 CFR 438.604(a)(1), 42 CFR 438.606, 42 CFR 438.818]. This requirement is a condition of the CMS grant award [42 CFR 438.242(b)(1) and 42 CFR 455.1 (a)(2)].

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

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

Professional, Institutional, and Dental Encounters not involving services eligible for Federal Drug Rebate processing shall be received by AHCCCS no later than 210 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. Failure to submit encounters within 210 days may result in sanctions as specified in the AHCCCS Encounter Manual.

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

The Contractor's health plan paid amount per pharmacy encounter that is submitted to AHCCCS shall be equal to the adjudicated and approved reimbursement amount between the PBM and the PBM's network pharmacy or in an emergent situation, a reimbursement made to a non-network pharmacy. A network pharmacy includes hospital outpatient, retail, compounding, specialty, long-term care pharmacies, or any other pharmacy type included in the PBM's Pharmacy Network.

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

The Contractor shall be subject to sanctions for noncompliance with encounter submission completeness, accuracy and timeliness requirements.

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

On a monthly basis AHCCCS will produce encounter reconciliation files containing the prior 30 months of approved, voided, plan-denied, pended and AHCCCS-denied encounters received and processed by AHCCCS. These files must be utilized to compare the encounter financial data reported with plan claims data, and to compare submitted encounters to processed claims to validate completeness of encounter submissions.

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

Encounter Corrections: The Contractor is required to monitor and resolve pended encounters and encounters denied by AHCCCS.

The Contractor is further required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. 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. Refer to the AHCCCS Encounter Manual for instructions regarding the submission of corrected, replaced or voided encounters.

Encounter Performance Standards: AHCCCS has established encounter performance standards as detailed in the AHCCCS Encounter Manual. All encounters, including, approved, pended, denied and voided encounters, impact completeness, accuracy and timeliness rates. Rates below the established standards (pended encounters that have pended for more than 120 days for example), or poor encounter performance overall, may result in Corrective Action Plans and/or sanctions.

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

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

64. ENROLLMENT AND CAPITATION TRANSACTION UPDATE

AHCCCS produces daily enrollment transaction updates identifying new members and changes to existing members' demographic, eligibility and enrollment data as outlined in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the AHCCCS Technical Interface Guidelines (TIG) available on the AHCCCS website. These files shall be utilized by the Contractor to update its member records on a timely and consistent basis. The daily enrollment transaction update, that is run 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 as outlined in the TIG, available on the AHCCCS website, which identifies enrollment or disenrollment activity that was not included on the 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 daily capitation transaction as outlined in the HIPAA Transaction Companion Guides, and Trading Partner Agreements, will be produced to provide the Contractor with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

On a daily and monthly basis AHCCCS provides the Contractor with the Rate Code Summary electronic file as outlined in the TIG, available on the AHCCCS website, which summarizes the capitation activity for the processing cycle.

The enrollment and capitation transaction updates distributed monthly are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The Contractor must reconcile the member files (including the member's Medicare status, TPL information, etc.) with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will work to resolve any discrepancies and record the results of the reconciliation. Results of the reconciliation will be made available to AHCCCS upon request. After completion of the reconciliation the Contractor will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation for the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCS/ISD.

65. PERIODIC REPORTING REQUIREMENTS

Under the terms and conditions of its CMS grant award, AHCCCS requires periodic reports, encounter data, and other information from the Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 70, Administrative Actions.

Standards applied for determining adequacy of required reports are as follows [42 CFR 438.242(b)(2)]:

1. *Timeliness*: Reports or other required data shall be received on or before scheduled due dates.
2. *Accuracy*: Reports or other required data shall be prepared in strict conformity with appropriate authoritative sources and/or AHCCCS defined standards.
3. *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. The Contractor shall submit any other data, documentation, or information relating to the performance of the entity's obligations as required by the State or Secretary [42 CFR 438.604(b), 42 CFR 438.606]. AHCCCS requirements regarding reports, including but not limited to, report content, report frequency, and report submission, are subject to change at any time during the term of the Contract. The Contractor shall comply with all changes specified by AHCCCS, including those pertaining to subcontractor reporting requirements. The Contractor shall be responsible for continued reporting beyond the term of the Contract.

66. REQUESTS FOR INFORMATION

AHCCCS may, at any time during the term of this Contract, request financial, clinical or other information from the Contractor. Responses shall fully disclose all financial, clinical 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 prior written consent of the Contractor except as required by law. Upon receipt of such requests for information from AHCCCS, the Contractor shall provide complete information to AHCCCS as requested no later than 10 business days after the receipt of the request unless otherwise specified in the request itself.

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

67. DISSEMINATION OF INFORMATION

Upon request, the Contractor shall disseminate information prepared by AHCCCS or the Federal government to its members and subcontractors. All costs shall be the responsibility of the Contractor.

68. READINESS REVIEWS

The purpose of a Readiness Review is to assess a Contractor's readiness and ability to provide covered services to members in accordance with this Contract. A Readiness Review is conducted at the discretion of AHCCCS to review programmatic operations of the Contractor. Programmatic operations subject to readiness reviews include but are not limited to: service delivery changes, IT system modifications, and change of Contractor. The Contractor must satisfy AHCCCS' requirements on all Readiness Review elements in order to continue operating under this Contract [42 CFR 438.66(d)(3)].

69. MONITORING AND OPERATIONAL REVIEWS

The Contractor shall comply with all reporting requirements contained in this Contract and AHCCCS Policy. In accordance with CMS requirements, AHCCCS has in effect procedures for monitoring the Contractors' operations and performance to ensure program compliance and identify best practices, including, but not limited to, evaluation of submitted deliverables, ad hoc reporting, and periodic focused and Operational Reviews (ORs) [42 CFR 438.66(a)].

These monitoring procedures will include, but are not limited to, operations related to the following [42 CFR 438.66(c)(1)-(12)]:

1. Member enrollment and disenrollment,
2. Processing member grievances and appeals,
3. Processing Provider Claim Disputes and Appeals,
4. Findings from the State's External Quality Review process,
5. Results of member satisfaction surveys conducted by the Contractor,

6. Performance on required quality measures,
7. Medical management committee reports and minutes,
8. Annual quality improvement plan,
9. Audited financial and encounter data,
10. Medical loss ratio summary reports,
11. Customer service performance data,
12. Any other data related to the provision of LTSS,
13. Violations subject to intermediate sanctions, as set forth in Subpart I of 42 CFR 438,
14. Violations of the conditions for receiving Federal financial participation, as set forth in Subpart J of 42 CFR 438, and
15. All other provisions of the Contract, as appropriate.

Operational Reviews: In accordance with CMS requirements 42 CFR 434.6(a)(5) and A.A.C. Title 9, Chapter 22 Article 5, AHCCCS, or an independent agent, will conduct periodic ORs of the Contractor to ensure program compliance and identify best practices [42 CFR 438.204].

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

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

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

In preparation for the reviews, the Contractor shall cooperate with AHCCCS by forwarding in advance policies, procedures, job descriptions, contracts, records, logs and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities. The Contractor shall provide an appropriate private workspace and internet access.

The Contractor will be furnished a copy of the draft OR Report and will be given an opportunity to comment on any OR findings prior to AHCCCS issuing the final OR report. AHCCCS reserves the right to publish information related to the results of any OR. The Contractor must develop corrective action plans based on recommendations provided in the final OR Report. The corrective action plans and modifications to the corrective action plans must be approved by AHCCCS. Unannounced follow-up reviews may be conducted at any time after the initial OR to determine the Contractor's progress in implementing recommendations and achieving compliance.

The Contractor shall not distribute or otherwise make available the OR Tool, draft OR Report or final OR Report to other Contractors.

70. ADMINISTRATIVE ACTIONS

Sanctions: In accordance with applicable Federal and State regulations, A.A.C. R9-22-606, ACOM Policy 408, ACOM Policy 440, Section 1932 of the Social Security Act or any implementing regulation, and the terms of this Contract, AHCCCS may impose sanctions for failure to comply with any provision of this Contract, including but not limited to: temporary management of the Contractor; monetary penalties; suspension of enrollment; withholding of payments; granting members the right to terminate enrollment without cause; suspension of new enrollments, suspension of payment for new enrollments, refusal to renew, or termination of the Contract, or any related subcontracts [42 CFR 457.1201(m), 42 CFR 457.1212, 42 CFR 422.208, 42 CFR 438.56(c)(2)(iv), 42 CFR 438.700, 702, and 704, 706, 722, 45 CFR 92.36(i)(1), 45 CFR 74.48, 42 CFR 438.726(b), 42 CFR 438.730(e)(1)(i)and(ii), Sections 1903 and 1932 of the Social Security Act]. See also Section E, Paragraph 44, Temporary Management/Operation of a Contractor and Paragraphs 46 through 49 regarding Termination of the Contract.

Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation pre-payment 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.

Notice to Cure: AHCCCS may provide a written Notice to Cure to the Contractor outlining the details of the non-compliance and timeframe to remedy the Contractor's performance. If, at the end of the specified time period, the Contractor has complied with the Notice to Cure requirements, AHCCCS may choose not to impose a sanction.

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

1. Recognize AHCCCS' technical assistance to help the Contractor achieve compliance with any relevant Contract terms or Contract subject matter issues does not relieve the Contractor of its obligation to fully comply with all terms in this Contract.
2. Recognize that the Contractor's acceptance of AHCCCS' offer or provision of technical assistance shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue.
3. Recognize that AHCCCS not providing technical assistance to the Contractor as it relates to compliance with a Contract requirement or any and all other terms, shall not be utilized as a defense or a mitigating factor in a Contract enforcement action in which compliance with Contract requirements is at issue, and
4. Recognize that a Contractor's subcontractor participation in a technical assistance matter, in full or in part, does not relieve the Contractor of its contractual duties nor modify the Contractor's Contractual obligations.

71. CONTINUITY OF OPERATIONS AND RECOVERY PLAN

The Contractor shall develop a Continuity of Operations and Recovery Plan as detailed in ACOM Policy 104, to manage unexpected events and the threat of such occurrences, that which may negatively and significantly impact business operations and the ability to deliver services to members. All staff shall be trained on, and be familiar with, the Plan. This Plan shall, at a minimum, include planning and training for:

1. Electronic/telephonic failure,
2. Complete loss of use of the main site and any satellite offices in and out of State,
3. Loss of primary computer system/records,
4. Extreme weather conditions,
5. Communication between the Contractor and AHCCCS in the event of a business disruption, and
6. Periodic testing (at least annually).

The Continuity of Operations and Recovery Plan shall be updated annually. The Contractor shall submit a summary of its Continuity of Operations and Recovery Plan to AHCCCS as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

72. RESERVED

73. PENDING ISSUES

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

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

CMDP Integration of Behavioral Health Services: Pursuant to Laws 2019, 1st Regular Session, Chapter 305, effective October 1, 2020, it is anticipated that behavioral health services for children in DCS custody will transition from the RBHA Contractors to CMDP. This will ensure integrated service delivery of physical and behavioral health services for CMDP members under a single Contractor, Contractors will be responsible for ensuring a smooth transition for members. AHCCCS will communicate associated Contractor requirements and readiness standards in AHCCCS Guidance at a later time.

Electronic Visit Verification (EVV): Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), AHCCCS is mandated to implement EVV for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) by January 1, 2020 and for in-home skilled nursing services (home health) by January 1, 2023.

The EVV system, must at a minimum, electronically verify the:

1. Type of service performed,
2. Individual receiving the service,
3. Date of the service,
4. Location of service delivery,
5. Individual providing the service, and
6. Time the service begins and ends.

EVV is mandated for the provision of the following provider types, services and places of service regardless of the population served (i.e. members receiving physical health, behavioral health and/or long term services and supports

The provider types, service codes and place of service codes are not all inclusive and may be modified or changed based on the Centers for Medicare and Medicaid Services, stakeholder or other information provided during the EVV design and development process.

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT FI
Habilitation Provider	PT 39
Home Health Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified Home Health Agency	PT 95
Private Nurse	PT 46

Service	HCPCS Service Codes
Attendant Care	S5125
Companion Care	S5135
Habilitation (hourly)	T2016 and T2017
Home Health Services (aide, therapy, and part-time/intermittent nursing services)	N/A
Nursing	G0299 and G0300
Home Health Aide	T1021
Physical Therapy	G0151 and S9131
Occupational Therapy	G0152 and S9129
Respiratory Therapy	S5181
Speech Therapy	G0153 and S9128
Private Duty Nursing (continuous nursing services)	S9123 and S9124
Homemaker	S5130
Personal Care	T1019
Respite	S5150 and S5151
Skills Training and Development	H2014

Place of Service Description	POS Code
Home	12
Assisted Living Facility	13
Other	99

More information on EVV may be found at: www.azahcccs.gov/EVV

Homeless Management Information System: AHCCCS is considering a relationship with the Continuum of Care (CoC) to gain access to the *Homeless Management Information Systems* (HMIS) in order to

identify AHCCCS members who are homeless. AHCCCS would then share this information with Contractors to provide early intervention and medically necessary services.

As part of this effort, AHCCCS will work with Contractors to identify opportunities and requirements for Contractors and related housing network providers.

Interoperability for Payers: The Contractor shall participate with AHCCCS in determining and effecting necessary implementation strategies and solutions to address CMS' and The Office of the National Coordinator for Health Information Technology's (ONC's) issued proposed rules, technical requirements and timelines encompassing the interoperability of Electronic Health Record (HER) and patient access to Protected Health Information (PHI), as initially published in the Federal Register of March 4, 2019 by a proposed implementation date of July 1, 2020 for Medicaid managed care plans. Such participation shall also include collaboration as a payer "participant" in and through the ONC's proposed Trusted Exchange Framework and Common Agreement (TEFCA) proposed Draft 2 requirements and timelines, as initially published on the ONC's website on April 19, 2019.

Section 1115 Waiver Demonstration: As part of the Agency's initiatives to improve and modernize the Medicaid program, AHCCCS continues to work with CMS on various pending waiver requests. Waiver approvals may necessitate changes to the terms of this Contract which will be executed through a Contract amendment, if necessary. Refer to the AHCCCS website for pending Waiver proposals and amendments.

Social Determinants of Health: AHCCCS is prioritizing social determinants of health (SDOH) as the next system innovation following integration to continue to enhance the service delivery system to focus on whole-person health. Contractors are expected to expand existing efforts with the provider network to screen for social needs of members, incorporate ICD-10 social determinant diagnosis codes on claims, properly refer members to community-based resources to address the social needs and document the completion of the referral and services provided.

Transplant Reinsurance: AHCCCS has established contracts for transplantation services to develop a network of facilities and practitioners to provide solid organ and tissue transplant services to eligible members. Reinsurance coverage is available to Contractors for transplants performed at an AHCCCS contracted facility. See Section D, Paragraph 53, Reinsurance for additional information. AHCCCS is reviewing the transplant contracts, the scope of those contracts, and the reimbursement methodologies. It is AHCCCS' intent that amended contracts be in place by October 1, 2020. To the extent that changes to those contracts impact the transplant reinsurance language found in Section D, Paragraph 53, Reinsurance, AHCCCS shall amend the paragraph prior to October 1, 2020.

74. VALUE-BASED PURCHASING

Value-Based Purchasing (VBP) is a cornerstone of AHCCCS' strategy to bend the upward trajectory of health care costs. AHCCCS is implementing initiatives to leverage the managed care model toward value-based health care systems where members' experience and population health are improved, per-capita health care cost is limited to the rate of general inflation through aligned incentives with managed care organization and provider partners, and there is a commitment to continuous quality improvement and learning. The Contractor shall participate in Value-Based Purchasing VBP efforts.

Centers of Excellence: Centers of Excellence are facilities and/or programs that are recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction. Identification of a Center of Excellence shall be based on criteria such as procedure volumes, clinical outcomes, and treatment planning and coordination. Identification of appropriate conditions and/or procedures most suitable to a relationship with a Center of Excellence shall be based on analysis of the Contactor's data which demonstrates a high degree of variance in cost and/or outcomes.

Children's System of Care: The Contractor shall contract with Centers of Excellence which implement evidence based practices and track outcomes for the following children with special healthcare needs:

1. Children aged birth to five with behavioral health needs: Staffed with specialists who are endorsed by the Infant Toddler Mental Health Coalition of Arizona (ITMHCA) or other Endorsement program recognized under the Alliance for the Advancement of Infant Mental Health (formerly the League of States using the Michigan Association for Infant Mental Health Endorsement®),
2. Children at risk of/with Autism Spectrum Disorder (ASD),
3. Adolescents with substance use disorders, e.g.
 - a. Adolescent Community Reinforcement Approach (A-CRA),
 - b. Assertive Community Care (ACC),
 - c. Global Appraisal of Individual Needs (GAIN), and
4. Transition Aged Youth:
 - a. First episode psychosis programs, and
 - b. Transition to Independence (TIP) Model.

To encourage Contractor activity which incentivizes utilization of the best value providers for select, evidenced based, high volume procedures or conditions, the Contractor shall submit a Centers of Excellence report incorporating the ongoing implementation of contracts with Centers of Excellence. The Contractor shall identify the Centers of Excellence under contract for the contract year being reported and shall include a description as to how these Centers were selected. See below for report details. The report shall be included in the Provider Network Development and Management Plan as required under ACOM Policy 415, and submitted annually to AHCCCS/DHCM, as specified in Section F, Attachment F3, Contractor Chart of Deliverables.

Centers of Excellence Attachment

The Centers of Excellence Attachment shall outline the Contractor's process to develop, maintain and monitor activities for Centers of Excellence. The Attachment shall be limited to no more than two pages and include at a minimum:

1. Description of the Contractor's initiatives to encourage member utilization,
2. The extent the Contractor's activities focus on social determinants of health interventions,
3. Goals and outcome measures for the Contract Year,
4. Description of monitoring activities to occur throughout the year,
5. Evaluation of the effectiveness of the previous year's initiatives,
6. Summary of lessons learned and any implemented changes,
7. Description of the most significant barriers, and
8. Plan for next Contract Year.

E-Prescribing: E-Prescribing is an effective tool to improve members' health outcomes and reduce costs as delineated in ACOM Policy 321. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to: reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, and increased prescription accuracy. The Contractor shall increase its E-Prescribing rate of original prescriptions in accordance with ACOM Policy 321.

The NCPDP Prescription Origin Code and Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide, in order for AHCCCS to measure the Contractor's success.

75. RESERVED

[END OF SECTION D: PROGRAM REQUIREMENTS]

SECTION E: CONTRACT TERMS AND CONDITIONS**1. ADVERTISING AND PROMOTION OF CONTRACT**

The Contractor shall not advertise or publish information for commercial benefit concerning this Contract without the prior written approval of the Contracting Officer.

2. APPLICABLE LAW

Arizona Law - The law of Arizona applies to this Contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it.

3. ARBITRATION

The parties to this Contract agree to resolve all disputes arising out of or relating to this Contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. §12-1518 except as may be required by other applicable statutes.

4. ASSIGNMENT AND DELEGATION

The Contractor shall not assign any rights nor delegate all of the duties under this Contract, without the prior written consent of AHCCCS. Delegation of less than all of the duties of this Contract must conform to the requirements of Contract Section D, Subcontracts.

5. RESERVED**6. AUDIT AND INSPECTION**

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 438.3(h)].

The Contractor's or any subcontractor's books and records shall be subject to audit at any time 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 438.3(h), Section 1903(m)(2)(A)(iv) of the Social Security Act].

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.

The right to audit under this section exists during the term of this Contract and for 10 years from the termination of this Contract or the date of completion of any audit, whichever is later [42 CFR 438.3(h)].

7. AUTHORITY

This Contract is issued under the authority of the Contracting Officer who signed this Contract. Changes to the Contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized State employee or made unilaterally by

the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized written Contract amendments, shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes.

8. CHANGES

AHCCCS may at any time, by written notice to the Contractor, make changes within the general scope of this Contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this Contract, the Contractor may request an adjustment in compensation paid under this Contract. The Contractor must request an adjustment within 30 days from the date of receipt of the change notice.

Contract amendments are subject to approval by the Centers for Medicare and Medicaid Services (CMS), and approval is withheld until all amendments are signed by the Contractor. When AHCCCS issues an amendment to modify the Contract, the Contractor shall ensure contract amendments are signed and submitted to AHCCCS by the date specified by AHCCCS. The provisions of such amendment will be deemed to have been accepted on the day following the date AHCCCS requires an executed amendment, even if the amendment has not been signed by the Contractor, unless within that time the Contractor notifies AHCCCS in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCS will initiate termination proceedings.

9. CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this Contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities), and the Americans with Disabilities Act of 1990 as amended; Section 1557 of the Patient Protection and Affordable Care 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 [42 CFR 438.3(f)(1), 42 CFR 438.100(d)]. The Contractor shall maintain all applicable licenses and permits.

In accordance with [42 CFR 438.3(d)(3) and 42 CFR 438.3(d)(4), A.R.S. §41-1461 et seq.], and Executive Order 2009-09, the Contractor will not discriminate against individuals eligible to enroll on the basis of health status or need for healthcare services, race, color, national origin, sex, sexual orientation, gender identity or disability and the Contractor will not use any policy or practice that has the effect of discriminating on any of these bases.

The Contractor accepts individuals eligible for enrollment in the order in which they apply without restriction (except as otherwise specified by CMS), up to the limits set under the Contract [42 CFR 457.1201(d), 42 CFR 438.3(d)(1)].

11. CONFIDENTIALITY AND DISCLOSURE OF CONFIDENTIAL INFORMATION

The Contractor shall safeguard information in accordance with Federal and State statutes and regulations, including but not limited to: the Health Insurance Portability and Accountability Act of 1996

(Public Law 104-191), 45 CFR Parts 160 and 164, 42 CFR Part 431, Subpart F, 42 CFR Part 2, A.R.S. 36-664, A.R.S. 36-2903, A.R.S. 36-2932, A.R.S. 41-1959, A.R.S. 46-135, and any rules implanting those State statutes (e.g. A.A.C. R9-22-503, A.A.C. R9-22-512 and A.A.C. R9-28-514).

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 individual other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this Contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Contractor by AHCCCS.

12. CONFLICT OF INTEREST

The Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCS or the State without prior written approval by AHCCCS. The Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Contractor is now performing or elects to perform during the term of this Contract any services for any AHCCCS health plan, provider or Contractor or an entity owning or controlling same, the Contractor shall disclose this relationship prior to accepting any assignment involving such party.

13. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination and as directed in the termination notice.

14. CONTRACT

The Contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the Contract until funds have been encumbered.

15. CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this Contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The Contract shall be modified only through a written Contract amendment within the scope of the Contract signed by the Contracting Officer on behalf of the State and signed by a duly authorized representative of the Contractor.

Administrative Changes - The Contracting Officer, or authorized designee, reserves the right to correct any obvious clerical, typographical or grammatical errors, as well as errors in party contact information (collectively, "Administrative Changes"), prior to or after the final execution of an Amendment. Administrative Changes subject to permissible corrections include: misspellings, grammar errors, incorrect addresses, incorrect Amendment numbers, pagination and citation errors, mistakes in the labeling of the rate as either extended or unit, and calendar date errors that are illogical due to typographical error. The Procurement Office shall subsequently notice the Contractor of corrections to administrative errors in a written confirmation letter with a copy of the corrected Administrative Change attached.

16. COOPERATION WITH OTHER CONTRACTORS

AHCCCS may award other contracts for additional work related to this Contract and Contractor shall fully cooperate with such other contractors and AHCCCS employees or designated agents. The Contractor shall not commit or permit any act which will interfere with the performance of work by any other Contractor or by AHCCCS employees.

17. COVENANT AGAINST CONTINGENT FEES

The Contractor warrants that no individual or agency has been employed or retained to solicit or secure this Contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this Contract without liability.

18. DATA CERTIFICATION

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful [42 CFR 438.604, 42 CFR 438.606(b)]. Certification of financial and encounter data must be submitted concurrently with the data [42 CFR 438.606(c), 42 CFR 438.604(a) - (b)]. Certification may be provided by the Contractor's Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO [42 CFR 438.604, 42 CFR 438.606(a)].

19. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with State Law, AHCCCS Rules and this Contract.

Except as provided by 9 A.A.C. Chapter 22, Article 6, the exclusive manner for the Contractor to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and A.R.S. §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this Contract, the Contractor shall proceed with performance of this Contract in accordance with AHCCCS' instructions, unless AHCCCS specifically, in writing, requests termination or a temporary suspension of performance.

20. E-VERIFY REQUIREMENTS

In accordance with A.R.S §41-4401, the Contractor warrants compliance with all Federal immigration laws and regulations relating to employees and warrants its compliance with Section A.R.S. §23-214, Subsection A.

21. EFFECTIVE DATE

The effective date of this Contract shall be the date referenced on page 1 of this Contract or any subsequent amendments.

22. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Contractor shall comply with all Federal, State and local immigration laws and regulations relating to the immigration status of their employees during the term of the Contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the Contract. The State shall retain the right to perform random audits of Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default and suspension and/or debarment of the Contractor.

23. GRATUITIES

AHCCCS may, by written notice to the Contractor, immediately terminate this Contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including the making of any determination or decision about Contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by the Contractor.

24. INCORPORATION BY REFERENCE

This Solicitation and all attachments and amendments, the Contractor's Proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the Contract.

25. RESERVED**26. RESERVED****27. RESERVED****28. IRS W9 FORM**

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W-9 Form on file with the State of Arizona.

29. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in Federal and State Law and regulations, the Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from an individual who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the system.

30. LOBBYING

No funds paid to the Contractor by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United

States Congress or State Legislature in connection with awarding of any Federal or State Contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State Contract, grant, loan, or cooperative agreement. The Contractor shall disclose if any funds paid to the Contractor by AHCCCS have been used or will be used to influence the individuals and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

31. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee the Contractor any minimum or maximum quantity of services or goods to be provided under this Contract.

32. NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCS under this Contract are not exclusive.

33. 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. No claims paid by the Contractor to a network provider, out-of-network provider, subcontractor or financial institution located outside of the United States are considered in the development of actuarially sound capitation rates [42 CFR 438.602].

34. 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 Section 1115 waiver for the State of Arizona; the Arizona State Plan; the Constitution and laws of Arizona, and applicable State Rules; the terms of this Contract which consists of the RFP, the Proposal of the Successful Offeror, and any Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCS policies and procedures.

35. OWNERSHIP OF INFORMATION AND DATA

Materials, reports and other deliverables created under this Contract are the sole property of AHCCCS. The Contractor is not entitled to any rights to those materials and may not transfer any rights to anyone else. Except as necessary to carry out the requirements of this Contract, as otherwise allowed under this Contract, or as required by law, the Contractor shall not use or release data, information or materials, reports, or deliverables derived from that data or information without the prior written consent of AHCCCS. Data, information, and reports collected or prepared by the Contractor in the course of performing its duties and obligations under this Contract shall not be used by the Contractor for any independent project of the Contractor or publicized by the Contractor without the prior written permission of AHCCCS. Subject to applicable State and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose, and otherwise use all such information.

At the termination of the Contract, the Contractor shall make available all such data to AHCCCS within 30 days following termination of the Contract or such longer period as approved by AHCCCS/OOD. 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 75].

36. RESERVED**37. 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.

38. 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.

39. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that the Contractor does not intend to perform or is unable to continue to perform this Contract, the procurement officer may demand in writing that the Contractor give a written assurance of intent to perform. The demand shall be sent to the Contractor by certified mail, return receipt required. Failure by the Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the Contract.

40. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of the Contractor or subcontractor that is related to the performance of this Contract, in accordance with A.R.S. §41-2547.

41. RESERVED**42. SEVERABILITY**

The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract.

43. SUSPENSION OR DEBARMENT

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 [42 CFR 438.610] or under guidelines implementing Executive Order 12549. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity. The Contractor is obligated to screen all employees and contractors to determine whether any of them have been excluded from participation in Federal health care programs. The Contractor can search the HHS-OIG website by the names of any individuals. The database can be accessed at: www.oig.hhs.gov/fraud/exclusions.asp.

The Contractor shall not retain as a director, officer, partner, or owner of 5% or more of the Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCS may, by written notice to the Contractor, immediately terminate this Contract if it determines that the Contractor has been debarred, suspended, or otherwise lawfully prohibited from participating in any public procurement activity.

44. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR

Temporary Management/Operation by AHCCCS: Pursuant to the Medicaid Managed Care Regulations, 42 CFR Part 438, Subpart I, 42 Part 457, and A.R.S. §36-2903, AHCCCS is authorized to impose temporary management for a Contractor under certain conditions. Under Federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by the Contractor, including but not limited to the following: substantial failure to provide medically necessary services the Contractor is required to provide; imposition on members premiums or charges that exceed those permitted by AHCCCS, discrimination among members 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 a member 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 members' health or that temporary management is necessary to ensure the health of members while the Contractor is correcting the deficiencies noted above or until there is an orderly transition or reorganization of the Contractor. Under Federal law, temporary management is mandatory if AHCCCS determines that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Pursuant to 42 CFR 438.706, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction [42 CFR 438.706(b)-(d), Section 1932(e)(2)(B)(ii) of the Social Security Act].

If AHCCCS undertakes direct operation of the Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the Contract performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party; such powers shall only apply with respect to activities occurring after AHCCCS undertakes direct operation of the Contractor in connection with this Section.

All reasonable expenses of AHCCCS related to the direct operation of the Contractor, including attorney fees, cost of preliminary or other audits of the Contractor and expenses related to the management of any office or other assets of the Contractor, shall be paid by the Contractor or withheld from payment due from AHCCCS to the Contractor.

45. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this Contract shall be one year, with annual options to extend. Whereas previously the Contract Year was July 1 through June 30 with an annual July 1 renewal, the term of this Contract is amended to July 1, 2018 through September 30, 2019, in order to transition the Contract to October 1

through September 30 with an annual October 1 renewal, effective October 1, 2019. The terms and conditions of any such Contract extension shall remain the same as the original Contract, except as otherwise amended. Any Contract extension or renewal shall be through Contract amendment [42 CFR 438.610(c)(3)], and shall be at the sole option of AHCCCS.

Contract amendments, including renewals, are subject to approval by the Centers for Medicare and Medicaid Services (CMS). When the Contracting Officer issues an amendment to extend or renew the Contract, the provisions of such extension or renewal will be deemed to have been accepted 30 days after the date of mailing by the Contracting Officer, unless a different time period is specified by AHCCCS, even if the extension or renewal 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 or renewal amendment. Failure of an existing Contractor to accept an amendment to extend or renew may result in immediate suspension/termination of member assignment. If the Contractor provides such notification, the Contracting Officer may initiate Contract termination proceedings.

46. TERMINATION

AHCCCS reserves the right to terminate this Contract in whole or in part by reason of force majeure, due to the failure of the Contractor to comply with any term or condition of the Contract, including, but not limited to, circumstances which present risk to member health or safety, and as authorized by the Balanced Budget Act of 1997 and [42 CFR 438.710]. The term force majeure means an occurrence that is beyond the control of AHCCCS and occurs without its fault or negligence. Force majeure includes acts of God and other similar occurrences beyond the control of AHCCCS which it is unable to prevent by exercising reasonable diligence.

AHCCCS reserves the right to terminate this Contract and transition members to a different Contractor, or provide Medicaid benefits through other state plan or 1115 Waiver authority, if the state determines that the Contractor has failed to carry out the substantive terms of its Contract or has failed to meet the applicable requirements of Sections 1932, 1903(m) or 1905(t) of the Social Security Act [42 CFR 438.708(a), 42 CFR 438.708(b), Sections 1903(m), 1905(t), 1932 of the Social Security Act].

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 [Section 1932(e)(4) of the Social Security Act, 42 CFR 438.722(a)-(b)]. Pursuant to the Balanced Budget Act of 1997 and [42 CFR 438.710, 42 CFR 438.10], AHCCCS shall provide the Contractor with a pre-termination hearing before termination of the Contract.

Upon termination, all documents, data, and reports prepared by the Contractor under the Contract shall become the property of and be delivered to AHCCCS immediately on demand.

The Contractor shall retain, preserve and make available records, within the timeframes required by State and Federal law, including but not limited to, those records related to member grievances and appeal records, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement and those covered under HIPAA, as required by Contract, State and Federal law, including but not limited to 45 CFR 164.530(j)(2) and 42 CFR 438.3(u). See ACOM Policy 440.

AHCCCS may, upon termination of this Contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable for any excess costs incurred by AHCCCS in re-procuring the materials or services.

47. TERMINATION - AVAILABILITY OF FUNDS

If funds are not presently available to support the continuation of performance under this Contract beyond the current fiscal year, this Contract may be terminated at the end of the period for which funds are available. No legal liability on the part of AHCCCS for any payment may arise under this Contract until funds are made available for performance of this Contract.

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Contractor shall have no further obligation to AHCCCS.

48. TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this Contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of AHCCCS is, or becomes at any time while the Contract or any extension of the Contract is in effect, an employee of, or a consultant to, any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided by A.R.S. §38-511.

49. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the Contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, of the termination at least 90 days before the effective date of the termination. Upon receipt of written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to AHCCCS immediately upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

50. THIRD PARTY ANTITRUST VIOLATIONS

The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor toward fulfillment of this Contract.

51. TYPE OF CONTRACT

Fixed-Price, stated as capitated per member per month, except as otherwise provided.

52. WARRANTY OF SERVICES

The Contractor warrants that all services provided under this Contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by the Contractor shall not relieve the

Contractor from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all of the provisions of this Contract in the manner and to the same extent as the services originally furnished.

[END OF SECTION E: CONTRACT TERMS AND CONDITIONS]

SECTION F: ATTACHMENTS

ATTACHMENT F1:

MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

CONTRACT NO. YH15-0001

SECTION F: ATTACHMENTS

ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS

The Contractor shall have a written policy delineating its Grievance and Appeal System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Contractor shall furnish Grievance and Appeal System information to members no later than 12 days after the Contractor receives notice of the enrollment and annually thereafter. The Contractor shall provide this information to subcontractors at the time of Contract and make this information available in its provider manual and on its website. 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 members describing the Grievance and Appeal System as well as Contractor appeal and grievance notices, including denial and termination notices, shall be available in the prevalent non English language spoken for each LEP population in the Contractor's service area [42 CFR 438.3(d)(3)]. These written materials must also be made available in alternate formats upon request at no cost. Auxiliary aids and services must also be made available upon request and at no cost. These written materials shall include taglines in the prevalent non-English languages in Arizona and in large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services to understand the information and include the Contractor's toll free and TTY/TDY telephone numbers for customer service. Oral interpretation services shall not substitute for written translation of vital materials. Refer to ACOM Policy 404 and ACOM Policy 406 for additional information and requirements [42 CFR 438.408(d)(1), 42 CFR 438.10].

The Contractor shall inform members that oral interpretation services are available in any language, and alternative communication formats are available for members who have hearing or vision impairment.

For additional information regarding the member Notice of Adverse Benefit Determination process, and State developed notice templates, refer to ACOM Policy 414 and 42 CFR Part 438 [42 CFR 457.1207, 42 CFR 438.10(c)(4)(ii)]. For additional information regarding member information requirements, refer to ACOM Policy 404 and ACOM Policy 406.

Failure to comply with any of these provisions may result in an imposition of sanctions.

At a minimum, the Contractor must comply with the following Grievance and Appeal System Standards and incorporate these requirements into its policies and/or procedures:

1. The Contractor shall maintain accurate records of all grievances and appeals in a manner accessible to the State and available upon request to CMS and which must contain at a minimum the following [42 CFR 457.1260, 42 CFR 438.416(a), 42 CFR 438.416(b)(1)-(6), 42 CFR 438.416(c)]:
 - a. A general description of the reason for an appeal or grievance,
 - b. The date received,
 - c. The date of each review or, if applicable, review meeting,
 - d. The resolution at each level of appeal or grievance,
 - e. The date of resolution at each level,

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- f. The name of the member for whom the appeal or grievance was filed,
 - g. The name of the individual filing the appeal or grievance on behalf of the member, if applicable, and
 - h. The date the request for hearing was received, if applicable.
2. The Contractor has an effective mechanism in place for tracking receipt, acknowledgement, investigation, and resolution of grievances and appeals and for tracking requests for hearing within the required timeframes.
3. The Contractor shall track and trend Grievance and Appeal System information as a source of information for quality improvement and in accordance with the AHCCCS Grievance and Appeal System Reporting Guide.
4. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to a hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievance and appeals and the requirements and timeframes for filing a grievance, appeal, or request for hearing [42 CFR 457.1260, 42 CFR 438.414, 42 CFR 438.10(g)(2)(xi)(A)-(C)].
5. The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps related to the grievance and appeal process. This included but is not limited to auxiliary aids and services upon request, such as interpreter services and toll free numbers that have adequate TTY/TTD and interpreter capability [42 CFR 457.1260, 42 CFR 438.406(a), 42 CFR 438.228(a)].
6. The availability of toll-free numbers that a member can use to file a grievance or appeal by phone if requested by the member.
7. Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as appeals and are confirmed in writing unless the member or the provider requests expedited resolution [42 CFR 457.1260, 42 CFR 438.406(b)(3)].
8. The Contractor shall permit both oral and written appeals and grievances [42 CFR 457.1260, 42 CFR 438.402(c)(3)(i), 42 CFR 438.402(c)(3)(ii)].
9. The Contractor shall acknowledge receipt of each grievance and appeal. For grievances, the Contractor is not required to acknowledge receipt of the grievance in writing, however, if the member requests written acknowledgement, the acknowledgement must be made within five business days of receipt of the request. For appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one day of receipt of expedited appeals [42 CFR 457.1260, 42 CFR 438.406(b)(1), 42 CFR 438.228(a)].
10. The Contractor shall ensure individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making, or a subordinate of such individuals. The Contractor shall also ensure individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) grievances regarding denials of expedited

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resolutions of appeals or 3) grievances or appeals involving clinical issues have the appropriate clinical expertise in treating the member's condition or disease [42 CFR 457.1260, 42 CFR 438.406(b)(2)(ii)(A)-(C), 42 CFR 438.228(a)]. Decision makers on grievance and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination [42 CFR 457.1260, 42 CFR 438.406(b)(2)(iii), 42 CFR 438.228(a)]. AHCCCS does not offer or arrange for an external medical review as described in 42 CFR 457.1260 and 42 CFR 438.402(c)(1)(i)(B).

11. The Contractor shall not delegate the Grievance and Appeal System requirements to its providers.
12. Define a grievance as a member's expression of dissatisfaction with any matter, other than an Adverse Benefit Determination [42 CFR 438.400(b)]. There are no time limits for filing a member grievance.
13. A member must file a grievance with the Contractor and the member is not permitted to file a grievance directly with AHCCCS [42 CFR 457.1260, 42 CFR 438.402(c)(3)(i)].
14. The Contractor shall address identified issues as expeditiously as the member's condition requires and must resolve each grievance within 10 business days of receipt, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor decisions on member grievances cannot be appealed [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(1) and (3)].
15. The Contractor responds to a grievance in writing, if a member requests a written explanation of the resolution, and the response must be mailed within 10 business days of resolution of the grievance.
16. If resolution to a grievance or appeal of an Adverse Benefit Determination is not completed when the timeframe expires, the member is deemed to have exhausted the Contractor's grievance process and the can file a request for hearing [42 CFR 457.1260, 42 CFR 438.408, 42 CFR 438.402(c)(1)(i)(A)].
17. The resolution timeframe for an appeal may be extended by up to 14 calendar days if the member requests the extension or if the Contractor shows that there is a need for additional information and that the delay is in the member's interest [42 CFR 457.1260, 42 CFR 438.408(b)(1)-(3), 42 CFR 438.408(c)(1)(i)-(iii)].
18. If the Contractor extends the timeframe for resolution of an appeal not at the request of the member, the Contractor must make reasonable efforts to give the member prompt oral notice of the delay and give the member written notice within two calendar days of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision [42 CFR 457.1260, 42 CFR 438.408(c)(2)(i)-(ii), 42 CFR 438.408(b)(1)-(3)].
19. Define a service authorization request as a request by the member, the representative, or a provider for a physical or behavioral health service for the member which requires Prior Authorization (PA) by

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the Contractor [42 CFR 438.210]. The Contractor shall ensure completion of the service authorization request decision within the timeframe applicable to the particular type of the authorization request: 1) authorization requests for medications and 2) authorization requests that do not involve medications. The Contractor shall process standard and expedited authorization requests as service authorization requests that do not involve medications. The Contractor shall process service authorization requests pertaining to medications according to the timeframes applicable to medication requests and not according to the standard or expedited timeframes used for non medication service authorization requests.

20. Define a standard authorization request for standard authorization decisions not involving medications: A standard authorization request is a request for a service that is not a medication and which does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the Contractor receives the request is considered the date of receipt and is used to determine the due date for completion of the decision. For standard authorization decisions (those not involving medications), the Contractor must provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 additional calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's best interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(1)(i)-(ii), 42 CFR 438.404(c)(3)-(c)(4)]. The Notice of Adverse Benefit Determination 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.
21. Define an expedited authorization request for expedited authorization decisions not involving medications: An expedited authorization request is a request for a service that is not a medication in which either the requesting provider indicates, or the Contractor determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. For expedited authorization decisions (those not involving medications), the Contractor must provide a Notice of Adverse Benefit Determination to the member as expeditiously as the member's health condition requires, but not later than 72 hours following the receipt of the authorization request, regardless of whether the 72 hour deadline falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Contractor establishes a need for additional information and the delay is in the member's interest [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(2)(i)-(ii), 42 CFR 438.404(c)(6)].
22. For service authorization decisions for medications, the Contractor must provide a Notice of Adverse Benefit Determination no later than 24 hours from receipt of the authorization request regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. If the prior authorization request for the medication lacks sufficient information for the Contractor to render a decision for the medication,

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the Contractor shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request. The Contractor must provide the Notice of Adverse Benefit Determination no later than seven business days from the initial date of the authorization request [42 CFR 438.3(s)].

23. The Contractor shall ensure that the date/hour it receives the request, whichever is applicable, is considered the date/time of receipt of the service authorization request. The Contractor may use electronic date stamps or manual stamping for logging the receipt.
24. Define an Adverse Benefit Determination as set forth below [42 CFR 438.400(b)] and permit a member, or their designated representative, to file an appeal of an Adverse Benefit Determination taken by the Contractor. Adverse Benefit Determinations are any of the following:
 - a. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit,
 - b. Reduction, suspension, or termination of a previously authorized service,
 - c. Denial, in whole or in part, of payment for a service,
 - d. Failure to provide services in a timely manner, as defined by the State,
 - e. Failure to act within the timeframes provided in 42 CFR 457.1260 and 42 CFR 438.408(b)(1)and(2) required for standard resolution of appeals and standard disposition of grievances,
 - f. Denial of a rural member'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, and
 - g. Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.
25. The Notice of Adverse Benefit Determination for a service authorization decision that is not completed within the standard, expedited, or medication authorization request timeframes, whichever is applicable, will be made on the date that the timeframes expire [42 CFR 438.404(c)(5)]. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the Contractor must give the member written notice of the reason to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the member's health condition requires and no later than the date the extension expires [42 CFR 457.1260, 42 CFR 457.1230(d), 42 CFR 438.210(d)(1)(ii), 42 CFR 438.404(c)(4)(i)-(ii)].
26. The Contractor shall notify the requesting provider, in writing, of the decision to deny or reduce a service authorization request.
27. The Contractor shall provide a Notice of Adverse Benefit Determination: 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 Adverse Benefit Determination in the case of alleged fraud; 3) at the time of any Adverse Benefit Determination affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 calendar days from receipt of a standard service authorization request, within 72 hours from receipt of an expedited service authorization request, unless an extension is in effect, or within 24 hours from

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receipt of a medication authorization request, unless additional information is needed from the prescriber in which case the determination must be provided no later than seven business days from receipt of the initial request. For service authorization decisions, the Contractor shall also ensure that the Notice of Adverse Benefit Determination provides the member 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 [42 CFR 438.404(c)(1), 42 CFR 431.211, 42 CFR 438.404(c)(1), 42 CFR 431.214, 42 CFR 438.404(c)(2)].

As described below, the Contractor may elect to mail a Notice of Adverse Benefit Determination no later than the date of Adverse Benefit Determination when [42 CFR 438.404(c)(1), 42 CFR 431.213, 42 CFR §431.231(d), Section 1919(e)(7) of the Social Security Act, 42 CFR 483.12(a)(5)(i), 42 CFR 483.12(a)(5)(i)-(ii)]:

- a. The Contractor receives notification of the death of a member,
- b. The member 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 member is admitted to an institution where he/she is ineligible for further services,
- d. The member's address is unknown and mail directed to the member has no forwarding address, and
- e. The member has been accepted for Medicaid in another local jurisdiction.

28. The Notice of Adverse Benefit Determination must explain: 1) the Adverse Benefit Determination the Contractor has taken or intends to take, 2) the reasons for the Adverse Benefit Determination including the right of the member to be provided upon request, and at no charge, reasonable access to copies of all documents, records and other information related to the Adverse Benefit Determination; this information includes medical necessity criteria, any processes, strategies or evidentiary standards used in setting coverage limits, 3) the member'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 member's right to receive continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the member may be required to pay for the cost of these services. The Notice of Adverse Benefit Determination shall comply with ACOM Policy 414 [42 CFR 457.1260, 42 CFR 438.404(b)(1)-(b)(6), 42 CFR 438.402(b)-(c)].

29. Define an appeal as the request for review of an Adverse Benefit Determination, as defined above [42 CFR 438.400(b)].

30. Define a standard appeal. The Contractor shall resolve standard appeals as expeditiously as the member's health condition requires but no later than 30 calendar days from the date of receipt of the appeal unless an extension is in effect [42 CFR 457.1260, 42 CFR 438.408(a), 42 CFR 438.408(b)(2)]. 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 [42 CFR 457.1260, 42 CFR 438.402(b), 42 CFR 438.228(a)].

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31. Define an expedited appeal as an appeal in which the Contractor determines (for a request from a member) or the Provider indicates (when making the request for the member or in support of the member's request) that taking the time for standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The Contractor shall resolve all expedited appeals as expeditiously as the member's health condition requires but not later than 72 hours from the date the Contractor receives the expedited appeal (unless an extension is in effect) [42 CFR 438.408(a), 42 CFR 438.408(b)(3)]. The Contractor shall make reasonable efforts to provide oral notice to a member regarding an expedited resolution appeal [42 CFR 457.1260, 42 CFR 438.408(d)(2)(ii)]. 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 [42 CFR 438.402(b), 42 CFR 438.228(a)].
32. A member shall be given 60 calendar days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal [42 CFR 457.1260, 42 CFR 438.402(c)(2)(ii)].
33. Explain that a provider or authorized representative acting on behalf of a member and with the member's written consent, may file an appeal, grievance, or request a state fair hearing [42 CFR 457.1260, 42 CFR 438.402(c)(1)(i)-(ii), 42 CFR 438.408]. The provider or authorized representative acting on behalf of the member shall be given 60 calendar days from the date of the Contractor's Notice of Adverse Benefit Determination to file an appeal either orally or in writing unless an expedited resolution is requested, oral appeals must be followed by a written, signed appeal [42 CFR 457.1260, 42 CFR 438.402(c)(1)(ii), 42 CFR 438.402(c)(2)(ii), 42 CFR 438.402(c)(3)(ii)].
34. The Contractor includes, as parties to the appeal, the member, the member's legal representative, or the legal representative of a deceased member's estate [42 CFR 457.1260, 42 CFR 438.406(b)(6)].
35. The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports a member's appeal [42 CFR 457.1260, 42 CFR 438.410(b)].
36. The resolution timeframes for standard appeals and expedited appeals may be extended up to 14 calendar days if the member requests the extension or if the Contractor establishes a need for additional information and that the delay is in the member's interest [42 CFR 457.1260, 42 CFR 438.408(c), 42 CFR 438.408(b)].
37. If the Contractor extends the timeframe for resolution of an appeal when not requested by the member, the Contractor shall make reasonable efforts to give the member prompt oral notice and follow-up within two calendar days with a written notice of the reason for the decision to extend the timeframe and the member's grievance rights [42 CFR 457.1260, 42 CFR 438.408(c)(2)(i)-(iii), 42 CFR 438.408(b)(2)and (3)].
38. The Contractor shall establish and maintain an expedited review process for appeals when 1) the Contractor determines (for a request from a member) the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function or 2) the provider indicates (in making the request on behalf of the member or in support of the member's request) the standard resolution timeframe could seriously

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jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function [42 CFR 457.1260, 42 CFR 438.210(d)(2)(i), 42 CFR 438.404(c)(6), 42 CFR 438.410(a)].

39. If the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30-calendar day timeframe for a standard appeal [42 CFR 457.1260, 42 CFR 438.410(c), 42 CFR 438.408(b)(2), 42 CFR 438.408(c)(2)]. The Contractor must make reasonable efforts to give the member prompt oral notice and follow-up within two calendar days with a written notice of the denial of expedited resolution and the member's grievance rights.
40. For appeals, the Contractor provides the member a reasonable opportunity to present evidence and to make legal and factual arguments in person and in writing [42 CFR 438.406(b)(4), 42 CFR 438.408(b), 42 CFR 438.408(c)]. The Contractor must inform the member of the limited time available to provide this information sufficiently in advance of the resolution timeframe [42 CFR 438.406(b)(4), 42 CFR 438.408(b), 42 CFR 438.408(c)].
41. For appeals, the Contractor provides the member and his/her representative the member's case file including medical records, other documents and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal. This information must be provided at no charge to the member and sufficiently in advance of the resolution timeframe [42 CFR 457.1260, 42 CFR 438.406 (b)(5)].
42. The Contractor shall provide written Notice of Appeal Resolution to the member and the member's representative or the representative of the deceased member'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 members: a) the member's right to request a State fair hearing (including the requirement that the member must file the request for a hearing in writing) no later than 120 days after the date the member receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing when the member has requested a hearing within 10 calendar days from the date the notice of resolution was sent and how to request continuation of benefits and c) information explaining that the member may be held liable for the cost of benefits if the hearing decision upholds the Contractor [42 CFR 438.408(d)(2)(i)-(ii), 42 CFR 438.10, 42 CFR 438.408(e)(1)-(2)].
43. The Contractor shall continue benefits if all of the following occur: [42 CFR 438.420, 42 CFR 438.402(c)(2)(ii)].
 - a. The member files the request for an appeal within 60 calendar days following the date on the Adverse Benefit Determination notice.
 - b. The appeal involves:
 - i. The termination, suspension, or reduction of a previously authorized service, or
 - ii. A denial and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.
 - c. The member's services were ordered by an authorized provider.
 - d. When the appeal was filed, the period covered by the original authorization has not expired, AND
 - e. The member files a request for continuation of benefits on or before the later of the following:

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- i. Within 10 calendar days of the Contractor sending the notice of Adverse Benefit Determination, or
 - ii. The intended effective date of the Contractor's proposed Adverse Benefit Determination.
44. If, at a member's request benefits are continued or are reinstated while the appeal or State fair hearing is pending, benefits shall be continued until one of the following occur [42 CFR 438.420(c)(1)-(3), 42 CFR 438.408(d)(2)]:
- a. The member withdraws the appeal or request for State fair hearing.
 - b. The member does not request a State fair hearing and continuation of benefits within 10 calendar days from the date the Contractor sends the notice of an adverse appeal resolution, or
 - c. A State fair hearing decision adverse to the member is issued.

The Contractor shall continue benefits regardless of the period of the initial prior authorization, if all of the requirements in 41 are met.

The Contractor may, consistent with AHCCCS policy on recoveries and as specified in Contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds the Contractor's Adverse Benefit Determination [42 CFR 438.420(d), 42 CFR 431.230(b)].

45. The Contractor shall continue extended benefits originally provided to the member until any of the following occurs: 1) the member withdraws the appeal or request for State fair hearing, 2) the member has not specifically requested continued benefits pending a hearing decision within 10 calendar days of the Contractor mailing of the appeal resolution notice, or 3) AHCCCS issues a State fair hearing decision adverse to the member.
46. If the member files a request for hearing the Contractor must ensure that the hearing request and supporting documentation is submitted to the AHCCCS Office of Administrative Legal Services (OALS) as specified by ACOM Policy 445 and Attachment F3, Contractor Chart of Deliverables. State fair hearing notices will be issued by the AHCCCS Administration and are not delegated to the Contractor [42 CFR 438.228(b)].
47. 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 as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 457.1260, 42 CFR 438.424(a)]. Services must be authorized within the above timeframe irrespective of whether the Contractor contests the decision.
48. 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 [42 CFR 457.1260, 42 CFR 438.424(b)].
49. 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

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provider shall have 90 days from the date of the reversed decision to submit a clean claim to the Contractor for payment. For all claims submitted as a result of a reversed decision, the Contractor is prohibited from denying claims for un-timeliness if they are submitted within the 90 day timeframe. The Contractor is also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

50. If the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending the appeal or State fair hearing decision, the Contractor may recover the cost of those services from the member.

[END OF ATTACHMENT F1: MEMBER GRIEVANCE AND APPEAL SYSTEM STANDARDS]

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ATTACHMENT F2:

PROVIDER CLAIM DISPUTE STANDARDS

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ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS

The Contractor shall have in place a written claim dispute policy for its subcontractors and non-contracted providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies.

Failure to comply with any of these provisions may result in the imposition of sanctions.

The Contractor shall comply with the following provisions:

1. The Provider Claim Dispute Policy shall stipulate that all claim disputes must be adjudicated in Arizona, including those claim disputes arising from claims processed by an Administrative Services Subcontractor.
2. The Provider Claim Dispute Policy shall be provided to all subcontractors at the time of Contract. For providers without a contract, the Contractor shall send a copy of its Provider Claims Dispute Policy within 45 days of receipt of a claim. The policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.
3. 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.
4. The Provider Claim Dispute Policy must specify a physical local address in Arizona for the submission of all provider claim disputes and hearing requests.
5. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.
6. The Contractor shall develop and maintain a tracking log for all claim disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claim dispute, resolution of the claim dispute and the date of resolution.
7. Claim disputes are acknowledged in writing and within five business days of receipt.
8. Claim disputes are thoroughly investigated using the applicable statutory, regulatory, Contractual and policy provisions, ensuring that relevant facts are obtained from all parties.
9. All documentation received by the Contractor during the claim dispute process is dated upon receipt.
10. All claim disputes are filed in a secure, designated area and are retained for five years following the Contractor's decision, the AHCCCS decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.

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11. The Provider Claim Dispute Policy must specify a copy of the Contractor's Notice of Decision (Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:
 - a. The nature of the claim dispute.
 - b. The specific factual and legal basis for the dispute, including but not limited to, an explanation of the specific facts that pertain to the claim dispute, the identification of the member name, pertinent dates of service, dates and specific reasons for Contractor denial/payment of the claim, and whether or not the provider is a contracted provider.
 - c. An explanation of 1) how the Contractor applies the relevant and specific facts in the case to the relevant laws to support the Contractor's decision and 2) the applicable statutes, rules, Contractual provisions, policies, and procedures, if applicable. Reference to general legal authorities alone is not acceptable.
 - d. The Provider's right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Decision.
 - e. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.
12. If the provider files a written request for hearing, the Contractor must ensure that the hearing request and supporting documentation is submitted to the AHCCCS Office of Administrative Legal Services (OALS), as specified by ACOM Policy 445 and Attachment F3, Contractor Chart of Deliverables.
13. If the Contractor upholds a claim dispute and a request for hearing is subsequently filed, the Contractor must review the matter to determine why the request for hearing was filed and resolve the matter when appropriate.
14. If the Contractor's Decision regarding a claim dispute is reversed, in full or in part, through the appeal process, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision, along with any applicable interest, within 15 business days of the date of the Decision.
15. If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives the notice reversing the determination [42 CFR 438.424]. Services must be authorized within the above timeframe irrespective of whether the Contractor contests the decision.

[END OF ATTACHMENT F2: PROVIDER CLAIM DISPUTE STANDARDS]

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**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

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ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES

The following table is a summary of the periodic reporting requirements for the Contractor and is subject to change at any time during the term of the Contract. The table is presented for convenience only and should not be construed to limit the Contractor's responsibilities in any manner. Content for all deliverables is subject to review. AHCCCS may assess sanctions if it is determined that late, inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM Arizona time on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM Arizona Time on the next business day.

All deliverables which are noted to be submitted via SharePoint are to be submitted to the SharePoint Contract Compliance site at: compliance.azahcccs.gov. Should AHCCCS modify any deliverables, or the submission process for deliverables, AHCCCS shall provide a notice of instruction to the Contractor outlining changes to the deliverable.

Refer to Contractor Chart of Deliverables below

SECTION F: ATTACHMENTS

**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DBF/TPL UNIT	Ad Hoc	Third Party Liability Reporting - Involving Commercial Insurance Payor Sources: TPL Leads File or Via the TPL Referral Web Portal	Within 10 days of discovery	D,56	AHCCCS Technical Interface Guidelines	N/A	AHCCCS FTP to AHCCCS ISD or TPL Referral Web Portal: ecenter.hmsy.com/ to AHCCCS TPL Contractor (HMS)
DBF/TPLUNIT	Ad Hoc	Third Party Liability Reporting - Other Third Party Liability Recoveries: For Determination of a Mass Tort, Total Plan Case, or Joint Case	Within 10 days of discovery	D,56	AHCCCS Technical Interface Guidelines	N/A	Email, Fax, or mail submission to AHCCCS TPL Contractor (HMS)
DBF/TPL UNIT	Ad Hoc	Total Plan Case Settlement Reporting via the Settlement Notification Form	Within 10 business days from the settlement date	D,56	ACOM Policy 434	ACOM Policy 434, Attachment A	Email, Fax, or mail submission to AHCCCS TPL Management Analyst

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DBF/TPL UNIT	Monthly	Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)	20th day of the month	D,56	ACOM Policy 434	ACOM Policy 434, Attachment A	Email, Fax, or mail submission to AHCCCS TPL Management Analyst
DHCM/CLINICAL ADMINISTRATOR	Ad Hoc	Communication of Adverse Action to Provider	Within one business day	D,22	AMPM Policies 910, 950, and 960	N/A	SharePoint
DHCM/CLINICAL ADMINISTRATOR	Quarterly	Key Staff: Staff Primary and Back-Up Contact Information for Urgent Issue Resolution-Non Business Hours	5 days after the start of each quarter	D,15	N/A	N/A	SharePoint
DHCM/CLINICAL RESOLUTION	Ad Hoc	Contractor Response to AHCCCS Regarding Member Grievances (Response to Problem Resolution)	Initial 2 to 72 hour response as indicated by complaint urgency	D,25	N/A	N/A	Email to DHCM Clinical Resolution Specialist

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/DATA ANALYSIS & RESEARCH	Ad Hoc	Corporate Compliance: CMS Compliance Issues Related to HIPAA Transaction and Code Set Complaints or Sanction	Immediately upon discovery	D,60	N/A	N/A	SharePoint
DHCM/DATA ANALYSIS & RESEARCH	Ad Hoc	Medical Records or Supporting Documentation	As specified in the requesting letter	D,63	AHCCCS Data Validation Technical Document	N/A	FTP server
DHCM/DATA ANALYSIS RESEARCH	Annually	AHCCCS Security Rule Compliance Report	June 1	D,62	ACOM Policy 108	ACOM Policy 108, Attachment A	SharePoint
DHCM/DATA ANALYSIS & RESEARCH	Monthly	Corrected Pended Encounter Data	Monthly, according to established schedule	D,63	AHCCCS Encounter Manual	N/A	FTP server
DHCM/DATA ANALYSIS & RESEARCH	Monthly	New Day Encounter	Monthly, according to established schedule	D,63	AHCCCS Encounter Manual	N/A	FTP server

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/DATA ANALYSIS & RESEARCH	Quarterly	Encounter Submission and Tracking	15 days after the end of each quarter	D,63	AHCCCS Encounter Manual	N/A	FTP server
DHCM/DATA ANALYSIS & RESEARCH	Quarterly	Plan Overrides	15 days after the end of each quarter	D,63	AHCCCS Encounter Manual	https://www.azahcccs.gov/PlansProviders/HealthPlans/encounters.html	FTP server
DHCM/DATA ANALYSIS & RESEARCH	Quarterly	Plan Voids	15 days after the end of each quarter	D,63	AHCCCS Encounter Manual	N/A	FTP server
DHCM/FINANCE	Ad Hoc	Advances, Loans, Loan Guarantees, Investments, or Equity Distributions to Related Parties or Affiliates	Submit for approval 30 days prior to anticipated date of distribution prior	D,47	AHCCCS Financial Reporting Guide	N/A	FTP server with email notification to DHCM Finance Manager

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/FINANCE	Ad Hoc	Change in Contractor Organizational Structure: Automatic Clearing House (ACH) Vendor Authorization Form	45 days prior to the effective date and commencement of operations	D,50	ACOM Policy 317	https://www.aahcccs.gov/PlansProviders/RatesAndBilling/FFS/directdeposit.html	SharePoint
DHCM/FINANCE	Ad Hoc	Corporate Cost Allocation Plans and Adjustment in Management Fees	Prior approval required	D,36	AHCCCS Financial Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Ad Hoc	Physician Incentives: Contractual Arrangements with Substantial Financial Risk	45 days prior to implementation of the Contract	D,41	N/A	N/A	SharePoint
DHCM/FINANCE	Annually	Draft Audit Financial Information for Contractor (Flat File)	90 days after the Contract Year End (12/29)	D,48	AHCCCS Financial Reporting Guide	N/A	FTP Server

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CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/FINANCE	Annually	Draft Audit Financial Reporting Package	90 days after the end of the Contractor's fiscal year end	D,48	AHCCCS Financial Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Annually	Final Audit Financial Reporting Package	120 days after the Contractor's fiscal year end	D,48	AHCCCS Financial Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Annually	Final Audit Financial Information for Contractor (Flat File)	120 days after the Contract Year End (1/28)	D,48	AHCCCS Financial Reporting Guide	N/A	FTP Server
DHCM/FINANCE	Annually	Medical Loss Ratio Report	5 months following the year end	D,48	Financial Reporting Guide	N/A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/FINANCE	Quarterly	Cost Avoidance Savings Recovery Report	Due 45 days after the reporting quarter: (Oct - Dec: Due Feb 14) (Jan – March: Due May 15) (Apr – June: Due August 14) (July – Sept: Due Nov 14)	D,56	AHCCCS Program Integrity Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Quarterly	Financial Reporting Package	60 days after the end of each quarter	D,48	AHCCCS Financial Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Quarterly	FQHC Member Information	60 days after the end of each quarter	D,33	AHCCCS Financial Reporting Guide	N/A	SharePoint
DHCM/FINANCE	Quarterly	Premium Tax Reporting	March 15 June 15 September 15 December 15	D,51	ACOM Policy 304	https://insurance.az.gov/insurers/taxes/ahcccs-contractor	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/FINANCE	Quarterly	Unaudited Financial Information for Contractor (Flat File)	60 days after the end of each quarter	D,48	AHCCCS Financial Reporting Guide	N/A	FTP Server
DHCM/FINANCE	Quarterly	Verification of Receipt of Paid Services	15 th 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)	D,48	ACOM Policy 424	ACOM Policy 424, Attachment A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MCH/EPST DT	Ad Hoc	AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Requests	30 days after the end of the month	D,9	AMPM Policy 410	N/A	SharePoint
DHCM/MCH/EPST DT	Ad Hoc	Stillbirth Supplement Request	Within six months from the delivery date	D,9	AMPM Policy 410	AMPM Policy 410, Attachment B	SharePoint
DHCM/MCH/EPST DT	Annually	Dental Plan and Evaluation	December 15	D,9	AMPM Policy 431	AMPM Policy 431, Attachment B	SharePoint
DHCM/MCH/EPST DT	Annually	EPST Plan and Evaluation	December 15	D,9	AMPM Policy 430	AMPM Policy 400, Exhibit 2B	SharePoint
DHCM/MCH/EPST DT	Annually	Maternity and Family Planning Services Plan and Evaluation	December 15	D,22	AMPM Policy 420; AMPM Policy 400	AMPM Policy 400, Exhibit 2A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MCH/EPST DT	Monthly	Pregnancy Termination Report	30 days after the end of the month	D,9	AMPM Policy 410	AMPM Policy 410, Attachment C, Attachment D, and Attachment E	SharePoint
DHCM/MCH/EPST DT	Monthly	Sterilization Reporting	30 days after the end of the month	D,9	AMPM Policy 420	AMPM Policy 420, Attachment B	SharePoint
DHCM/MCH/EPST DT	Quarterly	EPST and Adult Monitoring Report	15 days after the end of each quarter	D,9	AMPM Policy 430	AMPM Appendix A	SharePoint
DHCM/MCH/EPST DT	Semi-Annually	Number of Pregnant Women who are HIV/AIDS-Positive	30 days after the reporting periods of: [10/1 through 3/31] & [4/1 through 9/30]	D,22	AMPM Policy 410	AMPM Policy 410, Attachment A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MEDICAL MANAGEMENT	Ad Hoc	Changes to Interventions and Parameters to Contractor's Exclusive Pharmacy and/or Single Prescriber Process	30 days prior to implementation	D,23	AMPM Policy 310-FF; AMPM Policy 1020	AMPM Policy 1020, Attachment E	SharePoint
DHCM/MEDICAL MANAGEMENT	Ad Hoc	Mental Health Parity Deficiencies Report	Within 5 business days of identifying the deficiency	D,11	ACOM Policy 110	Reporting Form as provided by DHCM, Medical Management Manager	SharePoint
DHCM/MEDICAL MANAGEMENT	Ad Hoc	Non-Transplant and Catastrophic Reinsurance	Within 30 days for a newly enrolled member to plan or newly diagnosed	D,55	AHCCCS Reinsurance Policy Manual	N/A	Right Fax

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MEDICAL MANAGEMENT	Annually	Documentation Supporting Compliance with Mental Health Parity	August 15	D,11	ACOM Policy 110	Reporting Form as provided by DHCM, Medical Management Manager	SharePoint
DHCM/MEDICAL MANAGEMENT	Annually	Drug Utilization Review	To be determined depending on CMS submission requirements	D,22	N/A	N/A	SharePoint
DHCM/MEDICAL MANAGEMENT	Annually	High Need/High Cost Member List	October 31	D,23	AMPM Policy 1020	AMPM Policy 1020, Attachment G	SharePoint
DHCM/MEDICAL MANAGEMENT	Annually	MM Plan, Evaluation, and Work Plan	December 15	D,23	AMPM Chapter 1000	AMPM Policy 1020, Attachment H and Attachment I	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MEDICAL MANAGEMENT	Annually	Non-Transplant and Catastrophic Reinsurance	By October 30 of each contract year	D,55	AHCCCS Reinsurance Policy Manual	N/A	SharePoint
DHCM/MEDICAL MANAGEMENT	Quarterly	Inpatient Hospital Showings Report	15 days after the end of each quarter	D,23	AMPM Policy 1020	N/A	SharePoint
DHCM/MEDICAL MANAGEMENT	Quarterly	NOA Self-Audit Scores and Executive Summary	45 days after the end of each quarter	D,9	ACOM Policy 414	Reporting Form as provided by DHCM, Medical Management Manager	SharePoint
DHCM/MEDICAL MANAGEMENT	Quarterly	Pharmacy and/or Prescriber - Member Assignment Report	15 days after the end of each quarter	D,23	AMPM Policy 310-FF; AMPM Policy 1020	AMPM Policy 1020, Attachment E	SharePoint
DHCM/MEDICAL MANAGEMENT	Quarterly	Special Health Care Needs Report	15 days after the end of each quarter	D,10	AMPM Policy 1020	AMPM Policy 1020, Attachment D	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/MEDICAL MANAGEMENT	Quarterly	Transplant Log	15 days after the end of each quarter	D,23	AHCCCS Reinsurance Manual	AHCCCS Reinsurance Manual, Reinsurance Form, Quarterly Transplant Log	SharePoint
DHCM/MEDICAL MANAGEMENT	Semi-Annually	Emergency Department Diversion Summary	October 15 April 15	D,23	AMPM Policy 1020	AMPM Policy 1020, Attachment F	SharePoint
DHCM/NETWORK	Ad Hoc	Appointment Availability Review Methods	30 days prior to implementation of the proposed method	D,32	ACOM Policy 417	N/A	SharePoint
DHCM/NETWORK	Ad Hoc	Material Change to Provider Network	60 days prior to expected implementation of the change	Section D,28	ACOM Policy 439	ACOM Policy 439, Attachment A	SharePoint

SECTION F: ATTACHMENTS

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/NETWORK	Ad Hoc	Proposed Alternative Multispecialty Interdisciplinary Care Providers	60 days prior to implementation	D,25	ACOM Policy 436	N/A	SharePoint
DHCM/NETWORK	Ad Hoc	Unexpected Material Change to Provider Network - Analysis	Within one week of the 'Unexpected Material Change to Provider Network – Notification	D,28	N/A	N/A	SharePoint
DHCM/NETWORK	Ad Hoc	Unexpected Material Change to Provider Network - Notification	Within one business day	Section D,28	N/A	N/A	SharePoint
DHCM/NETWORK	Annually	Provider Network Development and Management Plan	November 15	Section D,26	ACOM Policy 415	ACOM Policy 415, Attachment B	SharePoint
DHCM/NETWORK	Quarterly	Appointment Availability Review	15 days after the end of each quarter	D,32	ACOM Policy 417	ACOM Policy 417, Attachment A	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/NETWORK	Quarterly	Provider Affiliation Transmission (PAT)	15 days after the end of each quarter (January, April, July, October)	D,27	AHCCCS Provider Affiliation Transmission Manual	N/A	FTP server with email notification to DHCM Network Administrator
DHCM/NETWORK	Quarterly	Provider/Network Changes Due to Rates Report	15 days after the end of each quarter	D,28	ACOM Policy 415	ACOM Policy 415, Attachment D	SharePoint
DHCM/OPERATIONS	Ad Hoc	Administrative Services Subcontractor Non-Compliance Reporting	Within 30 days of discovery	D,36	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Administrative Services Subcontracts	60 days prior to the beginning date of the subcontract	D,36	ACOM Policy 438	ACOM Policy 438, Attachment A	SharePoint
DHCM/OPERATIONS	Ad Hoc	AHCCCS Required Survey Results	45 days after the completion	D,18	N/A	N/A	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	Change in Contractor Organizational Structure: Notification	180 days prior to the effective date	D,50	ACOM Policy 317	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Change in Contractor Organizational Structure: Transition Plan Final Documents	90 days prior to the effective date	D,50	ACOM Policy 317	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Change in Contractor Organizational Structure: Transition Plan Initial Documents	180 days prior to the effective date	D,50	ACOM Policy 317	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Claim Recoupments >12 Months from Original Payment	Upon identification by Contractor	D,37	ACOM Policy 412	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Completed Change in Contractor Organizational Structure: Documents Required after AHCCCS Approval	Within 120 days of the completed change in Contractor organizational structure	D,50	ACOM Policy 317	N/A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	Contractor Request to Add Organizations to Attachment A, Organizations Recognized by AHCCCS	30 days prior to intended use	D,17	ACOM Policy 404	ACOM Policy 404, Attachment A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Data Processes for Recoupments	120 days from receipt of approval	D,37	ACOM Policy 412	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Final Survey Tool	90 days prior to the intended start	D,18	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	ID Cards requiring AHCCCS Approval	30 days prior to dissemination	D,17	ACOM Policy 433	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Independent Audits of Claims Payment/Health Information Systems	Upon request by AHCCCS	D,37	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Key Staff: Contact Information Change	Within one business day of the change	D,15	N/A	N/A	SharePoint

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**ATTACHMENT F3:
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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	Key Staff: Key Position Change	Within 7 days of learning of resignation	D,15	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Key Staff: Notification of Moving Functions Out of State	60 days prior to proposed change	D,15	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Material Change to Business Operations	60 days prior to expected implementation of the change	D,42	ACOM Policy 439	ACOM Policy 439, Attachment A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Member Handbook (Final Approved Version)	On or before the start of the contract year	D,17	ACOM Policy 406	ACOM Policy 406, Attachment A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Member Information Materials	15 days prior to release	D,17	ACOM Policy 404	N/A	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	Non-AHCCCS Required Survey Notification and Results	Notification: 15 days prior to conducting the survey. Results: 45 days after the completion	D,18	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Non-Title XIX/XXI Services Referral Report (Title XIX/XXI Contractor)	January 1, 2020	D,11	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Notification of Change to Website, Member Handbook, and/or Formulary URL	Within one business day	D,17	ACOM Policy 404	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Provider Advances, Equity Distributions, Loans, Loan Guarantees, or Investments	10 Days prior to disbursement of funds	D,47	ACOM Policy 418	N/A	SharePoint

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Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	Repayment of Advances, Equity Distributions, Loans, Loan Guarantees, or Investments	Upon completion of repayment or six months from date of AHCCCS approval, whichever comes first	D,47	ACOM Policy 418	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Requests for Changes to Uniform Warranty Requirements	As identified	D,9	AMPM Policy 431	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Single Claim Recoupments >\$50,000	Submit for approval 30 days prior to anticipated date of distribution	37D	ACOM Policy 412	N/A	SharePoint
DHCMOPERATIONS	Ad Hoc	Social Networking Applications Listing with URLs (if participating in Social Networking Activities)	Within 30 days of any changes	Section D	ACOM Policy 425	N/A	SharePoint

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**ATTACHMENT F3:
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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Ad Hoc	System Change Plan	Six months prior to expected implementation	D,62	N/A	N/A	SharePoint
DHCM/OPERATIONS	Ad Hoc	Telephone Performance Measures	15 days after the month of noncompliance	D,24	ACOM Policy 435	ACOM Policy 435, Attachment A	SharePoint
DHCM/OPERATIONS	Annually	Administrative Services Subcontractor Evaluation Report	Within 90 days of the start of the Contract Year	D,36	ACOM Policy 438	ACOM Policy 438, Attachment B	SharePoint
DHCM/OPERATIONS	Annually	Continuity of Operations and Recovery Plan Summary	15 days after the start of the Contract Year	D,71	ACOM Policy 104	ACOM Policy 104, Attachment A	SharePoint
DHCM/OPERATIONS	Annually	Cultural Competency Plan Assessment	45 days after the start of the Contract Year	D,19	ACOM Policy 405	ACOM Policy 405, Attachment A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Annually	Key Staff: Organization Chart, Functional Organization Chart, Listing of All Key Staff Information	15 days after the start of the Contract Year	D,15	N/A	N/A	SharePoint
DHCM/OPERATIONS	Annually	Language Access Plan	45 days after the start of the Contract Year	D,17	ACOM Policy 405	ACOM Policy 405, Attachment A	SharePoint
DHCM/OPERATIONS	Annually	Member Handbook	August 1	D,17	ACOM Policy 406	ACOM Policy 406, Attachment A	SharePoint
DHCM/OPERATIONS	Annually	Member Information Attestation Statement	45 days after the start of the Contract Year	D,17	ACOM Policy 404	ACOM Policy 404, Attachment C	SharePoint
DHCM/OPERATIONS	Annually	PBM Subcontract	April 1	D,36	N/A	N/A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM OPERATIONS	Annually	Social Networking Applications Listing with URLs (if participating in Social Networking Activities)	Within 90 days of the start of the Contract Year	Section D	ACOM Policy 425	N/A	SharePoint
DHCM OPERATIONS	Annually	Social Networking Attestation (if participating in Social Networking Activities)	Within 90 days of the start of the Contract Year	Section D	ACOM Policy 425	ACOM Policy 425, Attachment A	SharePoint
DHCM/OPERATIONS	Annually	Website Certification	45 days after the start of the Contract Year	D,17	ACOM Policy 404	ACOM Policy 404, Attachment B	SharePoint
DHCM/OPERATIONS	Monthly	Claims Dashboard	15 th day of the month following the reporting period	D,37	AHCCCS Claims Dashboard Reporting Guide	N/A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/OPERATIONS	Monthly	Grievance and Appeal System Report	First day of the 2 nd Month following the month Being Reported	D,25	AHCCCS Grievance and Appeal System Reporting Guide	N/A	SharePoint
DHCM/OPERATIONS	Quarterly	Telephone Performance Measures	15 th day of the month following the reporting quarter	D,24	ACOM Policy 435	ACOM Policy 435, Attachment A	SharePoint
DHCM/OPERATIONS	Semi-Annually	Member Newsletter	30 days prior to intended publication date	D,17	ACOM Policy 406	N/A	SharePoint
DHCM/QUALITY IMPROVEMENT	Ad Hoc	Accreditation Status – Receipt, Renewal, or Loss	Within 15 calendar days of notification or receipt	D,22	N/A	N/A	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY IMPROVEMENT	Ad Hoc	AHCCCS-Mandated PIP Report Updates	As requested by AHCCCS	D,22	AMPM Policy 980	AMPM Policy 980, Attachment B - Unless otherwise directed by AHCCCS. Submit a report for each applicable PIP during the reporting period.	SharePoint
DHCM/QUALITY IMPROVEMENT	Ad Hoc	Contractor Self-Selected PIP Report Updates	As requested by AHCCCS	D,22	AMPM Policy 980	AMPM Policy 980, Attachment B – unless otherwise directed by AHCCCS. Submit a report for each applicable PIP during the reporting period.	SharePoint

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CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY IMPROVEMENT	Ad Hoc	Immunization Audit	As requested by AHCCCS	D,22	AMPM Policy 430	Reporting Form as provided by DHCM, Quality Improvement Manager	FTP Server with email notification to DHCM Quality Improvement Manager
DHCM/QUALITY IMPROVEMENT	Ad Hoc	Physician Incentives: Contractor-Selected and/or Developed Pay for Performance Initiatives	Prior approval required	D,41	N/A	N/A	SharePoint

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**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY IMPROVEMENT	Annually	AHCCCS-Mandated PIP Reports-Baseline, Intervention, or Remeasurement	December 1	D,22	AMPM Policy 980	AMPM Policy 980, Attachment B - Submit a report for each applicable PIP within its Baseline, Intervention, or Remeasurement reporting year during the reporting period.	SharePoint

SECTION F: ATTACHMENTS

**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY IMPROVEMENT	Annually	Contractor Self-Selected-Baseline, Intervention, or Remeasurement	December 1	D,22	AMPM Policy 980	AMPM Policy 980, Attachment B - Submit a report for each applicable PIP within its Baseline, Intervention, or Remeasurement reporting year during the reporting period.	SharePoint
DHCM/QUALITY IMPROVEMENT	Annually	AHCCCS-Mandated PIP Reports - Final	Within 60 calendar days of notification from AHCCCS	D,18	AMPM Policy 980	AMPM Policy 980, Attachment B - Submit a report for each applicable PIP within its Final reporting year during the reporting period.	SharePoint

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ATTACHMENT F3:

CONTRACTOR CHART OF DELIVERABLES

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY IMPROVEMENT	Annually	Contractor Self-Selected PIP Reports - Final	Within 60 calendar days of completion	D,18	AMPM Policy 980	AMPM Policy 980, Attachment B - Submit a report for each applicable PIP within its Final reporting year during the reporting period.	SharePoint
DHCM/QUALITY IMPROVEMENT	Quarterly	Performance Measure Monitoring Report	15 days after the end of each quarter	D,22	AMPM Policy 920	AMPM Appendix B	SharePoint
DHCM/QUALITY MANAGEMENT	Ad Hoc	Actions Reported to the National Provider Data Bank (NPDB) or a Regulatory Board	Within one business day of decision for formal action to be taken in accordance with AMPM Chapter 900 requirements	D,22	AMPM Policy 960	N/A	Secure Email to DHCM Quality Management Manager and QM Lead Coordinator with cc to DHCM Clinical Administrator

SECTION F: ATTACHMENTS

**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY MANAGEMENT	Ad Hoc	Adverse Action Reporting (Including Limitations and Terminations) of decision for formal action to be taken in accordance with Chapter 900 requirements	Within 24 hours of awareness	D,22	AMPM Policy 960	N/A	Secure Email to DHCM Quality Management Manager and QM Lead Coordinator with cc to DHCM Clinical Administrator
DHCM/QUALITY MANAGEMENT	Ad Hoc	Advisement of Significant Incidents, Accidents, and Deaths	Within 24 hours of awareness	D,22	AMPM Policy 960	N/A	Secure Email to DHCM Quality Management Manager and QM Lead Coordinator with cc to DHCM Clinical Administrator
DHCM/QUALITY MANAGEMENT	Ad Hoc	Credentialing and Re-Credentialing Denials	Within one business day	D,22	AMPM Policy 950	N/A	Secure Email to DHCM Quality Management Manager

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**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY MANAGEMENT	Ad Hoc	Incident, Accident, and Death Reports for Members Within Specified Timeframes into the QMS Portal; Additionally, Significant and/or Potential Media-Coverage IADs Must Also be Sent Directly to Quality Management Staff as soon as the Contractor is Aware of the Issue	Within one day of awareness	D,22	AMPM Policy 960	N/A	QMS Portal and Email Notification to DHCM Quality Management Manager and QM Lead Coordinator with cc to DHCM Clinical Administrator as appropriate (*significant and/or potential media cases)
DHCM/QUALITY MANAGEMENT	Ad Hoc	QOC Resolution Report	Within 72 hours of completion	D,22	N/A	N/A	QMS Portal with QM Portal notification to assigned DHCM QM Coordinator
DHCM/QUALITY MANAGEMENT	Annually	Contractor Monitoring Summary	December 15	D,22	AMPM Policy 910	N/A	SharePoint

SECTION F: ATTACHMENTS

**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY MANAGEMENT	Annually	Quality Management/Performance Improvement (QM/PI) Program Plan	December 15	D,22	AMPM Policy 950; AMPM Policy 920	AMPM Policy 920, Attachment A	SharePoint
DHCM/QUALITY MANAGEMENT	Quarterly	Credentialing Report	30 days after the end of each quarter	D,22	AMPM Policies 950 and 950-A	AMPM Policy 950, Exhibit 950-1	SharePoint
DHCM/QUALITY MANAGEMENT	Quarterly	HCAC and OPPC	45 days after the end of each quarter	D,22; D,23	AMPM Policy 960	AMPM Policy 960, Attachment B	SharePoint
DHCM/QUALITY MANAGEMENT	Quarterly	Inter-Rater Reliability (IRR) Metrics and Evidence of Completed IRR Activities	45 days after the end of each quarter	D,22	N/A	N/A	SharePoint
DHCM/QUALITY MANAGEMENT	Quarterly	QM Report	45 days after the end of each quarter	D,22	AMPM Policy 960	AMPM Policy 960, Attachment A	SharePoint

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ATTACHMENT F3:

CONTRACTOR CHART OF DELIVERABLES

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
DHCM/QUALITY MANAGEMENT	Weekly	Quality of Care (QOC) Concerns Opened Report	Tuesday of the following week	D,22	AMPM Policy 960	Reporting Form as provided by DHCM, Quality Management Manager	SharePoint
DMS/CRS	Monthly	CRS Members with Completed Treatment	15 days after the start of the month (reporting for the prior month)	D,9	ACOM Policy 426	N/A	Email to: DMSCRS@azahcccs.gov
DMS/MEMBER CONTACT AND DATA UNIT	Ad Hoc	AHCCCS Notification to Waive Medicare Part D Co-Payments	Immediately upon identification	D,58	ACOM Policy 201	ACOM Policy 201, Attachment A	Email to: mcdumemberescalations@azahcccs.gov
OALS	Ad Hoc	Change in Contractor Organizational Structure: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information	No later than 35 days after any change	D,50	ACOM Policy 103; ACOM Policy 317	ACOM Policy 103, Attachment A and Attachment A1	SharePoint

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**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
OALS	Ad Hoc	State Fair Hearing Request Documentation: Claim Dispute Request	No later than five business days from receipt of the hearing request	F,Att F2	ACOM Policy 445	ACOM Policy 445, Attachment A	FTP server
OALS	Ad Hoc	State Fair Hearing Request Documentation: Expedited Member Appeal Request	No later than one business day from receipt of the expedited hearing request	F,Att F1	ACOM Policy 445	ACOM Policy 445, Attachment A	FTP server
OALS	Ad Hoc	State Fair Hearing Request Documentation: Standard Member Appeal Request	No later than five business days from receipt of the hearing request	F,Att F1	ACOM Policy 445	ACOM Policy 445, Attachment A	FTP server

SECTION F: ATTACHMENTS

**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/Policy	Checklist-Template-Reporting Form	Submitted Via
OALS	Annually	Disclosure Information: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime including Attestation	October 1	D,60	ACOM Policy 103	ACOM Policy 103; Attachment A and Attachment A-1	SharePoint
OIG	Ad Hoc	Corporate Compliance: External Auditing Schedule-Changes	Within 7 days of change	D,60	ACOM Policy 103	N/A	SharePoint
OIG	Ad Hoc	Corporate Compliance: Exclusions Identified Regarding Persons Convicted of a Crime	Immediately upon identification	D,60	N/A	N/A	SharePoint
OIG	Ad Hoc	Recovered Overpayment	Within 10 days of recovered overpayment	D,60	ACOM Policy 103	N/A	SharePoint

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**ATTACHMENT F3:
CONTRACTOR CHART OF DELIVERABLES**

CONTRACT NO. YH15-0001

Area	Timeframe	Report	When Due	Contract Section, Paragraph	Reference/ Policy	Checklist-Template-Reporting Form	Submitted Via
OIG	Ad Hoc	Report of Alleged Fraud, Waste, Abuse of the AHCCCS Program	Within 10 calendar days	D,60	ACOM Policy 103	N/A	AHCCCS Website: www.azahcccs.gov/Fraud/ReportFraud/
OIG	Ad Hoc	Transactions Between the Contractor and a Party in Interest	Within 7business days	D,60	ACOM Policy 103	ACOM Policy 103, Attachment A and Attachment A1	SharePoint
OIG	Annually	Corporate Compliance Plan	15 days after the start of the Contract Year	D,60	ACOM Policy 103	ACOM Policy 103, Attachment B	SharePoint
OIG	Semi-Annually	Corporate Compliance: Executive Audit Summary	July 15 January 15	D,60	ACOM Policy 103	N/A	SharePoint
OIG	Semi-Annually	Corporate Compliance: External Audit Plan/Schedule	November 1; May 1	D,60	ACOM Policy 103	ACOM Policy 103, Attachment C	SharePoint

[END OF ATTACHMENT F3: CONTRACTOR CHART OF DELIVERABLES]

SECTION F: ATTACHMENTS

ATTACHMENT F4: PERFORMANCE MEASURES

AHCCCS Comprehensive Medical and Dental Program (CMDP) Performance Measures

The Contractor shall monitor and report all CMS Children’s Core Set measures, as applicable, and may be required to monitor and report select NCQA HEDIS or other AHCCCS-required measures, as mandated by AHCCCS, for the applicable Contract Year. The tables below are inclusive of required performance measures and associated standards in place at the time the Contract was made effective. For measures not calculated by AHCCCS, the Contractor is required to calculate and report per AHCCCS instruction. The Contractor is required to monitor and report all measures included within the applicable CMS Core Measure Sets for the reporting period at the time of its publication, despite their inclusion within the tables below.

CMS CHILD CORE MEASURES**	
Primary Care Access and Preventive Care	
Weight Assessment and Counseling - Body Mass Index (BMI) Assessment for Children/Adolescents (WCC)	55%
Chlamydia Screening in Women (CHL)	57%
Screening for Depression and Follow-Up Plan (CDF)	Baseline Measurement Year*
Well-Child Visits in the First 15 Months of Life (W15)	62%
Developmental Screening in the First Three Years of Life (DEV)	55%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of life (W34)	72%
Adolescent Well-Care Visits (AWC)	65%
Children's Access to PCPs (CAP), by age: 12-24 months	95%
Children's Access to PCPs (CAP), by age: 25 months - 6 years	87%
Children's Access to PCPs (CAP), by age: 7 - 11 years	90%
Children's Access to PCPs (CAP), by age: 12 - 19 years	89%
Childhood Immunization Status (CIS)	
DTaP	76%
IPV	88%
MMR	89%
Hib	88%
Hepatitis B (HBV)	88%
VZV	88%
PCV	77%
Hepatitis A (HAV)	85%
Rotavirus	65%
Influenza	45%
Combination 3	68%
Combination 7	50%
Combination 10	25%

SECTION F: ATTACHMENTS

ATTACHMENT F4: PERFORMANCE MEASURES

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CMS CHILD CORE MEASURES**	
Immunizations for Adolescent (IMA)	
Adolescent Meningococcal	85%
Adolescent Tdap/Td	85%
Human Papillomavirus (HPV)	25%
Combination 1	85%
Combination 2	21%
Maternal and Perinatal Health	
Pediatric Central Line-Associated Bloodstream Infections (CLABSI)	Baseline Measurement Year*
PC-02: Cesarean Birth (PC02)	Baseline Measurement Year*
Audiological Diagnosis No Later Than 3 Months of Age (AUD)	Baseline Measurement Year*
Live Births Weighing Less Than 2,500 Grams (LBW)	Baseline Measurement Year*
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment (PPC)	80%
Contraceptive Care – Postpartum Women (CCP)	Baseline Measurement Year*
Contraceptive Care - All Women (CCW)	Baseline Measurement Year*
Care of Acute and Chronic Conditions	
Asthma Medication Ratio (AMR)	Baseline Measurement Year*
Ambulatory Care - ED Utilization (AMB)	43 Per 1,000 Member Months
Behavioral Health Care	
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	Baseline Measurement Year*
Follow-Up After Hospitalization for Mental Illness (FUH) - 7 Days, 30 Days	7 Days-60% 30 Days-85%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Baseline Measurement Year*
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)	2%
Dental and Oral Health Services	
Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (SEAL)	TBD*
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	46%

SECTION F: ATTACHMENTS

ATTACHMENT F4: PERFORMANCE MEASURES

CONTRACT NO. YH15-0001

Notes:

*AHCCCS will develop Minimum Performance Standards once baseline data has been analyzed for these measures.

**Contractors shall report all CMS Child Core Measures for both the Title XIX and Title XXI populations. Rates shall be calculated, analyzed, and reported separately.

[END OF ATTACHMENT F4: PERFORMANCE MEASURES]

[END OF SECTION F: ATTACHMENTS]