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

CONTRACT AMENDMENT

1. AMENDMENT NUMBER:	2. CONTRACT NUMBER:	3. EFFECTIVE DATE OF AMENDMENT:	4. PROGRAM:
35	**YH8-0002** **ADHS # 832007**	**July 1, 2009**	**DHCM** Behavioral Health

5. CONTRACTOR'S NAME AND ADDRESS:

Arizona Department of Health Services
150 N. 18th Avenue, 2nd Floor
Phoenix, AZ 85007

6. PURPOSE OF AMENDMENT: To amend the contract requirements, capitation rates and renew the contract term for 12 months effective July 1, 2009.

7. THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

A. The contract requirements are hereby amended in accordance with Section E, Paragraphs 14 and 19. Sections B, C, D, E and F and Attachments A, B, C, E, F, G, H and I are hereby replaced in their entirety by the attached sections.
B. Section B, Capitation Rates, has been revised to reflect capitation rates for the period July 1, 2009 through June 30, 2010.
C. Section C, Definitions has had 11 definitions clarified and one definition removed.
D. Section D, Program Requirements includes clarifying language to paragraphs 3, Covered Services for Native Americans, paragraph 5, Eligibility and Behavioral Health Recipient Verifications, paragraph 6, Member Information and Member Rights, paragraph 7, Referrals, paragraph 8, Service Delivery, paragraph 11, Coordination With AHCCCS Acute Contractors, paragraph 13, Transition of Title XIX and Title XXI Members, paragraph 16, Staff Requirements (with the addition of a contract compliance officer and training requirements), paragraph 17, ADHS Development of Title XIX and Title XXI Policies, paragraph 20, Quality Management Plan (including QM Program requirements, Performance Improvement, and new Performance Standards), and paragraph 21, Medical Management. Paragraph 22, Other Quality Monitoring and Reporting replaces the Quality Performance Standards paragraph now located in paragraph 20. Paragraph 26, Financial Operations includes a minimum medical expense ratio. Paragraph 28 contains a new paragraph to allow AHCCCS to pay current capitation rates until CMS approves new rates, followed by an adjustment and clarifying language for administrative costs. Fees in paragraph 29, Method of Payment have been updated. Paragraph 34 has been revised to clarify third party liability. Clarifying language has been added to paragraph 36, Provider Claims Time Limits and paragraph 39, Sanctions (item p.). Paragraph 48, Legislative Issues was updated as well as paragraph 52, Corporate Compliance, and paragraph 54, Medicare Modernization Act.
E. Attachment C, Periodic Reporting Requirements has been revised and updated including the Summary of Due Dates.
F. Attachment F(1), Enrollee Grievance System, has a new item 37 regarding the reversal of authorization decisions and Attachment F(2), Provider Claim Dispute System has a new item 9 specifying Notice of Decision requirement.
G. Attachment I is new and describes methodologies to be used in performance measurements.
H. The contract term is renewed for a 12 month period beginning July 1, 2009 through June 30, 2010.
I. By signing this contract amendment, ADHS is agreeing to the requirements contained herein.

NOTE: Please sign, and date both and return 1 original to: *Jamey Schultz, Sr. Procurement Specialist*
AHCCCS Contracts and Purchasing
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT REMAIN UNCHANGED AND IN FULL EFFECT.

IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT

9. SIGNATURE OF ADHS AUTHORIZED REPRESENTATIVE:	10. SIGNATURE OF AHCCCS CONTRACTING OFFICER:
TYPED NAME: **CHRISTINE RUTH**	TYPED NAME: **MICHAEL VEIT**
TITLE: **CHIEF PROCURMENT OFFICER**	TITLE: **CONTRACTS & PURCHASING ADMINISTRATOR**
DATE:	DATE:

SECTION B: CAPITATION RATES

The Arizona Department of Health Services (ADHS) shall provide services as described in this contract. AHCCCS will pay monthly capitation to ADHS in accordance with the terms of this contract at the following rates:

Title XIX eligible children, under the age of 18 (represents the cost of providing covered behavioral health services to Non-CMDP children):	$44.48 pmpm*
Title XIX waiver group eligible children, under the age of 18, and whose family income is up to one hundred percent (100%) of the FPL (represents the cost of providing covered behavioral health services to Non-CMDP children):	$44.48 pmpm*
Title XIX eligible children, under the age of 18 (represents the cost of providing covered behavioral health services to CMDP children):	$1,235.43 pmpm*
Title XIX waiver group eligible children, under the age of 18, and whose family income is up to one hundred percent (100%) of the FPL (represents the cost of providing covered behavioral health services to CMDP children):	$1,235.43 pmpm*
Title XIX eligible adults, age 18 and older (represents the cost of providing covered behavioral health services to SMI adults):	$77.10 pmpm*
Title XIX waiver group eligible adults, age 18 and older, and whose family income is up to one hundred percent (100%) of the FPL (represents the cost of providing covered behavioral health services to SMI adults):	$77.10 pmpm*
Title XIX eligible adults, age 18 and older (represents the cost of providing covered behavioral health services to non-SMI adults):	$42.48 pmpm*
Title XIX waiver group eligible adults, age 18 and older, and whose family income is up to one hundred percent (100%) of the FPL (represents the cost of providing covered behavioral health services to non-SMI adults):	$42.48 pmpm*
Title XXI eligible children under age 18 (represents the cost of providing covered behavioral health services to children):	$23.03 pmpm*
Title XXI eligible adults age 18 (represents the cost of providing covered behavioral health services to SMI and non-SMI adults):	$29.09 pmpm*
Title XXI waiver group eligible adults, age 18 and older, and whose family income is up to two hundred percent (200%) of the FPL (represents the cost of providing covered behavioral health services to SMI adults):	$9.42 pmpm*
Title XXI waiver group eligible adults, age 18 and older, and whose family income is up to two hundred percent (200%) of the FPL (represents the cost of providing covered behavioral health services to non-SMI adults):	$15.04 pmpm*

The agreed upon administrative rate is included in the above capitation rates and is as follows: three and 50/100 percent (3.50%).

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* Any subsequent changes in the rates paid will be made through contract amendment. Section D, Paragraph 28, Capitation, Paragraph 29, Method of Payment, and Attachment E, Shared Risk Methodology, contain further details regarding calculation of rates and conditions of payment to ADHS.

SECTION C: DEFINITIONS

638 TRIBAL FACILITY	A facility that is operated by an American Indian Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. See also "Tribal Facility."
ACOM	*AHCCCS Contractor Operations Manual*, available on the AHCCCS Website at http://www.azahcccs.gov/shared/ACOM.aspx?ID=contractormanuals
ACUTE CARE SERVICES	Medically necessary services that are covered for AHCCCS members. These services are provided through contractual agreements with the AHCCCS Health Plans, ALTCS Program Contractors or on a limited fee-for-service basis through the AHCCCS administration.
ADJUDICATED CLAIMS	Claims which have been received and processed by ADHS which resulted in a payment or denial of payment.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS	Arizona Health Care Cost Containment System, which is composed of the Administration, Contractors, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.
AHCCCS Care (See also NON-MED Definition)	AHCCCS Care Eligible individuals and childless adults whose income is less than or equal to 100% of the FPL, and who are not categorically linked to another Title XIX program. Also known as "NON MEDICAL EXPENSE DEDUCTION MEMBER (NON-MED)".
AHCCCS IHS FFS	See American Indian Health Program
AHCCCS Rules	See Arizona Administrative Code (A.A.C.)
AHCCCS STANDARDS	The standards established by AHCCCS in AHCCCS policies, the Title XIX State Plan, the Title XXI State Plan, the Title XIX waiver, applicable federal and state statutes and rules, and any subsequent amendments thereto.
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute and behavioral health care and case management services to members, as authorized by A.R.S. § 36-2932 et seq.
AMERICAN INDIAN HEALTH PROGRAM	The program that delivers health care to the eligible American Indian population living on reservations through the Indian Health Service (IHS). Formerly known as AHCCCS IHS FFS Program.
AMPM	AHCCCS Medical Policy Manual
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. For purposes of this contract, the relevant sections of the AAC are referred to throughout this document as "AHCCCS Rules".
A.R.S.	Arizona Revised Statutes.
AUTHORIZED REPRESENTATIVE	Authorized representative means a person who is authorized to apply for medical assistance or act on behalf of another person (R9-22-101).

BCCTP	Breast and Cervical Cancer Treatment Program, a Title XIX eligibility expansion program for women who are not otherwise Title XIX eligible and diagnosed as needing treatment for breast and/or cervical cancer or lesions.
BBA	The Balanced Budget Act of 1997.
BED HOLD	A twenty-four (24) hour per day unit of service that is authorized by ADHS or a subcontractor, which may be billed despite the member's absence from the facility. Bed hold days may not exceed 21 total days per contract year. Bed holds are applicable for members absent during a period of short-term hospitalization or therapeutic leave that meets the requirement specified in 42 CFR 483.12, from a Title XIX Certified Level I Residential Treatment Center.
BEHAVIORAL HEALTH MEDICAL PRACTITIONER	A medical practitioner, i.e., a physician, physician assistant, nurse practitioner, with one year of full-time behavioral health experience as specified in AAC Title 9, Chapter 22, Article 12.
BEHAVIORAL HEALTH PARAPROFESSIONAL	A staff member of a licensed behavioral health service agency as specified in AAC Title 9, Chapter 20.
BEHAVIORAL HEALTH PROFESSIONAL	As specified in AAC Title 9, Chapter 20, a psychiatrist, psychologist, social worker, counselor, marriage and family therapist, certified psychiatric nurse practitioner, registered nurse, behavioral health medical practitioner or physician assistant.
BEHAVIORAL HEALTH RECIPIENT	A Title XIX or Title XXI acute care member who is eligible for and is receiving behavioral health services through ADHS and the subcontractors.
BEHAVIORAL HEALTH SERVICES	Behavioral health services means the assessment, diagnosis, or treatment of an individual's behavioral health issue and include services for both mental health and substance abuse conditions. See "COVERED SERVICES".
BEHAVIORAL HEALTH TECHNICIAN	A staff member of a licensed behavioral health service agency as specified in AAC Title 9, Chapter 20.
CAPITATION	The method by which ADHS is paid to deliver covered services under this contract to members based on a fixed rate per member per month notwithstanding (a) the actual number of members who receive care from ADHS, and (b) the amount of health care services provided to any member.
CATEGORICALLY LINKED TITLE XIX MEMBER	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC-related), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), and SSI-related groups. To be categorically linked, the member must be aged (65 or over), blind, disabled, a child under age 19, parent of a dependent child or pregnant.
CERTIFICATION OF NEED FOR INPATIENT PSYCHIATRIC SERVICES	A specific federal requirement for treatment in inpatient hospitals (42 CFR 456.60); inpatient psychiatric facilities (inclusive of residential treatment centers and sub-acute facilities, 42 CFR 441.152); and mental hospitals (42 CFR 456.160).
CERTIFIED PSYCHIATRIC NURSE PRACTITIONER	A registered nurse licensed according to A.R.S. Title 32, Chapter 15 and certified under the American Nursing Association's Statement and Standards for Psychiatric-Mental Health Clinical Nursing Practice as specified in AAC Title 4, Chapter 19.
CLAIM	A service billed under a fee-for-service arrangement.

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	As specified in A.R.S. § 36-2904, a claim that may be processed without obtaining additional information from the provider or from a third party; does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
CLINICAL SUPERVISION	The oversight, guidance and direction for the delivery of behavioral health treatment services that are provided by a licensed psychiatrist, a psychologist, licensed behavioral health professional or clinical supervisor meeting the requirements of AAC Title 9, Chapter 20.
CMIA	Cash Management Improvement Act of 1990. 31 CFR Part 205. Provides guidelines for the drawdown and transfer of federal funds.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
CONTINUED STAY REVIEW	The process required for Title XIX funding by which stays in inpatient hospitals (42 CFR 456.128 to 132), inpatient psychiatric facilities (inclusive of residential treatment centers and sub-acute facilities 42 CFR 441.155), and mental hospitals (42 CFR 456.233 to 238) are reviewed to determine the medical necessity and appropriateness of continuation of the member's stay at an inpatient level of care.
CONTRACT SERVICES	See "COVERED SERVICES".
CONTRACT YEAR (CY)	Corresponds to State fiscal year (July 1 through June 30). For example, Contract Year 07 is 7/01/06 – 6/30/07.
CONTRACTOR	An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by contract in conformance with the stated contract requirements, AHCCCS statute and rules and federal law and regulations.
COPAYMENT	A monetary amount which the member pays directly to a provider at the time a covered service is rendered, as defined in R9-22-711.
COVERED SERVICES	Those medically necessary Title XIX and Title XXI behavioral health services to be delivered by ADHS to members as defined in AHCCCS Rules 9-22, Article 12 and Section D of this contract.
DAYS	Calendar days unless otherwise specified as defined in the text, as defined in R9-22-101.
DEFICIT REDUCTION ACT (DRA)	The Deficit Reduction Act (DRA) Public Law 109-171 works to eliminate fraud, waste and abuse in Medicaid.
DELEGATED AGREEMENT	A type of subcontract with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this contract.
DHCM	Division of Health Care Management, a division within the Arizona Health Care Cost Containment System (AHCCCS) Administration.
DIRECTOR	The Director of AHCCCS.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.

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)].
ENCOUNTER	An encounter is a record of a medically related service rendered by a provider or providers registered with AHCCCS to a behavioral health recipient
ENROLLEE	A Medicaid recipient who is currently enrolled with an acute care contractor. For purposes of this contract, see definition of Member [42 CFR 438.10(a)].
ENROLLMENT	The process by which an eligible person becomes a member of a contractor's plan.
EPSDT	Early and Periodic Screening, Diagnostic and Treatment: services for persons under 21 years of age as described in AHCCCS rules R9-22, Article 2. Mandatory preventive child health services required to be provided to Title XIX children. The behavioral health component of the EPSDT diagnostic and treatment services for Title XIX members under age 21 years are covered by this contract.
FEE-FOR-SERVICE (FFS)	A method of payment to registered providers on an amount-per service basis.
FEE-FOR-SERVICE MEMBER	A Title XIX or Title XXI eligible individual who is not enrolled with an Acute or ALTCS Contractor.
FFP	Federal Financial Participation. 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.

FREEDOM TO WORK (TICKET TO WORK)	Eligible individuals under the Title XIX expansion program that extends eligibility to individuals, 16 through 64 years old who meet SSI disability criteria, whose earned income, after allowable deductions, is at or below 250% of the FPL and who are not eligible for any other Medicaid program.
GAAP	Generally Accepted Accounting Principles.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing system.
HEALTH CARE PROFESSIONAL	A physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) requires states to comply with the Administrative Simplification requirements in Subpart F and the safeguarding of confidential information pursuant to 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903, 41-1959 and 46-135, and AHCCCS Rules.
HIFA	The CMS Health Insurance Flexibility and Accountability Demonstration Initiative, which targets State Children's Health Insurance Program (Title XXI) funding for populations with incomes at or below 200 percent of the Federal Poverty Level, seeking to maximize private health insurance coverage options. See Title XXI Member.
HIFA PARENTS	Parents of Medicaid (SOBRA) and KidsCare eligible children who are eligible for AHCCCS benefits under the HIFA Waiver. All eligible parents except American Indians must pay an enrollment fee and a monthly premium based on household income. See Title XXI Waiver Member.
IBNR	Incurred But Not Reported claims; liability for services rendered for which claims have not been received.
IGA	Intergovernmental Agreement. 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 (AR.S. § 11-952.A)
IHS	Indian Health Service; The bureau of the United States Department of Health and Human Services that is responsible for delivering public health and medical services to American Indians and Alaskan Natives throughout the country. The federal government has direct and permanent legal obligation to provide health services to most American Indians according to treaties with Tribal Governments.

IMD	Institution For Mental Disease; An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases [(42 CFR 435.1010)].
KIDSCARE	Individuals under the age of 19, eligible under the SCHIP program, in households with income at or below 200% FPL. All members, except American Indian members, are required to pay a premium amount based on the number of children in the family and the gross family income. Also referred to as Title XXI.
LIABLE PARTY	A person or entity that is or may be, by agreement, circumstances or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
MANAGED CARE	A system by which healthcare services are provided through contracted health plans, program contractors and provider networks, with operation and management oversight to ensure cost effective and efficient quality service delivery.
MANAGEMENT SERVICES AGREEMENT	A type of subcontract with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.
MATERIAL CHANGE	An alteration or development within a provider network that may reasonably be foreseen to affect the quality or delivery of behavioral health services provided under this contract.
MATERIAL GAP	A temporary change in a provider network that may reasonably be foreseen to jeopardize the delivery of behavioral health services to an identifiable segment of the AHCCCS member population. This change is considered temporary because ADHS is required under this contract to promptly remedy any network deficiency.
MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
MEDICAL EXPENSE DEDUCTION (MED) MEMBER	Title XIX Waiver member whose family income exceeds the limits for all other Title XIX categories (except ALTCS) and has family medical expenses that reduce income to or below forty percent (40%) of the Federal Poverty Level. The forty percent (40%) Federal Poverty Level will be adjusted annually to reflect annual Federal Poverty Level adjustments. MED members may or may not have a categorical link to Title XIX.
MEDICAL MANAGEMENT	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICAL SERVICES	Medical care and treatment provided by a Primary Care Provider, attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.
MEDICALLY NECESSARY 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.
MEDICARE PART D EXCLUDED DRUGS:	Medicare Part D is the Prescription Drug Coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit will not be covered by AHCCCS. Certain drugs that are excluded from coverage by Medicare will continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D Health Plans formulary are not considered excluded drugs, and will not be covered by AHCCCS.
MEMBER	For this document, a person eligible for AHCCCS who is enrolled with an acute Contractor or IHS for whom ADHS has responsibility to provide behavioral health services.
MEMBER INFORMATION MATERIALS	Any materials given to behavioral health recipients. This includes, but is not limited to: member handbooks, member newsletters, surveys, and health related brochures and videos. It includes the templates of form letters and website content as well.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. § 36-2901, but does not have a subcontract with an AHCCCS Contractor.
NON-MEDICAL EXPENSE DEDUCTION (NON-MED MEMBER)	See AHCCCS Care.
NPI	National Provider Identifier assigned by the CMS contracted national enumerator.
PCP	Primary Care Provider; An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of a member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as 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.
PERFORMANCE STANDARDS	A set of standardized indicators designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors. Specific descriptions of health services measurement goals are found in Section D, Paragraph 22, Quality Performance Standards.
PMMIS	AHCCCS's Prepaid Medical Management Information System.
POST STABILIZATION 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 an acute care contractor. For purposes of this contract, see definition of Member [42 CFR 438.10(a)].
PRIOR AUTHORIZATION	The process by which the appropriate entity approves a service subject to medical review later for appropriateness and covered for payment.

PRIOR PERIOD	The period of time, prior to the member's enrollment with an acute care contractor, or, if the member is FFS, prior to the date of AHCCCS eligibility determination, during which a member is eligible for covered services. The prior period time frame begins with the first day of the month in which eligibility for Title XIX benefits begins to the date of Title XIX prospective enrollment, or the date of eligibility determination for Fee-for-Service members, whichever is applicable.
QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)	A person, eligible under A.R.S. 36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB who is also eligible for Medicaid is commonly referred to as a QMB dual eligible.
RBUC	Reported But Unpaid Claims; liability for services rendered for which claims have been received but not paid.
REFERRAL	A verbal, written, telephonic, electronic or in-person request for behavioral health services.
REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)	An organization under contract with ADHS that administers covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a Tribal Regional Behavioral Health Authority (TRBHA) for the provision of behavioral health services to American Indian members living on-reservation.
REHABILITATIVE SERVICES	Rehabilitative services as specified in 42 CFR 440.130(d) include medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. Rehabilitative services do not include room and board in an institution.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by a contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act. The Arizona version of SCHIP is referred to as "KidsCare". See KidsCare.
SMI	Seriously Mentally Ill; A person 18 years of age or older who is seriously mentally ill as defined in A.R.S. §36-550.
SERVICE PROVIDER	An organization and/or behavioral health professional who meets the criteria established in this contract, has a contract with ADHS or a subcontractor, AHCCCS Health Plan, Program Contractor or Tribal Government, as applicable, and is registered with AHCCCS to provide behavioral health services.
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that required by members generally.
STATE	The State of Arizona

STATE PLAN	The written agreements between the State of Arizona and CMS which describe how the AHCCCS programs meet all CMS requirements for participation in the Medicaid program and the Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by ADHS with a provider of behavioral health services who agrees to furnish covered services to members or with any other organization or person who agrees to perform any administrative function or service for ADHS specifically related to fulfilling ADHS' obligations to AHCCCS under the terms of this contract.
SUBCONTRACTOR	(1) A provider of health care who agrees to furnish covered services to members. (2) A person, agency or organization with which ADHS has contracted or delegated some of its management/administrative functions or responsibilities. (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.
SUBSTANCE ABUSE	The chronic, habitual, or compulsive use of any chemical matter which, when introduced into the body, is capable of altering human behavior or mental functioning and, with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse.
SUPPLEMENTAL SECURITY INCOME (SSI)	Federal cash assistance program under Title XVI of the Social Security Act.
THIRD 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 R9-22-1001.
THIRD PARTY LIABILITY	The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member, as defined in R9-22-1001.
TITLE XIX	Means Title XIX of the Social Security Act, an entitlement program under which the federal government makes matching funds available to states for health and long term care services for eligible low-income individuals.
TITLE XIX MEMBER	Member eligible for federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under section 1931 provisions of the Social Security Act (previously AFDC-related), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Title XIX Waiver Groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
TITLE XIX WAIVER MEMBER	All Medical Expense Deduction (MED) members, and adults or childless couples at or below one hundred percent (100%) of the Federal Poverty Level who are not categorically linked to another Title XIX program. This would also include Title XIX linked individuals whose income exceeds the limits of the categorical program and are eligible for MED.
TITLE XXI	Title XXI of the Social Security Act known as the State Children's Health Insurance Program or KidsCare Plan in AZ. Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.

TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in federal legislation as the "State Children's Health Insurance Program" (SCHIP and HIFA). The Arizona version of SCHIP is referred to as "KidsCare."
TITLE XXI WAIVER MEMBER	Parents/stepparents of KidsCare or SOBRA children whose family income is at or below two hundred percent (200%) of the Federal Poverty Level, have no other health insurance and meet other eligibility requirements.
TREATMENT	The range of behavioral health care received by a member that is consistent with the therapeutic goals.
TRIBAL FACILITY (638 Tribal Facility)	A facility that is operated by an American Indian Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. See also "638 Tribal Facility."
TRIBAL SUBCONTRACTOR (TRBHA)	A subcontractor operated by a Tribal government, through an IGA with ADHS for the provision of behavioral health services to an American Indian member.
YEAR	See "Contract Year".

SECTION D: PROGRAM REQUIREMENTS

1. SCOPE OF RESPONSIBILITY

ADHS shall be responsible for the performance of all contract requirements. ADHS may delegate responsibility for services and related activities under this contract, but remains ultimately responsible for compliance with the terms of this contract [42 CFR 438.230(a)].

2. SCOPE OF SERVICES

ADHS, either directly or through subcontractors, shall be responsible for the provision of all medically necessary covered behavioral health services to AHCCCS Title XIX and Title XXI acute care members in accordance with applicable federal, state and local laws, rules, regulations and policies, including services described in this document and those incorporated by reference throughout this document and AHCCCS policies referenced in this document. ADHS shall ensure that policies and procedures are made available to all contracted service providers. ADHS shall provide technical assistance to subcontractors regarding covered services, encounter submission and documentation requirements on an as needed basis. The services are described in detail in AHCCCS Rules R9-22, Articles 2 and 12, and R9-31, Article 12, the *AHCCCS Behavioral Health Services Guide*, which is Attachment G of this contract and the *AHCCCS Medical Policy Manual* (AMPM), all of which are incorporated herein by reference. The *AHCCCS Behavioral Health Services Guide* is also available on the AHCCCS website at: http://www.azahcccs.gov/commercial/shared/BehavioralHealthServicesGuide.aspx?ID=contractormanuals and is updated on a quarterly or as needed basis. Covered services must be medically necessary and rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as AHCCCS providers. ADHS must ensure that the services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. Medically necessary behavioral health services must be related to the member's ability to achieve age-appropriate growth and development, and to attain, maintain, or regain functional capacity.

ADHS may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. ADHS 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)(1),(3), and (4)].

Eligibility: All Title XIX acute care and Title XXI members are eligible to receive covered behavioral health services. Covered services include:

a. Behavior Management (behavioral health personal assistance, family support, peer support)
b. Case Management Services
c. Emergency/Crisis Behavioral Health Services
d. Emergency Transportation
e. Evaluation and Screening (initial and ongoing assessment)
f. Group Therapy and Counseling
g. Individual Therapy and Counseling
h. Family Therapy and Counseling
i. Inpatient Hospital (ADHS/BHS may provide services in alternative inpatient settings that are licensed by ADHS/ALS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.)
j. Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
k. Institutions for Mental Diseases (with limitations and in accordance with 1115 Waiver Phase Down for services to AHCCCS enrollees ages 21 through 64). Allowable expenditures that will be recognized under the 1115 Waiver for enrollees ages 21 through 64 years of age residing in IMDs for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days will be phased down in accordance with the following:

Period	Allowable Portion of Expenditures
October 1, 2006 – September 30, 2007	100 %
October 1, 2007 – September 30, 2008	50 %
October 1, 2008 – September 30, 2009	0 %

l. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis

m. Non-Emergency Transportation
n. Partial Care (Supervised day program, therapeutic day program and medical day program)
o. Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching and employment support)
p. Psychotropic Medication
q. Psychotropic Medication Adjustment and Monitoring
r. Respite Care (with limitations)
s. Therapeutic Home Care Services

ADHS must notify AHCCCS if, on the basis of moral or religious grounds, it elects not to provide, reimburse for, or provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2). In the event that ADHS is notified that any of its contractors elects not to provide, reimburse for, or provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2), ADHS must ensure that its contractor makes alternative arrangements with another entity to provide the service. ADHS must submit notification prior to entering into a contract with AHCCCS or whenever it adopts the policy during the term of the contract. In turn, the RBHAs must submit notification to ADHS prior to entering into a contract with ADHS or whenever it adopts the policy during the term of the contract. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to behavioral health recipients during their initial appointment; and must be provided to behavioral health recipients at least 30 days prior to the effective date of the policy.

3. COVERED SERVICES FOR AMERICAN INDIANS

ADHS shall ensure that all covered services are available to all Title XIX and Title XXI eligible American Indians, whether they live on or off reservation.

Eligible American Indian members may choose to receive services through a T/RBHA, at an IHS or 638 tribal provider.

In general, and except as described in paragraph 8, Service Delivery, ADHS is responsible for payment of behavioral health services for acute care members whether or not they are enrolled with a T/RBHA. However, ADHS has no responsibility for payment of behavioral health services provided to American Indians at an IHS or 638 facility, even if the member is enrolled with a TRBHA. ADHS is responsible for payment for medically necessary behavioral health services provided to members referred off reservation from an IHS or 638 tribal facility, including all medically necessary behavioral health services rendered at non-IHS facilities.

IGA - ADHS shall continue to work in collaboration with the tribes to ensure that appropriate and accessible behavioral health services are available and may enter into or maintain an Intergovernmental Agreement (IGA) for behavioral health services with interested tribes who want to be a Tribal subcontractor. ADHS shall be responsible for the oversight and monitoring of all Title XIX and Title XXI behavioral health services delivered by Tribal subcontractors. ADHS shall provide technical assistance to the tribes upon request to improve the delivery of behavioral health services. If the ADHS enters into an IGA for behavioral health services with a Tribal subcontractor, specific requirements must be in the IGA for Utilization Management/Quality Management, Medical Care Evaluation Studies and Financial and Fraud and Abuse Reporting. Annually or as a part of the Operational and Financial Review, the ADHS must evaluate the Tribal subcontractors for their ability to assume more responsibility and the IGA must be amended to reflect the added responsibilities.

In the absence of an IGA, ADHS shall ensure that all covered services are available to all eligible American Indians. American Indians may choose to receive covered services within Indian Health Service (IHS) or PL 93-638 tribal facilities or through private providers and subcontractors. Subcontractors may serve eligible American Indians on reservation with agreement from the tribe.

4. ELIGIBILITY INFORMATION

AHCCCS shall provide ADHS and subcontractors with security access to automated Title XIX and Title XXI eligibility information. AHCCCS will provide ADHS appropriate technical assistance in interpreting the on-line systems. ADHS will provide appropriate technical assistance to subcontractors and Tribal subcontractors in interpreting the on-line system. ADHS shall be responsible financially for telecommunications and terminals.

Computer terminals shall provide ADHS and subcontractors with on-line read-only access to AHCCCS' member information.

In addition, AHCCCS will provide periodic reports to ADHS for purposes of describing the demographics of the eligible population for which ADHS is at risk. These reports are described in detail in the Technical Interface Guidelines (TIG) prepared by the AHCCCS Information Services Division, Attachment H, in this contract and available on the AHCCCS website at
http://www.azahcccs.gov/commercial/ContractorResources/TIG/default.htm.

5. ELIGIBILITY AND BEHAVIORAL HEALTH RECIPIENT VERIFICATIONS

ADHS shall be responsible for verifying the Title XIX and Title XXI recipient status of members who require behavioral health services. ADHS shall also respond to inquiries from AHCCCS acute Contractors, their PCPs, ALTCS Contractors, service providers and eligible persons regarding specific information about eligibility for Title XIX and Title XXI and behavioral health coverage within one business day. ADHS shall ensure notification to AHCCCS, Division of Member Services, if ADHS becomes aware of a member's death, incarceration or out-of-state move that may impact a member's eligibility status. ADHS shall ensure that confidentiality safeguards as defined in the User Affirmation Statement are strictly followed.

Providers may use AHCCCS' web-based verification and/or AHCCCS' contracted Medicaid Eligibility Verification Service (MEVS) to verify Title XIX and Title XXI eligibility 24 hours a day, 7 days a week. Also available is the Interactive Voice Response (IVR) system, 24 hours a day, 7 days a week. For specific problems, the Communication Center is open Monday through Friday from 7:00 am through 7:00 pm. Availability of the Center varies for each holiday.

If ADHS can demonstrate that it is not appropriate or cost effective for a tribal subcontractor to obtain an interface terminal, this contract requirement may be waived by AHCCCS. However, justification and an alternate plan for obtaining information must be submitted to AHCCCS at least 30 days prior to the inception of the tribal contract.

6. MEMBER INFORMATION AND MEMBER RIGHTS

Member Information Materials: ADHS shall ensure that subcontractors are accessible by phone for general member information during normal business hours. All behavioral health recipients will have access to a toll free phone number [42 CFR 438.10(b)(3)]. All member informational materials shall be reviewed for accuracy and approved by ADHS prior to distribution to members. All materials shall be translated when ADHS is aware that a language is spoken by 3,000 individuals or ten percent (10%) (whichever is less) of members in a geographic area who also have Limited English Proficiency (LEP). All vital material shall be translated when ADHS is aware that a language is spoken by 1,000 or five percent (5%) (whichever is less) of members in a geographic area who also have LEP [42 CFR 438.10(c)(3)]. Vital materials must include, at a minimum, notices for denials, reductions, suspensions or terminations of services, consent forms, communications requiring a response from the member, informed consent and all grievance, appeal and request for state fair hearing information included in the *Grievance System Standards and Policy* as described Attachment F(1) Enrollee Grievance System [42 CFR 438.404(a) and 42 CFR 438.10(c)]. When there are program changes, notification will be provided to the affected Title XIX and Title XXI members at least 30 days before implementation.

ADHS shall ensure that interpreters of any language are available free of charge for members to ensure appropriate delivery of covered services. ADHS shall ensure members are provided with information instructing them how to access these services [42 CFR 438.10(c)(4) and 438.10(c)(5)(i) and (ii)].

ADHS and subcontractors shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM Member Information Policy, as applicable. Regardless of the format chosen by ADHS and subcontractors, the member information must be printed in a type, style, and size which can be easily read by members with varying degrees of visual impairment or limited reading proficiency. ADHS and its subcontractors must notify its members that alternative formats are available and how to access them [42 CFR 438.10(d)(1)(i) and (ii), 42 CFR 438.10(d)(2)].

Provider Network: ADHS shall ensure that within 10 days of their first service members are provided with a description of the provider network. ADHS shall ensure that the following information is provided to all behavioral health recipients:

1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the behavioral health recipient's service area, including identification of providers that are not accepting new referrals.
2. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
3. The fact that the behavioral health recipient has a right to use any hospital or other setting for emergency care.
4. The names and locations of the pharmacies to be used for filling prescriptions for psychotropic medications.

ADHS shall ensure that written notice about termination of a contracted provider is given, within 15 days after receipt or issuance of the termination notice, to each member who received their behavioral health care from, or was seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(5)]. Affected members must be informed of any other changes in the network 30 days prior to the implementation date of the change [42 CFR 438.10(f)(4)].

Member Handbook [42 CFR 438.10(f)]: ADHS shall develop and implement policies and procedures that address minimum standards regarding the content, readability and distribution of member handbooks. ADHS shall submit the member handbook template annually by September 15th to AHCCCS for approval. ADHS shall produce or ensure that printed information is provided to behavioral health recipients within 10 days of receiving first service. ADHS shall ensure that handbooks are available at all provider sites and easily accessible to Title XIX and Title XXI members. ADHS shall ensure that upon request, copies of the member handbook are made available to known consumer and family advocacy organizations and other human service organizations in each geographic service area. ADHS shall review the member handbook at least once a year and revise as applicable to accurately reflect current policies, procedures and practices. The member handbook must be printed in a type-style and size which can easily be read by members with varying degrees of visual impairment. ADHS shall provide copies of each subcontractors' member handbooks and ADHS' review, including documentation of the location of required content in the handbook (completed review tool for each handbook with page numbers indicated), and feedback to subcontractors to AHCCCS annually by December 31st, and within 30 days of any handbook updates.

At a minimum the member handbook shall include:

a. A table of contents
b. A description of all available covered behavioral health services under the Title XIX and Title XXI programs, including EPSDT services for AHCCCS recipients under the age of 21 which covers all other necessary behavioral health care, diagnostic services, treatment and other measures to correct or ameliorate defects and mental illnesses and conditions discovered by screening services whether or not the services are covered in the State Plan., an explanation of any service limitations or exclusions from coverage and a notice stating that ADHS (and the subcontractor or Tribal subcontractor) will be liable only for those services authorized by ADHS (or the subcontractor or Tribal subcontractor) with the exception of emergency services [42 CFR 438.10 (f)(6)(v)]
c. How to obtain behavioral health services [42 CFR 438.10 (f)(6)(vi)]
d. How to make, change and cancel appointments with a provider
e. List of any applicable co-payments (including a statement that care will not be denied due to lack of co-payment). The member handbook must clearly state that Title XIX and Title XXI members cannot be billed for covered services (other than applicable co-payments) and under what circumstances a Title XIX and Title XXI member may be billed for non-covered services [42 CFR 438.10 (f)(6)(xi)]
f. How to contact the appropriate "member services" office (including telephone numbers) and a description of its function [42 CFR 438.10 (b)(2)]
g. What to do in case of an emergency and instructions for receiving advice on getting care in case of an emergency, both inside and outside the member's normal service area. The member handbook should instruct members, in a life threatening situation to use the emergency medical services (EMS) available or to activate EMS by dialing 9-1-1 [42 CFR 438.10 (f)(6)(viii)(c)]
h. How to obtain emergency and non-emergency medically necessary transportation
i. Out of county/out of state moves, referrals and records release

j. Grievance system information which defines member rights regarding disputed matters and explains grievance system requirements, including: a description of the right to a state fair hearing, the method for obtaining a state fair hearing, representation at the hearing, the right to file grievances and appeals, the requirements and timeframes for filing grievances and appeals, the availability of assistance in the filing process, the toll-free numbers for members to file a grievance or appeal by phone, the member's right to receive services in an appeal or state fair hearing request that is timely filed, that the member may be required to pay the costs of services furnished while the appeal is pending, if the decision is adverse to the member, and the member's right to give a provider permission to appeal on the member's behalf [42 CFR 438.10 (g)(6) and 42 CFR 438.400 thru 438.424].
k. Contributions the member can make toward his or her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential
l. Specific information regarding how members can have questions answered, problems resolved, complaints addressed, including telephone numbers for member advocates, subcontractor member services, ADHS and AHCCCS. Information should be included to encourage members to resolve problems at the lowest possible level but advise members that they can seek assistance at any level when they are unable to resolve at lower levels
m. Use of other sources of insurance
n. An explanation that sharing of medical record information with the PCP for coordination of care will occur within the limits of applicable regulations [42 CFR 438.10 (e)(2)(i)(C)]
o. Member's notification rights and responsibilities under AHCCCS Rules and policy. The description should include a brief explanation of the ADHS approval and denial process [42 CFR 438.10 (g)]
p. A description of Fraud and Abuse including instructions on how to report suspected fraud or abuse. This shall include a statement that misuse of a member's identification card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action against the member
q. Member's right to be treated fairly and with respect regardless of race, religion, sex, age, sexual preference, or ability to pay [42 CFR 438.100(b)(2)(ii)]
r. Confidentiality and confidentiality limitations
s. Information that coordination of care with schools and state agencies may occur, within the limits of applicable regulations [42 CFR 438.10 (e)(2)(i)(c)]
t. Statement of the Arizona Vision and information regarding the J.K. Principles
u. Instructions for obtaining culturally competent materials, including translated member materials. Members have the right to know of providers who speak languages other than English [42 CFR 438.10 (f) (6)]
v. Date of last revision (each page)
w. A statement that Title XIX and Title XXI covered services are funded under contract with AHCCCS
x. Advance directives for adults [42 CFR 438.10 (g)(2)]
y. The availability of interpretation services for oral interpretation at no cost to the member and how to obtain these services [42 CFR 438.10 (c)(5)(i) and (ii)]
z. Member's right to request information on Physician Incentive Plans of ADHS or subcontractors [42 CFR 438.10 (g)(3)(ii)]
aa. Member's right to request information on the structure and operation of ADHS or subcontractors [42 CFR 438.10 (g)(3)(i)]
bb. The availability of printed materials in alternative format and how to access them [42 CFR 438.10 (d)(2)]
cc. Dual eligibility (Medicare and Medicaid); services received in and out of the subcontractor's network and coinsurance and deductibles.

Materials Not Requiring Approval by ADHS: Customized letters for individual members need not be submitted for approval. Health related brochures developed by a nationally recognized organization do not require submission to ADHS for approval as long as they are written in easily understood language. ADHS will be held accountable for the content of materials developed by nationally recognized organizations. ADHS should review materials to ensure:

a. the services are covered under the AHCCCS program;
b. the information is accurate; and
c. the information is culturally sensitive.

It is important to note that in all instances where ADHS is required by this contract to educate behavioral health recipients, brochures developed by outside entities must be supplemented with information materials developed by ADHS which are customized for the Medicaid population. ADHS shall make every effort to ensure that all

information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM Member Information Policy, as applicable. Regardless of the format chosen by ADHS, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. ADHS must notify its members that alternative formats are available and how to access them [42 CFR 438.10 (d)].

Member Rights: ADHS 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.

ADHS shall ensure that each member is guaranteed the right to request and receive a copy of the member's medical record and to request that they be amended or corrected, as specified in 45 CFR Part 164.

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

At least annually, ADHS shall ensure all members are notified of their rights to request and obtain the following information [42 CFR 438.10(f)(6) and 42 CFR 438.100(a)(1) and (2)].

1. Name, locations, telephone numbers of, and non-English language spoken by current contracted providers in the member's service area, including identification of providers that are not accepting new referrals.
2. Any restriction on the member's freedom of choice among network providers.
3. Member rights and protections.
4. A description of how after-hours and emergency coverage is provided.
5. A description of what constitutes an emergency medical behavioral health condition, emergency services and post stabilization services.
6. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
7. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract.
8. The fact that the member has a right to use any hospital or other setting for emergency care.
9. The fact that prior authorization is not required for emergency services.
10. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that the member understands the benefits to which they are entitled, including coverage of behavioral health services as it pertains to EPSDT .
11. Procedures for obtaining benefits, including authorization requirements.
12. The extent to which, and how, the member may obtain benefits from out-of-network providers.
13. The post stabilization care services rules.
14. Cost sharing, if any.
15. How and where to access any benefits that are available under the State plan but are not covered under the contract, including any cost sharing, and how transportation is provided.
16. Advanced directives.
17. Information on the structure and operation of ADHS.
18. Physician incentive plan.
19. Grievance, appeal, and fair hearing procedures and timeframes that include the following:

    a. For State fair hearing-
        1. The right to hearing;
        2. The method for obtaining a hearing; and
        3. The rules that govern representation at the hearing.
    b. The right to file grievances and appeals.
    c. The requirements and timeframes for filing a grievance or appeal.
    d. The availability of assistance in the filing process.
    e. The toll-free numbers that the member can use to file a grievance or an appeal by phone.
    f. The fact that, when requested by the member:
        1. Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and

2. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.

g. Any appeal rights available to providers to challenge the failure of an organization to cover a service.

7. REFERRALS

ADHS shall establish written criteria and procedures for promptly accepting and acting upon referrals, including emergency referrals. A referral for behavioral health services is any oral, written, faxed or electronic request for services made by the member or member's legal guardian, family member, an AHCCCS acute Contractor, PCP, hospital, court, Tribe, American Indian Health Program (formerly known as IHS), school, or other state or community agency. ADHS shall ensure a timely response to all requests for services and shall schedule emergency and routine evaluations consistent with appointment standards stipulated in paragraph 9 of this contract. All referrals from a PCP involving a member who needs psychotropic medication shall be accepted and acted upon according to the needs of the member and ADHS shall ensure that the member does not experience a lapse in medically necessary psychotropic medications. ADHS shall monitor to ensure that all referrals are tracked, including the date of the request for services, date of initial appointment, the reason why the member declined the offered appointment, if applicable, and final disposition of referral.

Disposition of Referrals: ADHS shall ensure that the final disposition of all routine referrals from PCPs, AHCCCS Health Plans, Department of Education/School Districts and state social service agencies is communicated to the referral source and health plan behavioral health coordinator, if the member is enrolled in an acute care plan, within 45 days of the member receiving an initial assessment. If a member declines behavioral health services, the final disposition must be communicated back to the referral source and health plan behavioral health coordinator, when applicable, within 45 days of referral. The final disposition shall include, at a minimum, the date when the member was seen for an initial assessment and the name and contact information of the provider that will be assuming the primary responsibility for the member's behavioral health care or information establishing that a follow-up to the referral was conducted but no services will be provided including the reason. The reason for non provision of services must include evidence that the member was contacted at least three times (phone, mail) to engage in services and either declined or was unable to be located.

Consent and Authorization: Proper consent and authorization to release information must be obtained and ADHS must ensure adherence to confidentiality guidelines pursuant to 42 CFR Part 431, 45 CFR Parts 160 and 164, A.R.S. 36-509, AHCCCS rules and other relevant state and federal provisions. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release in order to share behavioral health related information with the member's parent/legal guardian, primary care provider (PCP), the member's Health Plan Behavioral Health Coordinator acting on behalf of the PCP or some social service state agencies.

Emergency Referrals: Emergency referrals shall be accepted and responded to twenty-four (24) hours a day, seven (7) days a week and do not require prior authorization. Emergency referrals include those initiated for hospitalized members and members seen in the emergency room. Upon receipt of an emergency referral, ADHS must respond within 24 hours which must identify the member as a behavioral health recipient effective the date of the response. Following both routine or emergency referrals and irrespective of the member's behavioral health recipient status, ADHS is financially responsible for the member's medically necessary behavioral health services as described in Paragraph 3 "Covered Services for American Indians", Paragraph 8 "Service Delivery", and Paragraph 11 "Coordination with AHCCCS Acute Care Contractors and Other Agencies". ADHS is financially responsible regardless of T/RBHA enrollment. For a hospitalized (inpatient) member who is enrolled in an acute care plan but who is not a behavioral health recipient, ADHS is responsible for all inpatient emergency behavioral health services from the earlier of: 1) the date on which the member becomes a behavioral health recipient or 2) the seventy-third hour after admission. (A.A.C. R9-22-210.01) ADHS or subcontractors must notify the inpatient facility in writing of the date on which the subcontractor is assuming financial responsibility for the provision of all medically necessary behavioral health services for the member. The subcontractor must also notify the inpatient facility in writing to submit any requests for prior authorization and payment to the subcontractor.

Provider Directory: Where the subcontractors have implemented a system of referral to the providers rather than a centralized intake, ADHS will ensure that provider directories are available to Health Plans for distribution to the PCPs. ADHS will ensure that when changes are made in the networks, Health Plans will receive revised and updated directories or referral information.

Referral to a Provider For a Second Opinion: Upon a member's request, ADHS must provide for a second opinion from a qualified health care professional within the network, or arrange for a member to obtain one outside the network at no cost to the member [42 CFR 438.206(b)(3)]. For purposes of this paragraph, a qualified health care professional is a provider who meets the qualifications to be an AHCCCS registered provider of behavioral health services, and who is a physician, a physician assistant, a nurse practitioner, a psychologist, or an independent Master's level therapist.

ADHS will ensure AzSH coordinates with members acute health plans prior to discharge when members are receiving treatment and services related to diabetes management.

8. SERVICE DELIVERY

ADHS provides behavioral health services for acute care services through the RBHA and TRBHA system. Pursuant to ARS §36-2907 ADHS is responsible for payment of all covered behavioral health services even when there is no T/RBHA enrollment, with the following exceptions;

a. Acute Care Health Plans are responsible for payment of emergency inpatient behavioral health services for its members up to a maximum of 72 hours as specified in AHCCCS Rule R9-22-210.01.
b. Acute Care Health Plans are responsible for payment of behavioral health services received by the acute care member during prior period coverage with the exception of prepetition screening and court ordered evaluation services which are the responsibility of a County pursuant to ARS §36-545 et seq.
c. The AHCCCS Administration is responsible for payment of behavioral health services provided to American Indians by IHS or 638 providers, including situations where the TRBHA is also a 638 provider.
d. The AHCCCS Administration is responsible for payment of emergency behavioral health services provided to individuals who are eligible for only emergency services pursuant to A.A.C. R9-22-217. These individuals are covered under the Federal Emergency Services Program (FESP). Coverage for these individuals is limited to emergency behavioral health services.
e. A County is responsible for payment of prepetition screening and court ordered evaluation services pursuant to ARS §36-545 et seq.

With regard to recipients identified as TRBHA enrolled, ADHS is responsible for payment of behavioral health services provided to American Indians through TRBHAs (except as described above for TRBHAs which are 638 entities. In this limited situation the AHCCCS Administration is responsible for payment.) With regard to non IHS/638 TRBHA claims, however, the AHCCCS Administration processes claims for ADHS as its Third Party Administrator (TPA) using ADHS monies. Claims for services provided to individuals identified as TRBHA enrolled must be filed with the AHCCCS Administration, but claim disputes must be filed with ADHS.

ADHS is also responsible for payment of behavioral health services provided to Fee-for-Service members who are not T/RBHA enrolled unless the services are provided by IHS or 638 providers. As stated above, the AHCCCS Administration is responsible for payment of behavioral health services provided by IHS or 638 entities.

Providers must timely file claims and claim disputes with the appropriate entity as described above. Absent a contract which established different timeframes: 1) initial claims must be filed no later than 6 months from the date of service or date of eligibility posting, whichever is later, 2) clean claims must be filed no later than 12 months from the date of service or from the date of eligibility posting, whichever date is later, and 3) claim disputes must be filed no later than 12 months from the date of service, 12 months from the date of eligibility posting, or within 60 days from the date of a timely submitted claim, whichever date is later.

Authorization of Services: For the processing of requests for initial and continuing authorizations of services, ADHS shall have in place, and follow, written policies and procedures. ADHS shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions and consult with requesting providers when appropriate. 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.

Notice of Adverse Action [42 CFR 438.210(c)] ADHS shall include an operational definition of medically necessary behavioral health services in policy [42 CFR 438.210 (a)(4)]. ADHS shall ensure notification to

requesting providers and give the behavioral health recipient written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, except for the requirement that the notice to the provider must be in writing.

Per the Balanced Budget Act of 1997, 42 CFR 438.114, 422.113 and 422.133, the following conditions apply with respect to coverage and payment of emergency and post stabilization services:

ADHS must ensure coverage and payment for emergency medical services for behavioral health recipients regardless of whether the provider that furnishes the service has a contract with ADHS or the subcontractors.

ADHS must ensure that payment is not denied for treatment obtained under either of the following circumstances:

1. A behavioral health recipient 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 in 42CFR 438.114.
2. A representative of ADHS (an employee, subcontractor or provider) instructs the behavioral health recipient to seek emergency medical services.

Additionally, ADHS may not:

1. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114(d)(1)(i), on the basis of lists of diagnoses or symptoms.
2. Refuse to cover emergency medical services based on the failure of the provider, hospital, or fiscal agent to notify ADHS or the subcontractors of the behavioral health recipient's screening and treatment within 10 calendar days of presentation for emergency services. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)].

A behavioral health recipient 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 behavioral health recipient, is responsible for determining when the behavioral health recipient is sufficiently stabilized for transfer or discharge and such determination is binding on ADHS [42 CFR 438.114(d)(3)].

The following conditions apply with respect to coverage and payment of post-stabilization care services. ADHS must cover and pay for post-stabilization care services without authorization, regardless of whether the provider that furnishes the service has a contract with ADHS or the subcontractors, for the following situations:

1. Post-stabilization care services that were pre-authorized by ADHS or the subcontractors; or
2. Post-stabilization care services that were not pre-approved by ADHS or the subcontractors because ADHS or the subcontractors 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; or
3. ADHS or the subcontractor's representative and the treating physician cannot reach agreement concerning the member's care and an ADHS or subcontractor physician is not available for consultation. In this situation, ADHS or the subcontractor must give the treating physician the opportunity to consult with a contracted physician and the treating physician may continue with care of the member until a contracted physician is reached or one of the criteria in CFR 422.113(c)(3) is met.

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

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

When a Title XIX or Title XXI member presents in an emergency room setting, the member's AHCCCS acute health plan is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. ADHS is responsible for medically necessary psychiatric and/or psychological consultations provided to Title XIX and Title XXI behavioral health recipients in emergency room settings. ADHS is responsible for transportation of Title XIX/XXI behavioral health recipients to the emergency room in situations where the behavioral health recipient is directed by a representative of ADHS to present to this setting to resolve a behavioral health crisis.

A member shall be immediately identified as a behavioral health recipient when a network provider delivers a covered service, including emergency or crisis services. The effective date of identifying a member as a behavioral health recipient shall be no later than the date on which the first behavioral health service was delivered.

To the extent possible and appropriate, ADHS must allow members to choose their behavioral health provider(s) [42 CFR 438.6(m)].

ADHS shall ensure that the following activities are performed for all Title XIX and Title XXI members:

a. Assessments and treatment recommendations are completed in collaboration with member/family and with clinical input from a clinician who is credentialed and privileged and who is either a behavioral health professional or a behavioral health technician under the supervision of a behavioral health professional [42 CFR 438.208(c)(2) and (3)].
b. A clinician deemed competent, privileged and credentialed by ADHS is assigned and responsible for providing clinical oversight, working in collaboration with the member and his/her family or significant others to implement an effective treatment plan, and serving as the point of contact, coordination and communication with other systems where clinical knowledge of the case is important [42 CFR 438.208(b)(1)].
c. Responsibility is defined or assigned to ensure the following activities are performed as part of the service delivery process:
    1. Ongoing engagement of the member, family and others who are significant in meeting the behavioral health needs of the member, including active participation in decision-making process.
    2. Assessments are performed to elicit strengths, needs and goals of the member and his/her family, identify the need for further or specialty evaluations that lead to a treatment plan which will effectively meet the member's needs and result in improved health outcomes.
    3. For members referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, ensure the review of the initial assessment and treatment recommendations by a licensed medical practitioner with prescribing privileges.
    4. Provision of all covered services as identified on the treatment plan that are clinically sound, medically necessary, include referral to community resources as appropriate and for children, services are provided consistent with the Arizona Vision and Principles.
    5. Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the member and input from the member and other relevant persons resulting in modification to the treatment plan, if necessary.
    6. Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is important to achieving positive outcomes, e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers.
    7. Clinical oversight to ensure continuity of care between inpatient and outpatient settings, services and supports.
    8. Transfers out-of-area, out-of-state, or to an ALTCS Contractor.
    9. Development and implementation of transition, discharge, and aftercare plans prior to discontinuation of behavioral health services.
    10. Documentation of the above is maintained in the member's behavioral health record by the point of contact as identified in (b.) above.

ADHS shall provide ongoing technical assistance regarding required training for subcontractor staff and providers who serve Title XIX and Title XXI members. ADHS must ensure that training occurs for subcontractor's staff and within the provider network including, but not limited to, the following:

a. How to conduct a comprehensive assessment

b. Coordination of care requirements (including coordination with PCPs and other state agencies)
c. Sharing of treatment/medical information
d. Behavioral health record documentation requirements
e. Confidentiality/HIPAA
f. Fraud and abuse requirements and protocols
g. Best practices in the treatment and prevention of behavioral health disorders
h. Managed care concepts
i. Title XIX and Title XXI covered services (including information on how to assist members in accessing all medically necessary services regardless of a members' mental health indicator or involvement with any one type of service provider)
j. Grievance system standards and procedures
k. Member's rights and responsibilities
l. Customer service (i.e. responses to complaints)
m. Early Periodic Screening, Diagnostic and Treatment (EPSDT), including coverage of all other necessary behavioral health care, diagnostic services, treatment and other measures to correct and ameliorate defects and mental illnesses and conditions discovered by screening services whether or not they are covered in the State Plan.
n. Eligibility and behavioral health recipient verifications, and
o. Management of difficult cases including high risk members and members that are court ordered for treatment
p. Clinical training as it relates to specialty populations and/or conditions.

9. APPOINTMENT STANDARDS

ADHS shall develop and implement policies and procedures to monitor the availability and timeliness of appointments as well as disseminate information regarding appointment standards to members, subcontractors and service providers. ADHS shall ensure appointments are provided as follows:

a. Emergency appointments within 24 hours of referral (including but not limited to the requirement to respond to referrals for hospitalized members who are not yet identified as a behavioral health recipient);
b. Routine appointment for initial assessment within 7 days of referral;
c. Routine appointments for ongoing services within 23 days of initial assessment: and
d. For members referred by a PCP / Health Plan Behavioral Health Coordinator for psychiatric evaluation / medication management, appointments with a psychiatric prescriber (MD, DO, NP, PA), according to the needs of the member, and within the appointment standards described above, and ensuring that the member does not experience a lapse in medically necessary psychotropic medications.

ADHS shall monitor compliance with these standards and shall require corrective action when appointment standards are not met.

Appointments shall be scheduled in a timely manner according to the needs of the member and in accordance with the requirements in Section D, Paragraph 7 and Paragraph 8 of this contract. The waiting time for an established appointment shall not exceed 45 minutes except when the service provider is unavailable due to an emergency. Emergency appointments may be triaged.

Disputes regarding the need for emergency or routine appointments between the subcontractor and the referring source that cannot be resolved informally shall be promptly resolved by ADHS.

If a Title XIX or Title XXI member needs medically necessary transportation, ADHS shall ensure that transportation is provided and that the member arrives no sooner than one hour before the appointment, and does not have to wait for more than one hour after the conclusion of the appointment for transportation home.

10. MEDICAL INSTITUTION NOTIFICATION

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay co-payments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to the Center for Medicare and Medicaid Services (CMS), effective

January 1, 2006 ADHS must, using the approved form, notify the AHCCCS Member Database Management Administration (MDMA), via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

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

For purposes of the medical institution notification, medical institutions are defined as acute hospitals, psychiatric hospital – Non IMD, psychiatric hospital – IMD, residential treatment center – Non IMD, residential treatment center – IMD, skilled nursing facilities, and Intermediate Care Facilities for the Mentally Retarded.

11. COORDINATION WITH AHCCCS ACUTE CONTRACTORS AND OTHER AGENCIES [42 CFR 438.208(b)(2)]

AHCCCS Acute Contractors: ADHS is responsible for coordination of care with AHCCCS acute Contractors. ADHS shall also ensure that behavioral health recipient care is coordinated with other state agencies providing services to Title XIX and Title XXI members. For members who are enrolled with an acute care Contractor and who receive behavioral health services during prior period coverage, the acute Contractor is responsible for payment of all claims for medically necessary covered behavioral health services with the exception of prepetition screening and court ordered evaluation services which are the fiscal responsibility of a County pursuant to ARS §36-545 et seq. ADHS is responsible for payment of all behavioral health services provided to Fee-for-Service members who are not enrolled with an acute care Contractor, except for prepetition screening and court ordered evaluation services as mentioned above and services provided by IHS or 638 facilities. ADHS is responsible for payment of behavioral health services for certain populations even when there is no T/RBHA enrollment (Also see Section 3, Covered Services for American Indians and 8, Service Delivery.) ADHS shall establish policies and procedures regarding confidentiality and for ensuring implementation and monitoring of coordination between subcontractors, AHCCCS acute Contractors, behavioral health providers, and other state or county agencies.

ADHS shall ensure that the behavioral health records (copies or summaries of relevant information) of each Title XIX and Title XXI member are forwarded to the member's PCP as needed to support quality medical management and prevent duplication of services. At a minimum, for all members who are behavioral health recipients who are referred by the PCP or are determined by ADHS to have a serious mental illness, the member's diagnosis, critical labs as defined by the laboratory and prescribed medications, including notification of changes in class of medications must be provided to the PCP [42 CFR 438.208(b)(3)]. Information must be provided to the PCP upon request for any behavioral health recipient and no later than 10 days of the request.

ADHS must approve any standardized forms that may be utilized to meet these requirements. ADHS must monitor to ensure compliance with these notification requirements through periodic case file review, trends in grievance and appeal and problem resolution data and other quality management activities.

In order to ensure effective coordination of care, proper consent and authorization to release information to Health Plans should be obtained. For medical records and any other health and member information that identifies a particular behavioral health recipient, ADHS must establish and implement procedures consistent with confidentiality requirements in 42 CFR 431.300 et. seq., 42 CFR 438.224 and 45 CFR parts 160 and 164, and A.R.S. §36-509. Unless prescribed otherwise in federal regulations or statute, it is not necessary for subcontractors or providers to obtain a signed release form in order to share mental health related information with the PCP or the member's Health Plan Behavioral Health Coordinator acting on behalf of the PCP.

ADHS will ensure consultation services are available to health plan PCPs and have materials available for the Acute Health Plans and PCPs describing how to access consultation services and how to initiate a referral for ongoing behavioral health services. Behavioral health recipients currently being treated by ADHS for depression, anxiety or attention deficit hyperactivity disorders may be referred back to the PCP for ongoing care only after consultation with and acceptance by the member and the member's PCP. ADHS must ensure the systematic review of the appropriateness of decisions to refer members to PCPs for ongoing care under the above mentioned three (3)

diagnoses. Upon request, ADHS shall ensure that PCPs are informed about the availability of resource information regarding the diagnosis and treatment of behavioral health disorders.

ADHS will ensure the following required staff position in contract with each T/RBHA. An Acute Health Plan and Provider Coordinator(s) who shall be, or be supervised by and have direct priority access to, a behavioral health professional (BHP) as described in Health Services Rule R9-20-204. The Acute Health Plan and Provider Coordinator(s) shall devote sufficient time to assure that the following functions and performance measurements are met:

Functions:

a. Gathering, reviewing and communicating clinical information requested by primary care physicians, Acute Care Plan Behavioral Health Coordinators, and other treating professionals for the purposes of triage or care coordination;
b. Locating the member's affiliated provider in the T/RBHAs system;
c. Understand and be capable of resolving any administrative or programmatic issues, or have the clinical expertise to problem solve any case management or medical management issues and recognition of issues requiring immediate attention and the ability to act accordingly;
d. Ensures that there is adequate follow up for resolution of requests or issues;
e. Collaboration and coordination with the Acute Health Plans regarding member specific issues or needs.

Performance Requirements:

a. The T/RBHA must have a designated and published contact number for the Health Plan and Provider Coordinator. Each T/RBHA would have a single phone number or a prompt for the use of the AHCCCS Contractors and their providers, as well as AHCCCS for the purpose of coordination of care for individual members. The contact number must be staffed during business hours.
b. The T/RBHA must have adequate staff to ensure timely response to requests for information as defined below:
    1. "Urgent" – Requests for intervention, information, or response within 24 hours.
    2. "Routine" – Requests for intervention, information or response within 10 days.
c. The T/RBHA must have a mechanism to track/log all the received requests for general information, any interventions, and inquiries from Health Plans, Primary Care Providers, and other treatment providers. ADHS/DBHS will report, in an agreed upon format, to AHCCCS DHCM Operations Unit the timeliness of the responses and compliance with the standards outlined above.
d. ADHS/DBHS would direct the T/RBHA to perform these functions and be responsible for meeting these standards.
e. ADHS/DBHS must provide oversight and monitoring to assure that the T/RBHA complies.

Department of Economic Security/Disability Determination Services Administration (ADES/DDSA): ADHS shall require that the subcontractors coordinate the sharing of information between the RBHAs and AHCCCS/SSI-MAO to assist in the applicant's eligibility determination. Information will include the applicant's behavioral health history including the SMI status, as needed. ADHS will cooperate with ADES/DDSA in its review and sampling of applicants' determinations of SMI status, in compliance with AHCCCS' state plan amendment.

12. BEHAVIORAL HEALTH RECORDS

Behavioral health records are to be maintained in a detailed and comprehensive manner, which conforms to the requirements of the AHCCCS Medical Policy Manual. The behavioral health record must contain documentation of any authorized representative. AHCCCS or its designee may inspect such records at any time during regular business hours at the offices of ADHS, subcontractors, at hospitals or other service providers.

13. TRANSITION OF TITLE XIX AND TITLE XXI MEMBERS

ADHS shall develop and implement policies and procedures regarding the transition of Title XIX and Title XXI members between subcontractors and the transition of Title XIX and Title XXI members to ALTCS Contractors as appropriate. ADHS shall, no less than monthly, provide each subcontractor with a listing of Title XIX and Title XXI members who are behavioral health recipients and have become ALTCS eligible. To ensure that Title XIX and Title XXI members who need behavioral health services receive them, ADHS and the subcontractors shall cooperate when a transition from one subcontractor to another including an ALTCS/Acute Contractor is necessary. When a member has completed step therapy, for behavioral health medications used to treat anxiety, depression and/or

ADHD, ADHS/DBHS must ensure that the member's care is transitioned back to his/her primary care physician and that there is no interruption in the member's medications. ADHS/DBHS must ensure the RBHA/behavioral health provider initiates the transition process to return the member back to the care of his/her primary care physician and that the RBHA/behavioral health provider provides the primary care physician with, at a minimum, the following documentation:

a. A written statement indicating that step therapy has been completed;
b. A medication sheet or list of medications currently prescribed by the RBHA/behavioral health provider;
c. A psychiatric evaluation;
d. Any relevant psychiatric progress notes that may assist in the ongoing treatment of the member;
e. A discharge summary outlining the member's care and any adverse responses the member has had to treatment or medications.

This shall include identification of transitioning members, provision of appropriate referrals, forwarding of the medical record, as allowed under federal law, and transferring responsibility for court orders, as applicable.

14. OUTREACH AND FOLLOW-UP ACTIVITIES

ADHS shall ensure the provision of outreach activities designed to inform Title XIX and Title XXI members of the availability of behavioral health services. ADHS shall utilize penetration rates and other quality management measures to assess the effectiveness of outreach efforts.

ADHS shall develop and implement a policy and procedure regarding required outreach activities, including outreach in cases involving transfers between subcontractors. ADHS shall ensure active participation in outreach activities to Title XIX and Title XXI members in high-risk groups, including but not limited to the homeless, seriously mentally ill members, members with co-morbid medical and behavioral health disorders and substance abusing pregnant women. ADHS shall ensure initiation of follow-up activities consistent with ADHS policy for Title XIX and Title XXI members who do not appear for scheduled appointments. ADHS shall ensure initiation of follow-up activities for individuals for whom a crisis service has been provided as the first service to ensure engagement with ongoing services as clinically indicated.

Upon request, ADHS shall ensure outreach and dissemination of information to the general public, other human service providers, county and state governments, school administrators and teachers and other interested parties regarding behavioral health services available to Title XIX and Title XXI members.

15. DISSEMINATION OF INFORMATION

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

16. STAFF REQUIREMENTS

ADHS shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, the ADHS shall not employ or contract with any individual or entity that 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 12549. [42 CFR 438.610(a) and (b)]

ADHS must employ sufficient staffing and utilize appropriate resources to achieve contractual compliance. ADHS' resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contractual and AHCCCS policy requirements, including the requirement for providing culturally competent services. If ADHS does not achieve the desired outcomes or maintain compliance with contractual obligations, additional monitoring and regulatory action may be employed by AHCCCS, up to and including actions specified in Section D, Paragraph 39, Sanctions, of the Contract.

ADHS shall inform AHCCCS, Division of Health Care Management, in writing within seven days, when an employee leaves one of the Key Staff positions listed below (this requirement does not apply to Additional Required

Staff, also listed below). The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place. At a minimum, the following key staff are required:

a. A Division Director who is available fulltime to fulfill the responsibilities of the position and to oversee the entire operation of the Division of Behavioral Health Services to ensure adherence to program requirements and timely responses to AHCCCS Administration
b. A Chief Financial Officer who is available to fulfill the responsibilities of the position and to oversee the budget and accounting systems implemented by ADHS
c. A Medical Director who shall be an Arizona-licensed physician who is a psychiatrist. The ADHS Medical Director shall be actively involved in all major clinical programs and provide leadership and consultation to the ADHS quality and utilization management program
d. Quality Management Coordinator who is an Arizona-licensed registered nurse, physician or physician's assistant or a Certified Professional in Healthcare Quality (CPHQ). The Quality Management Coordinator must have experience in quality management and quality improvement.
e. Performance/Quality Improvement Coordinator who has a minimum qualification as a Certified Professional in Healthcare Quality (CPHQ) or comparable education and experience in data and outcomes measurement.
f. Medical Management Coordinator who is an Arizona-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations, or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations. The primary functions of the Medical Management Coordinator are:
    - Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria.
    - Ensure appropriate concurrent review and discharge planning of inpatient stays is conducted.
    - Develop, implement and monitor the provision of care coordination, disease management and case management functions.
    - Monitor, analyze and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services.
g. An Information Systems Officer and a Technical Applications Contact
h. Grievance and Appeals Officer who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals, and requests for hearing and provider claim disputes.
i. Clinical Program Administrators; one or more persons, one of which must be a behavioral health professional, responsible for the implementation and oversight of clinical programs.
j. Compliance Officer who will implement and oversee the ADHS compliance program. The compliance officer shall be an on-site management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCS, Office of Program Integrity. See Paragraph 52, Corporate Compliance, for more information.
k. Cultural Competency Plan Contact, sufficient to implement and oversee compliance with both the ADHS Cultural Competency Plan and the ACOM Cultural Competency Policy, and to oversee compliance with all AHCCCS requirements pertaining to limited English proficiency (LEP), and
l. A Business Continuity Planning and Recovery Coordinator as noted in the AHCCCS Contractor Operations Manual Business Continuity and Recovery Planning Policy.
m. Contract Compliance Officer who will serve as the primary point of contact for all Contractor/Subcontractor operational issues. The primary functions of the contract Compliance Officer are;
    - Coordinate the tracking and submission of all contract deliverables
    - Field and coordinate responses to AHCCCS inquiries
    - Coordinate the preparation and execution of contract requirements such as OFRs, random and periodic audits and ad hoc visits

ADHS shall establish minimum staffing requirements for subcontractors. ADHS shall include these staffing requirements in contract.

By May 31st, prior to each contract year, ADHS shall submit to AHCCCS, Division of Health Care Management the following:

a. ADHS/DBHS' organizational chart that includes names of staff and position titles;
b. A current description of staff member's functions and percentage of time allocated to overseeing ADHS/DBHS operations;
c. A crosswalk of ADHS/DBHS staff members and AHCCCS required staff positions.

Staff Training and Meeting Attendance

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

ADHS must provide initial and ongoing staff training that includes an overview of AHCCCS; AHCCCS Policy and Procedure Manuals; Contract requirements and State and Federal requirements specific to individual job functions. ADHS 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.

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

17. ADHS DEVELOPMENT OF TITLE XIX AND TITLE XXI POLICIES

For the purpose of ensuring that all applicable contract requirements are met fully and consistently by all subcontractors and providers in the ADHS network, ADHS shall develop, maintain, post and distribute comprehensive policies. ADHS shall ensure that each subcontractor is issued a copy of the policies. ADHS remains responsible for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements such as covered services, billing, etc. At its option, ADHS may impose more restrictive standards than those contained in this contract.

All policies (which may include requirements, manuals or standards) pertaining to Title XIX and/or Title XXI members must be reviewed and approved by AHCCCS prior to implementation pursuant to 42 CFR 431.10, and shall be subject to monitoring through the Operational and Financial Review. Any policy adopted by ADHS pertaining to fulfilling the requirements of this contract shall be incorporated by reference in each subcontract.

ADHS shall have effective procedures in place for the periodic updating and revision of the policies to include the prompt and accurate communication of these revisions to subcontractors and documentation of the location in the policies of content required under this contract, which shall be submitted to AHCCCS upon request. The Medical Director or the Medical Director's designee shall identify medical policy requirements, and ensure annual review of ADHS' and subcontractors' medical policies. All medical and quality management policies must be approved and signed by the ADHS Medical Director. The ADHS policies shall contain detailed specifications of standards and procedures for all operational, fiscal, program and administrative policies applicable to subcontractors including, but not limited to, the following:

a. Advance Directives in accordance with 42 CFR 422.128
b. Appointment Standards, timeliness of client referral, intake and service delivery [42 CFR 438.206]
c. Claims and encounter submission
d. Coordination of care and communication with AHCCCS acute Contractors [42 CFR 438.208]
e. Covered services, non-covered services and service limitations for Title XIX and Title XXI members
f. Credentialing of providers consistent with Chapter 900 of the AHCCCS Medical Policy Manual [42 CFR 438.214(b)(1) and (2)]
g. Data processing requirements
h. Description of sanctions for non-compliance with contract requirements
i. Termination of identification as a behavioral health recipient
j. Discharge plans
k. The Grievance System, including the grievance, appeal and fair hearing processes and member rights and responsibilities
l. Eligibility and behavioral health recipient verification
m. Financial management, audit and reporting, disclosure
n. Fraud and abuse and Corporate Compliance as specified in Section D, Paragraph 52

o. Member handbook
p. Outreach and follow-up activities
q. Prior authorization system and criteria and notification of denial [42 CFR 438.210(b)(1)]
r. Provider network requirements
s. Quality Management including annual Quality Management Plan, development, implementation, monitoring
t. Medical Management, including annual Medical Management Plan, Medical Management workplan and evaluation of outcomes
u. Referral management
v. Reimbursement and third party procedures, including reporting changes in health insurance (3rd party coverage)
w. Assessment and treatment planning process
x. Special delivery systems (e.g., American Indians)
y. Transition of members
z. Behavioral health category assignment: SED, Non-SED, SMI, Non-SMI
aa. Cultural Competency
bb. Responsibility for clinical oversight and point of contact
cc. Confidentiality
dd. Medically Necessary Covered Services
ee. Formulary
ff. Approval of out-of-state placements
gg. Physician Incentive Plans in accordance with 42 CFR 422.208 and 422.210
hh. Responsibility for Emergency and Post Stabilization Services
ii. Second Opinions
jj. Provider-Recipient Communications
kk. Provider network policies addressing [42 CFR 438.214]:
    1. Provider selection and retention criteria [42 CFR 438.214(a)]
    2. Communicating with providers regarding contract requirements and program changes
    3. Monitoring and maintaining providers' compliance with AHCCCS and ADHS policies and rules
    4. Ensuring the delivery of covered services throughout the network
    5. Ensuring the provision of medically necessary covered services should the network become temporarily insufficient within the contracted service area
    6. Monitoring network capacity to ensure that there are sufficient qualified providers to serve the number and specialized needs of members
    7. Ensuring service accessibility, including monitoring appointment standards, appointment waiting times and service provision standards
    8. Selection and retention of providers should consider performance and outcome measures
    9. Guidelines to establish reasonable geographic access to service for members
    10. Ensuring that information is collected on the cultural needs of communities and that the provider network adequately addresses identified cultural needs
    11. Provider capacity by provider type needed to furnish covered services
    12. Monitoring the adequacy, accessibility and availability of the provider network to meet the needs of the members, including the provision of care to members with limited proficiency in English, and
    13. Expedited and temporary credentialing process
ll. Inter-rater reliability to assure the consistent application of coverage criteria.
mm. Prior Period Coverage
nn. Community Service Agencies
oo. Other items, as considered necessary by AHCCCS

In the event of discrepancy between ADHS policies and this contract, the contract shall take precedence.

18. PROVIDER NETWORK REQUIREMENTS

ADHS shall develop and implement policies, procedures and standards to monitor the adequacy, accessibility and availability of its provider network to meet the needs of Title XIX and Title XXI members including the provision of care to members with limited proficiency in English, as listed in Paragraph 17, ADHS Development of Title XIX and Title XXI Policies. Although the performance of network functions may be delegated to subcontractors, ADHS

is responsible for the provider network requirements and must analyze information and make assessments regarding the sufficiency of the network. ADHS must monitor subcontractors to ensure that the provider network is sufficient to provide all behavioral health covered services to TXIX and TXXI members [42 CFR 438.206(1)(iv)].

Network Development: ADHS shall establish and maintain a statewide network of providers that is sufficient to provide all covered behavioral health services under this contract [42 CFR 438.206(b)(1)]. ADHS shall ensure covered behavioral health services are provided promptly and are accessible in terms of location and hours of operation and shall develop pertinent written standards. There shall be sufficient professional personnel for the provision of covered behavioral health services, including emergency care on a twenty-four (24) hours a day, seven (7) days a week basis [42 CFR 438.206(c)(1)(iii)]. To promote sufficient access for members and families who cannot easily get leave from their employment, ADHS must ensure that providers offer evening and/or weekend access to appointments [42 CFR 438.206(c)(1)(ii)].

ADHS 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)]. In addition, ADHS 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 ADHS from limiting provider participation to the extent necessary to meet the needs of ADHS members. This provision also does not interfere with measures established by ADHS to control costs consistent with its responsibilities under this contract nor does it preclude ADHS from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If ADHS declines to include individuals or groups of providers in its network, it must give the affected providers written notice of the reason for its decision [42 CFR 438.12(a)(1)]. ADHS may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

ADHS shall establish a process to identify essential minimum network requirements for each GSA regarding the number of providers by provider type and specialty providers. In assessing the sufficiency of the provider network, ADHS must utilize multiple data sources including, but not limited to, appointment standard data, problem resolutions, reported member concerns, grievance and appeal data, Title XIX and Title XXI eligible data, penetration rates, member satisfaction surveys, demographic data, national data sources and information on the cultural needs of communities.

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

a. Anticipated number of Title XIX and Title XXI members;
b. Expected utilization of services, considering Title XIX and Title XXI member characteristics and health care needs;
c. Number and types (in terms of training, experience and specialization) of providers required to provide the contracted services;
d. Network providers who are not accepting new Title XIX and Title XXI members, and
e. The geographic location of providers and Title XIX and Title XXI members, considering distance, travel time, the means of transportation used by Title XIX and Title XXI members and whether the location provides physical access for Title XIX and Title XXI members with disabilities.

If the network is unable to provide medically necessary services required under contract, ADHS shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted [42 CFR 438.206(b)(4)]. ADHS shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR 438.206(b)(5)].

Network Management: ADHS shall develop provider selection criteria based on licensure and certification standards and privileging and credentialing activities that are consistent with AHCCCS Contractor Operations Manual (ACOM) and contract. At a minimum, these criteria must be consistent with state and federal regulations governing the professional areas for those providers involved in the performance of this contract and shall indicate that ADHS shall monitor licensed providers for continued compliance with these criteria. Any proposed revisions of these criteria by ADHS must be submitted in advance to AHCCCS for prior approval.

ADHS shall demonstrate that its qualified health care professionals are credentialed and shall follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with ADHS/designee.

ADHS shall notify AHCCCS, Division of Health Care Management, within one business day of ADHS becoming aware of any unexpected changes that would impair its provider network. This notification shall include (1) information about how the change will affect the delivery of covered services, (2) ADHS' plans for maintaining the quality of member care if the provider change is likely to result in deficient delivery of covered services and (3) ADHS' plan to address and resolve any network deficiency.

If a licensed and/or certified provider is being terminated or suspended, ADHS shall notify AHCCCS Provider Registration within five days of learning of the termination or suspension.

Provider-Behavioral Health Recipient Communication: ADHS 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 behavioral health recipient who is his or her patient, for;

a. the behavioral health recipient's health status, medical care or treatment options, including any alternative treatment that may be self-administered [42 CFR 438.102(a)(1)(i)],
b. any information the behavioral health recipient needs in order to decide among all relevant treatment options [42 CFR 438.102(a)(1)(ii)],
c. the risks, benefits, and consequences of treatment or non-treatment [42 CFR 438.102(a)(1)(iii)], and,
d. the behavioral health recipient's right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment, and to express preferences about future treatment decisions [42 CFR 438.102(a)(1)(iv)].
e. All communication regarding the patient in regard to the above areas will be clearly documented in the patients' medical record.

ADHS shall monitor timely accessibility for routine and emergency services for Title XIX and Title XXI members [42 CFR 438.206(c)(1)(i)]. Monitoring activity must incorporate the members distance from the offered appointment location, time the appointment was offered and member's response.

ADHS shall ensure that children with special health care needs have adequate access to behavioral health practitioners with experience in treating the child's diagnosed condition.

ADHS shall submit an Annual *Provider Network Development and Management Plan* and quarterly provider network status updates as required in the Quarterly Contractor Performance Improvement Activity Report (see Attachment C). The Annual Provider Network Development and Management Plan shall be evaluated, updated annually and submitted to AHCCCS within 45 days from the start of the contract year. The submission of the network management and development plan to AHCCCS is an assurance of the adequacy and sufficiency of ADHS/DBHS' provider network. ADHS shall also submit as needed an assurance when there has been a significant change in operations that would affect adequate capacity and services based on the previously determined essential minimum network requirements. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population [42 CFR 438.207(c)].

The *Annual Provider Network Development and Management Plan* shall identify:

a. The current status of the ADHS network;
b. Anticipated number of TXIX and TXXI membership growth;
c. Number and types (in terms of training, experience and specialization) of providers that exist in the Contractor's service area, as well as the number of prescribers available to deliver outpatient medication services;
d. Numbers of providers not accepting new Medicaid patients; and
e. Availability of weekend and after-hours appointments in each GSA.

Requirements for the *Network Development and Management Plan* are in Attachment C.

19. PROVIDER REGISTRATION

ADHS shall ensure that each Title XIX and Title XXI service provider registers with AHCCCS as an approved service provider. At a minimum, individual practitioners who are physicians, psychologists, nurse practitioners and licensed physician assistants who meet the criteria to bill independently shall register with AHCCCS even in cases where the practitioner is affiliated with and providing services under the auspices of an AHCCCS registered provider. This provider registration process must be completed in order for ADHS to report services rendered to members through encounter data. [Section 1932(d)(4) of the Social Security Act]

The National Provider Identifier (NPI) will be required on all claim submissions and subsequent encounters (from providers that are eligible for an NPI) effective for dates of service on or after May 23, 2007. ADHS shall work with providers to obtain the NPI.

20. QUALITY MANAGEMENT

ADHS shall ensure provision of quality behavioral health care to recipients, regardless of eligibility category (Title XIX/Title XXI). ADHS shall promote improvement in the quality of care provided to recipients through established quality management and performance improvement processes. ADHS shall institute processes to assess, plan, implement and evaluate the quality management and performance improvement activities, as specified in the AHCCCS Medical Policy Manual (AMPM) provided by subcontractors to Title XIX and Title XXI members. [42 CFR 438.240(a)(1) and (e)(3)]

During its annual operational review process, ADHS shall assess the subcontractor's quality management and performance improvement program and evaluate compliance with federal regulations and with AHCCCS and ADHS requirements.

ADHS must provide subcontractors and their providers with technical assistance regarding quality management as needed and shall impose sanctions, including financial sanctions, for subcontractors who consistently (2 or more reporting periods or at the discretion of ADHS/DBHS) fail to meet quality management objectives, including, but not limited to, the submission of complete, timely and accurate quality data.

ADHS quality assessment and performance improvement programs, at a minimum, shall comply with the requirements outlined in the AHCCCS Medical Policy Manual (AMPM) and this Paragraph.

A. Quality Management (QM) Program
   ADHS shall have an ongoing quality management program for the services it furnishes to members that includes the requirements listed in AMPM Chapter 900 and the following:
   1. A written Quality Assessment and Performance Improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and Quarterly QA/PI reports that address its strategies for performance improvement and conducting the quality management activities;
   2. QM/PI program monitoring and evaluation activities that includes Peer Review and Quality Management Committees chaired by ADHS' Chief Medical Officer;
   3. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements;
   4. Member rights and responsibilities;
   5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. Subcontractors shall demonstrate that its providers are credentialed and reviewed through the subcontractor's Credentialing Committee that is chaired by the subcontractor's Medical Director [42 CFR 438.214]. The process;
      a. Shall follow a documented process for provisional credentialing, initial credentialing, re-credentialing and organizational credential verification of providers who have signed contracts or participation agreements with the subcontractor;
      b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
      c. Shall not employ or contract with providers excluded from participation in Federal health care programs.
   6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include;
      a. Acknowledgement letter to the originator of the concern;

b. Documentation of all steps utilized during the investigation and resolution process;
c. Follow up with the member to assist in ensuring immediate health care needs are met;
d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a subcontractor contact name/telephone number to call for assistance or to express any unresolved concerns;
e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
f. Analysis of the effectiveness of the intervention taken.

7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs;
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO);
9. Performance improvement programs including performance measures and performance improvement projects.

B. Performance Improvement

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

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

Performance Measures

ADHS shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Complete methodologies of the clinical quality Performance Measures can be found in Attachment I, Performance Measures Methodologies. All performance standards described below apply to all Title XIX and Title XXI members and services.

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

ADHS must have in place a process for internal monitoring of Performance Measure rates, using a standard methodology established or adopted by AHCCCS, for each required Performance Measure. ADHS' Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration.

ADHS must meet, and ensure that each subcontractor meets, AHCCCS Minimum Performance Standards. [42 CFR 438.240(b)(1), (2), and (d)(1)] It is equally important that ADHS ensures continually improved performance measure outcomes from year to year, as defined by the AHCCCS Medical Policy Manual (AMPM). ADHS shall strive to meet the Goal established or approved by AHCCCS. Any statistically significant drop in ADHS' performance level for any measure must be explained by ADHS in its Annual Quality Management Plan. If ADHS has a statistically significant drop in any measure, ADHS will be required to submit a corrective action plan to AHCCCS, and may be subject to sanctions until an adequate level of performance is achieved.

Minimum Performance Standard – A Minimum Performance Standard (MPS) is the minimal expected level of performance by ADHS. If ADHS does not achieve this standard, ADHS will be required to submit a corrective action plan and may be subject to a sanction of up to $100,000 dollars for each deficient measure.

Goal – If ADHS has already met or exceeded the AHCCCS Minimum Performance Standard for any measure, ADHS must strive to meet the established Goal for the measure(s).

AHCCCS may require ADHS to conduct an Administrative Review Chart Audit for validation of any performance measure that falls below the minimum performance standard. Should ADHS not show demonstrable and sustained improvement toward meeting AHCCCS established or approved Performance Standards, ADHS shall develop a corrective action plan (CAP). The corrective action plan must be received by AHCCCS within 30 days of receipt of notification from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up onsite reviews or other audit processes to verify compliance with a corrective action plan. Failure to achieve adequate improvement may result in sanction imposed by AHCCCS.

ADHS shall require a corrective action plan from and may impose sanctions on ADHS, as described above, based on ADHS' performance, which is interpreted to mean the statewide average performance of the subcontractors weighted by GSA. An evidence-based, best practice or documented successful practice, corrective action plan must be received by AHCCCS within 30 days of receipt of notification of the deficiency from AHCCCS. This plan must be approved by AHCCCS prior to implementation. AHCCCS may conduct one or more follow-up onsite reviews to verify compliance with a corrective action plan.

ADHS shall monitor subcontractors' progress toward implementing corrective action plans focused on making progress toward meeting the standards, minimally on a quarterly basis. ADHS shall submit to AHCCCS as part of the Annual Quality Management Plan, an analysis of the subcontractor(s) corrective action plan(s) and a summary of ADHS' actions taken and planned, to ensure that the subcontractor(s) not meeting standards are making progress toward meeting the standards.

ADHS shall require a corrective action plan from, and may impose sanctions on, any subcontractor when:

a. The subcontractor does not achieve the minimum standard for any measure for two consecutive years;
b. The subcontractor's performance for any measure declines to a level below the AHCCCS Minimum Performance Standard;
c. There is a statistically significant decline in the subcontractor's performance on any measure without a justifiable explanation.

ADHS shall report performance to AHCCCS on performance measures by GSA for Title XIX/Title XXI adults (21 years of age and over) and for Title XIX/Title XXI children (0 through 20 years), by race/ethnicity, as requested by AHCCCS. All Performance Measures apply to all member populations. [42 CFR 438.240(a)(2), (b)(2) and (c)]

ADHS must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. AHCCCS may impose sanctions on ADHS that do not show statistically significant improvement in a measure rate and require ADHS to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS also may require a corrective action plan and may sanction ADHS for any Performance Measure that shows a statistically significant decrease in its rate, even if it meets or exceed the Minimum Performance Standard.

Performance Measures

ADHS shall ensure compliance with AHCCCS' quality management requirements to improve performance for all AHCCCS established performance measures/aspects of care. Specifically, ADHS shall ensure that affirmative steps are taken to attain and sustain performance at, or above, the minimum performance standard established for each of the following aspects of care.

The following table identifies the Minimum Performance Standards (MPS) and Goals for each measure:

ADHS Performance Standards

Performance Measure	Minimum Performance Standard	Goal
Access to Care	85%	95%
Behavioral Health Service Plan	85%	95%
Behavioral health Service Provision	85%	95%
Coordination of Care #1 - Referral	80%	95%
Coordination of Care #2 – Communication	70%	90%

Follow Up after Hospitalization for Mental Illness within 7 Days	70%	90%
Follow Up after Hospitalization for Mental Illness within 30 Days	80%	90%
Treatment of Depression*	TBD	90%

NOTE: AHCCCS may increase Minimum Performance Standards for the above measures in the CYE 2011 contract, particularly for new measures after baseline rates are calculated.
* AHCCCS will develop a Minimum Performance Standard for Treatment of Depression after the baseline measurement for this measure.

Methodologies can be found in Attachment I, Performance Measures Methodologies.

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

a. Measurement of performance using objective quality indicators;
b. Implementation of system interventions to achieve improvement in quality;
c. Evaluation of the effectiveness of the interventions;
d. Planning and initiation of activities for increasing or sustaining improvement.

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

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

a. Annual Quality Management Plan: ADHS shall submit a written Quality Management Plan with measurable goals and objectives and Quality Management evaluation of the previous year's Quality Management program by October 1st of each contract year that conforms with the requirements of Chapter 900 of the AHCCCS Medical Policy Manual. The Annual Quality Management Plan shall include an annual appraisal that assesses progress made by ADHS in achieving the goals and objectives identified in the previous year's QM Plan. The plan must be submitted to AHCCCS 30 days prior to planned implementation and must include a change matrix that identifies proposed changes in those sections required by AHCCCS contract and policy. ADHS shall ensure that subcontractors develop an annual quality management plan that is consistent with federal regulations and AHCCCS requirements.
b. ADHS shall track and resolve member problems. ADHS shall trend member issue referrals by problem type, by program and by subcontractor and compare trends with other available data to detect correlations and to implement system improvements.
c. ADHS shall report quarterly and/or annually to AHCCCS on quality management activities required by this contract and ensure quarterly and/or annual reporting by subcontractors to ADHS.
d. ADHS shall ensure the consistent analysis of grievances and appeals, expedited hearings, mortality, and incident/accident data as part of the QM process. ADHS shall provide AHCCCS with timely notification and periodic status reports regarding significant incidents/accidents and all cases of suspected abuse and neglect involving Title XIX or Title XXI members. ADHS must inform AHCCCS within one business day of its knowledge of significant incidents/accidents involving Title XIX or Title XXI members and provide a summary of findings and corrective actions required, if any, following investigation of the incident/accident.

e. ADHS shall ensure the completeness and accuracy of quality management data reported to AHCCCS.
f. Performance Improvement Projects (PIPs): ADHS shall submit PIP proposals and reports as required by Chapter 900 of the AHCCCS Medical Policy Manual.
g. Performance measures of the Title XIX and Title XXI children's system of care shall incorporate in-depth case review, member and family satisfaction surveys and functional outcomes.
h. ADHS is required to submit complete, accurate and timely quality management and utilization management deliverables as described in Attachment C of this contract.

Investigation, analysis, tracking and trending of quality of care issues, abuse and/or complaints that includes:
a. Acknowledgement letter to the originator of the concern
b. Documentation of all steps utilized during the investigation and resolution process
c. Follow-up with the member to assist in ensuring immediate health care needs are met
d. Closure/resolution letter that provides sufficient detail to ensure that the originator has an understanding that necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns
e. Documentation of Implemented corrective action plan(s) or action(s) taken to resolve the concern
f. Evidence of the resolution implemented
g. Referring the issues to the Contractor peer review committee when appropriate
h. Referring/reporting the issue to appropriate regulatory agency, Child or Adult Protective Services and AHCCCS for further research/review or action
i. Notifying the appropriate regulatory/licensing board or agency, and AHCCCS when a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated because of quality of care issues

ADHS shall ensure active participation in data collection and analysis. ADHS shall actively participate in the monitoring and tracking of quality improvement findings and shall take such actions as determined necessary to improve the quality of care to Title XIX and Title XXI members. ADHS shall actively monitor subcontractors' quality management activities to ensure compliance with federal regulations, AHCCCS and ADHS requirements, and adherence with its quality management plan. [42 CFR 438.240(a)(1) and (2)]

ADHS may combine its quality management plan with the plan that addresses medical management as described below.

21. MEDICAL MANAGEMENT

ADHS shall comply with Chapter 1000 of the AHCCCS Medical Policy Manual (AMPM). ADHS shall comply with federal utilization control requirements, including the certification of need and re-certification of need for continued stay in inpatient settings. ADHS shall also ensure that hospitals and inpatient psychiatric facilities (residential treatment centers and sub-acute facilities) comply with federal requirements regarding utilization review plans, MM committees, plan of care and medical care evaluation studies as prescribed in 42 CFR, parts 441 and 456. ADHS shall actively monitor subcontractors' medical management activities to ensure compliance with federal regulations, AHCCCS and ADHS requirements, and adherence to its medical management plan.

ADHS must develop, adopt and disseminate practice guidelines that consider the needs of enrolled members and are (AMPM Chapter 1000, 1020-E):
1. Based on valid and reliable medical evidence or a consensus of health care professionals in the field;
2. Have considered the needs of behavioral health members;
3. Are adopted in consultation with contracting health care professionals and National Practice Standards; or
4. Are developed in collaboration with health care professionals and other stakeholders knowledgeable in the specific topic. Available literature should be reviewed and incorporated as indicated in the practice guidelines. Practice guidelines require AHCCCS approval 30 days prior to implementation.
5. Are disseminated by ADHS to all affected providers and, upon the request, to members and potential members; and
6. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply;

7. ADHS must annually evaluate the Practice Guidelines through a multidisciplinary committee to determine if the guidelines remain applicable and represent the best practice standards and reflect current psychiatric/behavioral health standards; and
8. ADHS will document the review and adoption of practice guidelines as well as the evaluation of efficacy of the guidelines [42 CFR 438.236(b)].

Guidelines, including any admission, continued stay and discharge criteria used by ADHS or subcontractors, must be communicated to all affected providers and, to Title XIX and Title XXI members when appropriate, and to individual Title XIX and Title XXI members upon their request. Decisions regarding utilization management, behavioral health recipient and provider education, coverage of services, provision of services, and other areas to which guidelines are applicable must be consistent with the guidelines [42 CFR 438.236(c) and (d)].

During its annual operational review process, ADHS shall assess subcontractor's medical management activities to measure compliance with federal regulations and AHCCCS and ADHS requirements.

ADHS must provide the subcontractors and their providers with technical assistance regarding medical management as needed and shall impose sanctions, including financial sanctions, for subcontractors who consistently (for three or more consecutive reporting periods or at ADHS' discretion) fail to meet medical management objectives, including, but not limited to, the submission of complete, timely and accurate utilization/medical management data.

ADHS shall ensure compliance with the following requirements related to medical management:

a. Annual Medical Management Plan: ADHS shall submit a written Medical Management Plan with measurable goals and objectives and Utilization Management evaluation of the previous year's Medical Management plan by October 1st of each contract year that conforms with the requirements of Chapter 1000 of the AHCCCS Medical Policy Manual. The Annual Medical Management Plan shall include an annual appraisal that assesses progress made by ADHS in achieving the goals and objectives identified in the previous years Medical Management Plan. The plan must be submitted to AHCCCS and must include a change matrix that identifies proposed changes in those sections required by AHCCCS contract and policy. ADHS shall ensure that subcontractors develop an annual medical management plan that is consistent with federal regulations and AHCCCS requirements.
b. ADHS shall ensure that all admission and continued stay authorizations for hospitals and inpatient psychiatric facilities (residential treatment services and sub-acute facilities) are conducted by behavioral health professionals. All decisions that the criteria for admission or continued stay are not met must be reviewed and approved by a physician prior to issuing such a decision [42 CFR 438.210(b)(3)].
c. ADHS shall ensure the completeness and accuracy of utilization/medical management data reported to AHCCCS.
d. ADHS shall have mechanisms in place to monitor and evaluate over and/or underutilization of services in compliance with AMPM Chapter 1000 [42 CFR 438.240(b)(3)].
e. ADHS shall actively monitor and analyze case management utilization and cost data by subcontractor and program type.
f. For the processing of requests for initial and continuing authorizations of services for hospitals, mental hospitals, and inpatient psychiatric facilities (residential treatment centers and sub-acute facilities), ADHS shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and for consultation with the requesting provider when appropriate [42 CFR 438.210(b)(1) and (2)].
g. Medical Care Evaluation (MCE) Studies: ADHS shall ensure that network inpatient facilities (including inpatient hospitals and mental hospitals) conduct MCE studies which meet the requirements of 42 CFR Part 456 subparts C and D, and that inpatient psychiatric facilities (including RTCs and sub-acute facilities) conduct MCE studies which meet the same requirements. ADHS shall develop a process for annual review of subcontractors' analyses of results of facility MCE studies. ADHS will ensure results are used to improve member care and services and to assess the provider facility performance.

ADHS shall have a process to report Medical Management data and management activities through a MM Committee. ADHS' MM Committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. ADHS shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. [42 CFR 438.240(b)(4)]

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

ADHS shall maintain a written MM plan that addresses its plan for monitoring MM activities described in this section. The plan must be submitted for review by AHCCCS Division of Health Care Management within timelines specified in Attachment C.

ADHS must proactively and regularly review complaint, grievance and appeal data to identify members who have filed multiple complaints, grievances or appeals regarding services or the AHCCCS program. In the event a particular member is identified as an outlier, ADHS shall coordinate to ensure that any necessary clinical interventions or service plan revisions are effectuated. This approach shall further apply, but is not limited, to members who do not meet ADHS' criteria for case management as well as members who contact governmental entities for assistance, including AHCCCS.

ADHS is required to submit complete, accurate and timely medical management deliverables as described in this contract.

22. OTHER QUALITY MONITORING AND REPORTING

ADHS shall continue to report to AHCCCS results for the following metrics related to the quality of care received by AHCCCS members on an annual basis or more frequently if requested by AHCCCS. AHCCCS will monitor outcomes and require corrective actions up to and including sanctions based on outcomes and/or if improvement is not achieved.

Monitoring Reports
ADHS/DBHS will utilize existing methodologies for monitoring outcomes and reporting on the following metrics:

Sufficiency of Assessments
Assessments are sufficiently comprehensive for the development of functional treatment recommendations.

Member/family involvement in developing treatment recommendations
Staff actively engage members/families in the treatment planning process.

Cultural competency
Members'/families' cultural preferences are assessed and included in the development of treatment plans.

Informed consent
Members and/or parents/guardians are informed about and give consent for prescribed medications.

Symptomatic Improvement
There is evidence of positive clinical outcomes for members receiving behavioral health services.

23. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS Special Terms and Conditions and the BBA requirements, AHCCCS, or an independent external agent, will conduct annual Operational and Financial Reviews of the quality outcomes, timeliness of, and access to the services covered under this contract for the purpose of (but not limited to) ensuring structural, operational and financial program compliance for Title XIX and Title XXI programs. The reviews will be performed consistent with CMS Protocols For External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans to identify areas where improvements can be made and make recommendations accordingly, monitor ADHS' progress towards implementing mandated programs and provide ADHS with technical assistance, if necessary. ADHS shall comply with all other medical audit provisions as required by AHCCCS [42 CFR 438.204].

The type and duration of the Operational and Financial Review will be solely at the discretion of AHCCCS and may include AHCCCS participation in reviews of ADHS contractors. Except in cases where advance notice is not

possible or advance notice may render the review less useful, AHCCCS will give ADHS at least three weeks advance notice of the date of the on-site review or intent to accompany ADHS on contractor reviews. In preparation for the on-site Operational and Financial Reviews, ADHS shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, logs and other information that AHCCCS may request. ADHS shall have all requested medical records available. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. ADHS personnel as identified in advance shall be available to the Review Team during AHCCCS on-site review activities. While on-site, ADHS shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

ADHS will be furnished a copy of the Operational and Financial Review Report and given an opportunity to comment on any review findings prior to AHCCCS publishing the final report. Operational and Financial Review findings may be used in the evaluation of subsequent service proposals by ADHS. Findings of the report will be made available by AHCCCS as required by 42CFR 438.364. Recommendations made by the Review Team and approved ADHS corrective action plans to bring ADHS into compliance with federal, state, AHCCCS, and/or contract requirements must be implemented by ADHS. ADHS shall provide a written update on corrective action plan activities six months following the approval of the corrective action plan submitted as a result of the Operational and Financial Review. AHCCCS may conduct a follow-up Operational and Financial Review to determine ADHS' progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial Operational and Financial Review.

AHCCCS may conduct an Operational and Financial Review in the event ADHS undergoes a reorganization or makes changes in three or more key staff positions within a 12-month period.

24. PERIODIC REPORT REQUIREMENTS

AHCCCS, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data, and other information from ADHS. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in this contract. 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 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.

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

ADHS shall be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data will likely continue beyond the term of the contract because of lag time in the filing of source documents by subcontractors.

In addition to its own reporting requirements, ADHS is also solely responsible under this contract for all subcontractor and provider reporting requirements as stated within this document as well as all other documents incorporated by reference. In cases where ADHS receives reports directly from subcontractors, ADHS shall be responsible for analyzing the information, verifying it is accurate (resolving discrepancies, if needed) and developing a summary report, if appropriate, prior to submitting the required information to AHCCCS. ADHS shall monitor subcontractors, taking corrective action if needed, to ensure required reports are accurate, complete and submitted on time. ADHS is responsible for submitting to AHCCCS during the term of this contract the periodic reports listed and described in detail in Attachment C, Periodic Reports.

25. RECORDS RETENTION

ADHS shall maintain books, records and documents in either traditional or electronic formats relating to covered services and expenditures including reports to AHCCCS and working papers used in the preparation of reports to AHCCCS. ADHS shall comply with all specifications for record keeping established by AHCCCS. All books and

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 or documents specified by AHCCCS.

ADHS agrees to make available at its office at all reasonable times during the term of this contract and the period set forth below any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, state or federal government [42 CFR 438.242(b)].

ADHS shall preserve and make available all records for a period of six years [45 CFR 164.530(j)] from the date of final payment under this contract.

26. FINANCIAL OPERATIONS

Financial data regarding all programs in this contract shall be identified and reported separately on any financial statements or any other report required of ADHS and its subcontractors. All funds shall be accounted for in accordance with generally accepted accounting principle (GAAP). The precise manner of reports will be determined by mutual agreement so that AHCCCS can monitor expenditures under this contract.

ADHS shall ensure that it and each subcontractor has a system to produce complete, timely, reliable and accurate financial records in accordance with contract requirements for financial reporting. ADHS shall test the accuracy of subcontractor reported service expenditures by comparing quarterly encounter value to service dollars paid to the RBHAs. ADHS shall provide AHCCCS with a copy of the comparison one hundred thirty-five (135) days after the end of the quarter. ADHS shall strive to meet the statewide benchmark.

Aspect of Performance	How Measured	Minimum Performance Standard	Benchmark Performance Standard
1st Quarter service expenditures	Compare service encounters at the RBHA paid amount to Total Service Dollars paid to the RBHA	35%	70%
YTD service expenditures at 2nd Quarter	Compare service encounters at the RBHA paid amount to Total Service Dollars paid to the RBHA	45%	75%
YTD service expenditures at 3rd Quarter	Compare service encounters at the RBHA paid amount to Total Service Dollars paid to the RBHA	55%	80%
YTD service expenditures at 4th Quarter	Compare service encounters at the RBHA paid amount to Total Service Dollars paid to the RBHA	65%	85%
6 to 9 months after Year end	Compare service encounters at the RBHA paid amount to Total Service Dollars paid to the RBHA	85%	85%

Each subcontractor shall design and implement its financial operations system to ensure compliance with Generally Accepted Accounting Principles. Each subcontractor shall also file with ADHS an annual (more frequently if required by ADHS) CMS approved disclosure statement and related party transactions statement. ADHS shall evaluate all such statements to ensure that they conform to CMS requirements and, through its periodic audit and review procedures, shall ensure that the statements are complete and accurate. ADHS shall take immediate corrective action upon discovery of any failure to meet contract requirements.

ADHS shall strive to maintain a statewide medical expense ratio of 92.5 percent; this ratio shall be no less than 85 percent. ADHS shall provide AHCCCS with a copy of the medical expense ratio analysis no later than 60 days after the end of the quarter. A final analysis must be received no later than 120 days after the end of the contract year. The medical expense ratio must compare total service dollars spent by all RBHAs divided by total capitation paid to the RBHAs.

27. FINANCIAL VIABILITY STANDARDS/PERFORMANCE GUIDELINES

AHCCCS and ADHS have established the following financial viability standard/performance guidelines. These guidelines are analyzed as part of AHCCCS's due diligence in contract oversight. On a quarterly and annual basis, AHCCCS will review, among other items, the following:

Aspect of Performance	How Measured	CYE 08 Minimum Performance Standard	CYE-08 Goal	CYE-08 Benchmark
Subcontractor viability ratios: Current Ratio Admin Ratio Medical Expense Ratio Equity per member	Financial Formula	Acceptable explanation for deviation from goal	>= to 1.0 <=7.5% <=92.5% >=$300	>= to 1.0 <=7.5% <=92.5% >=$300
Subcontractor footnotes identifying at least the following 1. Large financial statement account fluctuation (+/- 10%) 2. IBNR 3. RBUC 4. Explanation if outside of risk corridor 5. Deferred revenue	Prescribed Format	Substantial Compliance	Full Compliance	Full Compliance
ADHS analysis of subcontractor financial statement to include a discussion of the above items	Outline Format	Substantial Compliance	Full Compliance	Full Compliance

28. CAPITATION

AHCCCS will make monthly capitation payments to ADHS in advance of the performance of services under this contract. Separate capitation payments will be made as follows:

a. The capitation payment for Title XIX eligible children, under the age of 18, which represents the cost of providing covered behavioral health services to Non-CMDP children.
b. The capitation payment for Title XIX waiver group eligible children, under the age of 18, and whose family income is up to one hundred percent (100%) of the FPL, which represents the cost of providing covered behavioral health services to Non-CMDP children.
c. The capitation payment for Title XIX eligible children, under the age of 18, which represents the cost of providing covered behavioral health services to CMDP children.
d. The capitation payment for Title XIX waiver group eligible children, under the age of 18, and whose family income is up to one hundred percent (100%) of the FPL, which represents the cost of providing covered behavioral health services to CMDP children.
e. The capitation payment for Title XIX eligible adults, age 18 and older, which represents the cost of providing covered behavioral health services to SMI adults.
f. The capitation payment for Title XIX waiver group eligible adults, age 18 and older, and whose family income is up to one hundred percent (100%) of the FPL, which represents the cost of providing covered behavioral health services to SMI adults.
g. The capitation payment for Title XIX eligible adults, age 18 and older, which represents the cost of providing covered behavioral health services to non-SMI adults.
h. The capitation payment for Title XIX waiver group eligible adults, age 18 and older, and whose family income is up to one hundred percent (100%) of the FPL, which represents the cost of providing covered behavioral health services to non-SMI adults.
i. The capitation payment for Title XXI eligible children under age 18 which represents the cost of providing covered behavioral health services to children.
j. The capitation payment for Title XXI eligible adults, age 18, which represents the cost of providing covered behavioral health services to SMI and non-SMI adults.

k. The capitation payment for Title XXI waiver group eligible adults, age 18 and older, and whose family income is up to two hundred percent (200%) of the FPL, which represents the cost of providing covered behavioral health services to SMI adults.
l. The capitation payment for Title XXI waiver group eligible adults, age 18 and older, and whose family income is up to two hundred percent (200%) of the FPL, which represents the cost of providing covered behavioral health services to non-SMI adults.

In the event that CMS does not approve an amendment to this contract by June 15 of each year, AHCCCS will continue to pay the current capitation rates until such approval is granted by CMS even if the current contract has expired. Following CMS approval of the contract amendment, AHCCCS will perform a mass adjustment to correct and implement the new rates effective July 1 of the new contract year.

ADHS shall not, without prior approval of AHCCCS, make any advances (not withstanding regularly scheduled capitation payments to RBHAs or transfers to AHCCCS for tribal fee for service payments) to a related party or subcontractor. ADHS shall not, without similar approval, make any distribution, loan or loan guarantee to any entity, including another fund or line of business not covered by this contract, within its organization. All requests for prior approval are to be submitted to the Division of Health Care Management. ADHS is required to provide AHCCCS with a monthly report showing distribution of capitation to subcontractors. This report is due to AHCCCS within forty-five (45) days from receipt of capitation from AHCCCS.

For each of these groups, the capitation amount will be based on the number of Title XIX and Title XXI members as of the monthly capitation processing. The capitation received shall represent payment in full for any and all covered services provided to eligible Title XIX and Title XXI members, including all administrative costs of ADHS, subcontractor and provider during the month. Payment will be deposited as near to the first day of the month as is practicable except that payment will not be deposited later than the fifth business day of the month for which payment is due.

ADHS shall receive additional payments such as lien recoveries and third party payments to which it is entitled pursuant to AHCCCS Rules and AHCCCS policies and procedures.

Because the capitation payment will be calculated based on the number of Title XIX and Title XXI members on the first day of each month, no adjustments will be made for members who are (1) eligible after the beginning of the month's payment cycle, or (2) ineligible after the beginning of the month's payment cycle. However, if ADHS is in any manner in default in its performance under this contract, AHCCCS may, at its option and in addition to other remedies, adjust the amount of payment until there is satisfactory resolution of the default.

If ADHS intends to offer reinsurance to the subcontractors, ADHS shall submit the details of such proposed reinsurance to AHCCCS for approval prior to its proposed effective date.

ADHS shall provide AHCCCS with documentation relevant to the capitation rate calculation and is responsible for developing proposed capitation rates to be paid by AHCCCS for Title XIX and Title XXI members. ADHS shall include AHCCCS in capitation rate development meetings with its actuaries throughout the rate development process. ADHS must submit proposed capitation rates and supporting documentation to AHCCCS no later than April 15 of each year. If AHCCCS does not receive a proposal and supporting documentation from ADHS for updating capitation rates, AHCCCS will use available information to update the rates or, if sufficient data is not available, will maintain rates at existing levels. Neither ADHS nor AHCCCS will consider costs of non-covered services in development of capitation rates [42 CFR 438.6(e)].

Administrative costs not directly related to the responsibilities covered by this contract may be eligible for Federal Financial Participation (FFP) at the 50% administrative participation rate. To be eligible, the cost must be determined to be reasonable and necessary for the proper and efficient administration of the Medicaid program. Any costs deemed to be State Medicaid administrative costs shall be reviewed and approved by AHCCCS and CMS and shall be excluded from capitation rate development.

Currently, the only costs this exception applies to are actuarial costs for capitation rate development. Federal Financial Participation applicable to administrative expenditures shall be available and the Contractor shall be responsible for providing the necessary state match. When AHCCCS draws FFP for qualifying disbursements,

including these under the administrative FFP rate, AHCCCS will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to ADHS.

Capitation rates are developed based on costs, encounters, and utilization information as reported by ADHS. AHCCCS may request ADHS to perform reevaluations of the capitation rates if AHCCCS receives information which varies significantly from the information used to calculate the rates. This change may result in a retrospective rate increase or decrease. Annually, by April 1st, ADHS shall submit to AHCCCS a report analyzing current activity against significant or key assumptions used in development of the previous year capitation rates. The scope of such a report will be mutually agreed upon by ADHS and AHCCCS.

Attachment E, Shared-Risk Methodology, contains a detailed description of the retroactive review and potential retrospective and prospective adjustments of capitation rates.

29. METHOD OF PAYMENT

Compensation: The method of compensation under this contract shall be prepaid capitation as described herein. AHCCCS shall transfer the capitation payments, both federal and state match, to ADHS, 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.

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

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

The legislative authorization for payments made under this contract governs the source of the state match that is required in order to draw Federal Financial Participation. The following are the programs funded under this contract and the source of the state match:

	Program	**State Match Source**
1.	Title XIX – Acute Care Base	ADHS
2.	Title XIX – Acute Care Expansion	ADHS
3.	Ticket to Work	AHCCCS
4.	Breast & Cervical Cancer	AHCCCS
5.	Title XXI – Children	AHCCCS
6.	Title XXI – SOBRA and KidsCare Parents	AHCCCS

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

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

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services. [Section 1932(d)(4) of the Social Security Act]

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

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

When AHCCCS draws FFP for qualifying ADHS disbursements, including those under separate contract (Contract Number YH03-0025) for Title XIX DES/DDD ALTCS members, AHCCCS will also withdraw the appropriate state match from the IGA Fund and disburse both the FFP and the state match to ADHS.

AHCCCS also will use monies in the IGA Fund to make monthly disbursements to CMS for the ADHS share of Medicare phase-down payments made in accordance with the MMA for drug benefit costs assumed by Medicare for full dual eligible members. Payments amounts will be made in a manner specified by CMS.

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

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

Collection of Co-payments: ADHS or the subcontractors shall collect any permitted co-payment from Title XIX and Title XXI members in accordance with AHCCCS Rules R9-22-711 and 42 CFR 447, but service will not be denied for inability to pay the co-payment. Except for permitted co-payments, ADHS or the subcontractors shall not bill or attempt to collect any fee from, or for, a Title XIX and Title XXI member for the provision of covered services. Any required co-payments collected shall belong to ADHS or the subcontractors, as appropriate. ADHS or the subcontractors shall not bill a member for more than the statutory co-payment amount. Refer to Section D, Paragraph 34, Coordination of Benefits and Third Party Liability, Paragraph 35, Medicare Services and Cost Sharing, and R9-22-702 for exceptions.

Liability for Payment: ADHS must ensure that Title XIX and Title XXI behavioral health recipients are not held liable for:

a. ADHS or subcontractor's debts in the event of ADHS' or the subcontractor's insolvency [42 CFR 438.116(a)(1)],
b. covered services provided to the behavioral health recipient, for which AHCCCS does not pay ADHS and ADHS does not pay subcontractors [42 CFR 438.106(b)], or,
c. payments to ADHS or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the behavioral health recipient would owe if ADHS or the subcontractor provided the services directly [42 CFR 438.106(a)(b)(c) and 438.230].

Tribal Subcontractor Claims and Encounters: Effective for dates of service October 1, 1998 and later, the AHCCCS will, on behalf of ADHS, pay claims submitted by providers for behavioral health services provided to Title XIX and Title XXI members who are behavioral health recipients of Tribal subcontractors. Tribal subcontractors (or their providers) are to submit claims directly to AHCCCS.

A. Fees. In consideration for the services outlined in this section, ADHS agrees to pay AHCCCS a fee that will reimburse it for the costs associated with this section. The estimated fee for fiscal year 2010 is $967,150. Payment is to be made quarterly by the fifth business day of the quarter, subject to availability of funds. AHCCCS reserves the right to suspend or terminate these services if a quarterly payment is not received when due.

   AHCCCS will reconcile the claims volume estimate used to calculate the initial fee with the actual claims volume. If the actual claims volume exceeds 267,300 claims (10% more than the initial estimate), ADHS will reimburse AHCCCS $3.98 for each claim in excess of 267,300. If the actual claims volume is less than 218,700 (10% less than the initial estimate), AHCCCS will reimburse ADHS $3.98 for the difference between actual

claims processed and 218,700. For purposes of this agreement, the estimated number of claims to be processed is 243,000 and the cost per claim is $3.98.

In addition, ADHS shall be liable for ISD programmer and consultant time to develop a new report, modify existing reports, time for system modifications specific to processing claims associated with this agreement and to attend meetings with ADHS staff. The charge for ISD time billed pursuant to this agreement will be at the rate of $100 per hour. ADHS shall not be liable for ISD programming or any other costs associated with changes made to the AHCCCS claims processing system pursuant to the Health Insurance Portability and Accountability Act of 1996 unless such costs are directly associated with the Tribal subcontractor payment process and the only reason for the change is for the processing of Tribal claims. In its role as TPA for ADHS, AHCCCS shall not hold ADHS liable for ISD programming or any other costs associated with restoring functionality to the AHCCCS system as a result of programming changes that were not requested by ADHS.

B. Claim Processing Requirements. In accordance with the Balanced Budget Act of 1997 and 42 CFR 447.45:
   1. And in accordance with ARS 36-2904 (G), an initial claim for services provided to an AHCCCS recipient must be received by AHCCCS not later than 6 months from the date of service, or six months after the date of eligibility posting, whichever is later. For inpatient claims, "date of service" means the date of discharge of the patient.
   2. AHCCCS Shall pay all other claims within 12 months of the date of receipt, providing that the original claim was received not later than 6 months from the date of service or six months after the date of eligibility posting, whichever is later, except in the following circumstances:
      (a) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in 42 CFR 447.272.
      (b) If a claim for payment under Medicare has been filed in a timely manner AHCCCS may pay a Medicaid claim relating to the same services within six months after AHCCCS, ADHS or the provider receives initial notice of the disposition of the Medicare claim.
      (c) The time limitation does not apply to claims from providers under investigation for fraud or abuse.
      (d) ADHS may require payments be made at any time in accordance with a court order, to carry out hearing decisions or corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.
      (e) ADHS may require payments to be made at any time in accordance with ADHS' grievance appeal process.
   3. Pay ninety percent (90%) of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 30 days of receipt, and
   4. Pay ninety nine percent (99%) of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

C. Provider Assistance and Training: AHCCCS Provider Assistance and Provider Registration staff will be available to assist the Tribal subcontractor's behavioral health providers with registration, claims processing, research, and overall AHCCCS claims submission and training as outlined in the AHCCCS Fee-for-Service Manual. Such training is to be provided at AHCCCS's Phoenix Office. If AHCCCS is required to travel for training, ADHS will reimburse AHCCCS for reasonable and necessary travel costs including, but not limited to, transportation and per diem payments.

D. Claims Data and Reports*:* AHCCCS shall provide ADHS with the following deliverables:

Report or File	**Frequency**
Paper remittance advices	Per claim processing cycle
Claims aging report	Monthly
Encounter data[1]	Monthly
Report of Claims Processed[2]	Monthly

[1] New Day or other electronic file format agreed to between AHCCCS and ADHS.
[2] This report is to include: (a) the number and dollar amount of claims paid, denied, and voided by form type and (b) the top five denial reasons by form type.

E. Financial Functions*:* AHCCCS shall provide ADHS with the "Payment Register by Group Pay" along with the AFIS status of Grant report on a weekly basis. This report should be adjusted to reflect the current or weekly pay cycle for Tribal subcontractor claims processed. Payment of the claims is contingent upon sufficient ADHS funds being set aside and made available to AHCCCS in advance.

30. CAPITATION RECOUPMENT

Any recoupments imposed by the federal government and passed through to ADHS shall be reimbursed to AHCCCS upon demand.

31. BUDGET CAP

AHCCCS will not be responsible for costs incurred by ADHS which exceed the budget cap associated with its legislative appropriation.

32. TERM OF AUTHORIZATION

Federal funds provided under the annual authorization addressed above shall be available for the term defined in the annual authorization. If at any time during the term of this contract ADHS determines that the funding authorization is insufficient, ADHS shall notify AHCCCS in writing and shall include in the notice recommendations as to resolution of the shortage.

33. COST DATA SUBMISSIONS

ADHS shall notify AHCCCS of problems in the fee schedule, make recommendations to AHCCCS to change the fee schedule, and provide AHCCCS with information about providers' costs.

Annually by April 1, ADHS shall provide a Rate Study with current provider cost data, financial reports, and any other relevant documentation to support recommendations for updating the fee schedule for behavioral health services. AHCCCS will use this information as necessary to update the rates. AHCCCS has approval authority for the fee schedule.

34. COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY

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

The two methods used in the coordination of benefits are cost avoidance and post-payment recovery. ADHS shall use these methods as described in A.A.C. R9-22-1001 et.seq and federal and state law. See also Section D, Paragraph 35, Medicare Services and Cost Sharing.

Cost Avoidance: ADHS shall take reasonable measures to determine all legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. ADHS shall cost-avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when ADHS 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 ADHS must adjudicate the claim. ADHS must then utilize post payment recovery which is described in further detail below. If the Administration determines that ADHS is not actively engaged in cost avoidance activities ADHS shall be subject to sanctions in an amount not less than three times the amount that could have been cost avoided.

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

If a third party insurer other than Medicare requires the member to pay any copayment, coinsurance, or deductible, then ADHS is responsible for making these payments under the method described below even if the services are provided **outside** of the ADHS network.

A. IF THE PROVIDER IS **CONTRACTED** with ADHS:

ADHS shall pay the **lesser** of the **difference** between:
1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance
OR
2) The Primary Insurance Paid amount and the ADHS Contracted Rate

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

B. IF THE PROVIDER IS **NOT CONTRACTED** with ADHS:

ADHS shall pay the **lesser** of the **difference** between:
1) The Primary Insurance Paid amount and the Primary Insurance Rate, i.e., the member's copayment required under the Primary Insurance
OR
2) The Primary Insurance Paid amount and the AHCCCS Fee for Service Rate

Examples

Scenario 1 AHCCCS FFS Rate $50 ADHS Rate $55 Primary Insurance Rate $45 Primary Paid $30	
ADHS Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $45-$30 vs. $55 - $30)
ADHS Payment to NonContracted Provider in this example	$15 (this is calculated from the lesser of: $45-30 vs. $50-30)
Scenario 2 AHCCCS FFS Rate $50 ADHS Rate $55 Primary Insurance Rate $60 Primary Paid $40	
ADHS Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $60 - $40 vs. $55-$40)
ADHS Payment to NonContracted Provider in this example	$10 (this is calculated from the lesser of: $60-$40 vs. $50-$40)
Scenario 3 AHCCCS FFS Rate $50 ADHS Rate $55 Primary Insurance Rate $70	

Primary Paid $60	
ADHS Payment to Contracted Provider in this example	$0 (this is calculated from the lesser of: $70 - $60 vs. $55-$60)
ADHS Payment to NonContracted Provider in this example?	$0 (this is calculated from the lesser of: $70- $60 vs. $50-$60)

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

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

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

Reporting Requirements: If ADHS discovers the probable existence of a liable party that is not known to AHCCCS, ADHS must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. In addition, ADHS shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the *Technical Interface Guidelines*. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 39, Sanctions.

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

35. MEDICARE SERVICES AND COST SHARING

AHCCCS has members who are eligible for both Title XIX and Medicare. These members are referred to as “dual eligible”. Generally, ADHS is responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. ADHS is responsible for adhering to the cost sharing responsibilities presented in the *AHCCCS Medicare Cost Sharing* policy [42 CFR 447.50 thru 60 and 438.108]. ADHS has no cost-sharing obligation if the Medicare payment exceeds what ADHS would have paid for the same service of a non-Medicare member.

36. PROVIDER CLAIMS TIME LIMITS

Unless a shorter period of time is specified in contract, ADHS and the subcontractors shall not pay claims for covered services that are initially submitted more than six months after the date of service, or six months after the date of eligibility posting, whichever is later. In addition, ADHS and the subcontractors shall not pay clean claims which are received more than 12 months after the date of service or 12 months after the date of eligibility posting, whichever is later, except as directed by AHCCCS, as a result of an AHCCCS or ADHS Director Decision, or as otherwise noted in this contract.

In accordance with the Balanced Budget Act of 1997, ADHS shall ensure that ninety percent (90%) of all clean claims are paid within 30 days of receipt of the clean claim and ninety nine percent (99%) are paid within 90 days of receipt of the clean claim.

37. MIS STANDARDS AND PERFORMANCE CRITERIA

ADHS shall maintain a management information system (MIS) that meets AHCCCS data processing requirements. AHCCCS reserves the right to review and approve or disapprove the ADHS MIS or any component therein if AHCCCS has reasonable concerns regarding its suitability or its ability to support the requirements of this contract. All components of the ADHS MIS shall be made available for review or audit upon request by AHCCCS. ADHS must seek and acquire prior approval from AHCCCS whenever it is anticipated that Title XIX and Title XXI funds will be used for systems enhancements, software, hardware or network procurement.

ADHS shall perform a quarterly internal reconciliation of all systems which may contain data on Title XIX and Title XXI members who are (or who may be) determined eligible for behavioral health services to ensure appropriate identification, control and correction of discrepant member information. The reconciliation shall include the client information system, the claims processing system and all other automated systems used by ADHS and the subcontractors in collecting, processing, service reimbursement or reporting of Title XIX and Title XXI member data. ADHS shall notify AHCCCS of any problems related with the reconciliation, along with corrective action plans, within 30 days of discovering the issue.

If ADHS plans to make any modifications which may affect any of the data interfaces (such as the Daily Eligibility Transaction process), it must first provide AHCCCS the details of the planned changes, the estimated impact upon the interface process, and unit and parallel test files. ADHS must allow sufficient time for AHCCCS to evaluate the test data before approving the proposed change. ADHS must also notify AHCCCS in advance of the exact implementation date of all changes so AHCCCS can monitor for any unintended side effects of the change.

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

38. DATA EXCHANGE

Encounter Data: ADHS shall submit encounter data and will be assessed penalties for noncompliance with encounter submission standards. The penalties will be applied based on the criteria of timeliness, correctness and omission of data. Penalties also will be applied for failure to timely correct pended encounters. Refer to Attachment B, Encounter Submission Requirements, for a discussion of encounter data validation.

Member Match: ADHS shall transmit to AHCCCS daily via electronic transfer the names of members who are or were being served by ADHS subcontractors during the past six months. AHCCCS shall identify any ADHS member who is Title XIX, Title XXI or DDD eligible and provide information back to ADHS. AHCCCS shall provide ADHS a separate file of all ADHS members who are long-term care eligible. AHCCCS shall provide a separate file of ADHS members that could not be uniquely identified in the AHCCCS database for research by ADHS. ADHS may resolve the discrepancies and resend these records for match with AHCCCS.

AHCCCS shall provide ADHS a file of ADHS members that were matched to AHCCCS member database but contain a demographic discrepancy. ADHS shall timely research and resolve the discrepancies to ensure continuation of match process.

AHCCCS shall update ADHS information on matched members to AHCCCS's member database. AHCCCS shall notify ADHS of matched members who have lost their Title XIX, Title XXI or DDD eligibility.

On a regularly scheduled basis, AHCCCS shall provide a full file of all members that AHCCCS had previously reported as matched. ADHS shall compare file supplied by AHCCCS to ADHS's member database and identify any inconsistencies. ADHS shall research and resolve the discrepancies. Specifications on the Member Match can be found in the BHS Technical Interface Guidelines.

Third Party Liability/Medicare File (TPL): AHCCCS shall transmit to ADHS daily via electronic transfer the name of ADHS matched members who have information updated in AHCCCS's Third Party Liability database and Medicare database. Specification on the TPL File can be found in the BHS Technical Interface Guidelines.

On a yearly basis, AHCCCS will provide a full TPL file to ADHS.

At Risk Population: ADHS shall receive from AHCCCS monthly via electronic transfer the names and other limited information of all Title XIX and Title XXI eligibles as of the first of each month. The members included in this file were used for the basis of the monthly At Risk capitation. ADHS shall receive the monthly At Risk capitation payment via HIPAA 820 TCS. Specifications on the At Risk Population file can be found in the BHS Technical Interface Guidelines. Specifications on the HIPAA 820 TCS can be found in the HIPAA Trading Partner Agreement.

Health Insurance Portability and Accountability Act (HIPAA): ADHS shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all federal regulations implementing that Subpart that are applicable to the operations of ADHS by the dates required by the implementing federal regulations as well as all subsequent requirements and regulations as published.

39. SANCTIONS

AHCCCS may impose monetary sanctions, regarding this contract or any related subcontracts in accordance with AHCCCS Rules R9-22-606, DHCM's Sanction Policy, the terms of this contract and applicable Federal or State law and regulations [42 CFR 422.208, 42 CFR 438.700, 702, 704, and 45 CFR 92.36(i)(1)]. Written notice will be provided to ADHS specifying the sanction to be imposed, the grounds for such sanction, the length of suspension and/or the amount of sanction. AHCCCS will prepare the AHCCCS side of the (GAO-614) transfer documents and forward them to ADHS to complete its side of the transactions. One transfer will reduce the Federal Share of the capitation payment and the second transfer document is intended for ADHS to account for their state match sanction expenditure funded by a state match source chosen by ADHS. A copy of the transfer document will be sent with the monthly capitation payment to notify ADHS that the sanction has taken place. ADHS may dispute the decision to impose a sanction in accordance with AHCCCS Rules.

Intermediate sanctions may be imposed for, but not limited to, the following actions:

a. Substantial failure to provide medically necessary services that ADHS is required to provide under the terms of this contract.
b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
c. Discrimination among behavioral health recipients on the basis of their health status of need for health care services.
d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
e. Misrepresentation or falsification of information furnished to a member, potential member, or provider.
f. Distribution, as applicable, directly, or indirectly through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
g. Failure to meet AHCCCS Financial Viability Standards.
h. Material deficiencies in ADHS provider network.
i. Failure to meet quality of care and quality management requirements.
j. Failure to meet AHCCCS encounter standards.
k. Violation of other applicable State or Federal laws or regulations.
l. Failure to fund accumulated deficit in a timely manner.
m. Failure to require subcontractors to increase the Performance Bond in a timely manner.
n. Failure to comply with any provisions contained in this contract.
o. Failure to report third party liability cases as described in paragraph 34.
p. Failure of an exiting subcontractor to meet financial obligations.

AHCCCS may impose the following types of intermediate sanctions:

a. Civil monetary penalties
b. Suspension of payment for members after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
c. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

Cure Notice Process: Prior to the imposition of a sanction for non-compliance, AHCCCS may provide a written cure notice to ADHS regarding the details of the non-compliance. The cure notice will specify the period of time during which ADHS must bring its performance back into compliance with contract requirements. If, at the end of

the specified time period, ADHS has complied with the cure notice requirements, AHCCCS will take no further action. If, however, ADHS has not complied with the cure notice requirements, AHCCCS will proceed with the imposition of sanctions. The Administration shall impose on ADHS any financial penalties or disallowances imposed on the state by the federal government related to ADHS' performance under this Agreement. The imposition of these sanctions upon ADHS shall not be levied until such time as the federal government shall have actually imposed sanctions upon the state for conduct related to ADHS' performance under this Agreement. The Administration shall confer with ADHS concerning defenses or objections to the imposition of such sanctions at all stages of the sanction process. In the event that the federal government imposes sanctions upon the state, ADHS shall reimburse the Administration upon demand, or the Administration will process a transfer (GAO-614) document, any such sanction or disallowance amount or any amount determined by the federal government to be unallowable, after exhaustion of the appeals process (if federal regulations so permit) as long as the federal government does not levy the sanctions until after the appeals process is completed. ADHS shall bear the administrative cost of such an appeals process.

40. GRIEVANCE SYSTEM

ADHS shall have in place a written grievance system for subcontractors, behavioral health recipients and providers, which defines their rights regarding disputed matters with ADHS. ADHS' grievance system for members includes a grievance process (the procedures for addressing member complaints), an appeals process and access to the state's fair hearing process. ADHS shall provide the appropriate personnel to establish, implement and maintain the necessary functions related to the grievance systems process. Refer to Attachments F(1) and F(2) for *Enrollee Grievance System* and *Provider Claim Dispute System*, respectively.

ADHS may delegate the grievance system process to the subcontractors, however, ADHS must ensure that standards which are delegated comply with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F, Title 9 Chapter 34 of AHCCCS Administrative Rules, and ACOM Policies. ADHS shall remain responsible for compliance with all requirements. ADHS shall also ensure that it timely provides written information to behavioral health recipients, their legal representative and providers, which clearly explains the grievance system requirements [42 CFR 438.414 and 438.10(g)(1)]. This information must include a description of: the right to a state fair hearing, a method for obtaining a state fair hearing, the rules that govern representation at the hearing, the right to file grievance and appeals, the requirements and timeframes for filing grievance and appeals, the availability of assistance in the filing process, the toll-free numbers that the behavioral health recipient can use to file a grievance or appeal by phone, that benefits will continue when requested by the behavioral health recipient in an appeal or state fair hearing request which is timely filed, that the behavioral health recipient may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of a behavioral health recipient with the behavioral health recipient's written consent. Information to behavioral health recipients must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 6, Member Information, and Paragraph 50, Cultural Competency.

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

41. SUBCONTRACTS

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

All subcontracts entered into by ADHS with subcontractors are subject to prior review and written approval by AHCCCS, Contracts and Purchasing, and shall incorporate by reference the terms and conditions of this contract. ADHS and/or the subcontractors shall not contract or subcontract with any individual or entity that 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 12549 [42 CFR 438.610(a), and (b)]. Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modifications of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition 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. ADHS must timely submit final, signed copies of each contract which it enters into with subcontractors and Tribal subcontractors and any subsequent amendments. ADHS shall require that copies of executed contracts between a subcontractor and service provider shall be made available within five days of a request by AHCCCS. It is ADHS' responsibility to prepare and distribute to all interested parties upon request the subcontractors' contract amendments resulting from federal or state legislative changes or changes in the terms of this contract and to ensure that subsequent provider subcontract amendments are completed in a timely manner. ADHS shall ensure that its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes. In addition, ADHS shall ensure subcontractors have a process to accept and manage provider inquiries, complaints, and requests for information that are received outside the claim dispute process.

If ADHS delegates duties or responsibilities to a subcontractor, then ADHS shall establish a written delegated agreement that specifies the activities and reporting responsibilities delegated to the subcontractor [42 CFR 438.230(b)(2)]. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate [42 CFR 438.230(b)(2)]. In order to determine adequate performance, ADHS shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by AHCCCS. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the corrective action plan shall be communicated to AHCCCS upon completion [42 CFR 438.230(b)(3)].

ADHS shall ensure that compensation to entities that conduct utilization management activities is not structured so as to provide incentives for the subcontractor or provider to deny, limit, or discontinue medically necessary services to any behavioral health recipient [42 CFR 438.210(e)].

ADHS must ensure that subcontractors enter into a contract with any provider the subcontractor anticipates will be providing services on its behalf except in the following circumstances:

a. A provider anticipated to provide services less than 25 times during the contract year;
b. A provider refuses to enter into a contract with the subcontractor, in which case the subcontractor shall submit documentation of such refusal to ADHS within seven days of its final attempt to gain such agreement; or
c. A provider performs emergency services.

ADHS shall ensure that the following provisions are included in writing in each of its contracts and all further subcontracts with networks and providers [42 CFR 438.206(b)(1)].

a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor
b. Identification of the name and address of the subcontractor
c. Identification of the population, to include member capacity, to be covered by the subcontractor
d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid
e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation
f. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability
g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to ADHS
h. A description of the subcontractor's member, medical and cost record keeping system

i. Specification that the subcontractor shall cooperate with quality management/quality improvement programs and comply with the utilization management and review procedures specified in 42 CFR Parts 441 and 456, as implemented by AHCCCS
j. A provision stating that a merger, reorganization or change in ownership of a subcontractor that is related to or affiliated with ADHS shall require a contract amendment and prior approval of ADHS
k. Procedures for identifying and terminating identification of behavioral health recipients
l. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage
m. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract
n. A provision stating the AHCCCS policy on claims processing by subcontractors, and
o. A provision that emergency services do not need prior authorization and that, in utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a "prudent layperson" is defined as a person without medical training who exercises those qualities of attention, knowledge, intelligence and judgment which society requires of its members for the protection of their own interest and the interests of others. The phrase does not apply to a person's ability to reason, but rather the prudence with which he acts under a given set of circumstances.
p. For subcontractors conducting utilization management activities, a provision that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee [42 CFR 438.210(e)].

ADHS shall ensure that the provisions in Attachment A, Minimum Subcontract Provisions, are included in each subcontract.

42. SUBCONTRACTOR COMPLIANCE WITH CONTRACT REQUIREMENTS [42 CFR 438.6(l)]

ADHS shall include provisions in its subcontracts that allow it to suspend, deny, refuse to renew, or terminate any subcontracts in accordance with the terms of this contract and applicable law and regulations. ADHS may, in addition to these remedies, impose financial sanctions on subcontractors for failure to perform as required, failure to submit timely and accurate reports, engaging in actions which jeopardize Federal Financial Participation or for any other breach of the terms of this contract. Written notice must be provided to the subcontractor specifying the grounds for sanction, the amount of funds to be withheld from capitation payments and steps necessary to avoid future sanctions. Other sanctions may be imposed against the subcontractors and their service providers in accordance with defined ADHS policies. ADHS accepts responsibility for any federal imposed utilization or quality management penalties or disallowances related to behavioral health services.

ADHS shall be held fully liable for the performance of all contract requirements and shall develop and maintain a system for regular and periodic assessment of all subcontractors' compliance with its terms. ADHS shall advise AHCCCS in writing within five business days of any subcontractor non-compliance and of the corrective measures taken, including the amount and duration of sanctions, to ensure subsequent compliance.

43. COORDINATION AND APPROVAL OF ADHS REQUESTS FOR PROPOSALS

ADHS shall coordinate with AHCCCS on the development of any Requests for Proposals (RFPs) soliciting offers from entities wishing to contract to provide covered services as described in this contract. The coordination shall be designed to ensure that issues relevant to Title XIX and Title XXI services and members are adequately addressed in the RFPs. ADHS shall submit to AHCCCS for prior approval copies of all proposed RFPs to be issued to solicit offers to furnish behavioral health services under this contract.

44. CAPITALIZATION REQUIREMENTS FOR SUBCONTRACTORS

Minimum capitalization requirements for subcontractors shall be specified in all Requests For Proposals issued by ADHS to solicit offers from entities, other than direct providers, to furnish behavioral health services under this

contract. No more than fifty percent (50%) of the minimum capitalization requirement may be met by an irrevocable letter of credit issued by one of the following:

a. A bank doing business in this state and insured by the Federal Deposit Insurance Corporation.
b. A savings and loan association doing business in this state and insured by the Federal Savings and Loan Insurance Corporation.
c. A credit union doing business in this state and insured by the National Credit Union Administration.

All subcontracts shall include terms necessary to ensure subcontractor financial stability and adequate performance. These terms shall include the maintenance of deposits, performance bonds, financial reserves and other financial security. In lieu of a performance bond or other security requirement, ADHS may, at its discretion, accept evidence that a subcontractor has posted other security, equal to or greater than that required by ADHS, with a state agency for the performance of health service contracts. The funds from such other security must be available to ADHS upon default or nonperformance by the subcontractor.

45. ADHS' RIGHT TO OPERATE SUBCONTRACTOR

All subcontracts shall include terms describing the circumstances under which ADHS would be authorized to step in and operate the subcontractor directly. Where warranted, ADHS shall, after delivering appropriate notice to the deficient subcontractor, operate the subcontractor for only so long as it is necessary to assure delivery of uninterrupted care to members, transition the members to a new subcontractor, or until the deficient subcontractor corrects all deficiencies.

46. DECLARATION OF EMERGENCY

Upon a declaration by the Governor that an emergency situation exists in the delivery of behavioral health services in which the health, safety or welfare of the public will be threatened without intervention by government agencies, ADHS may operate as the subcontractor or undertake actions to negotiate and award, with or without bid, a contract to an entity to operate as subcontractor. Contracts awarded under this section are exempt from the requirements of A.R.S. Title 41, Chapter 23. ADHS shall immediately notify affected subcontractor(s) of its intentions.

47. LABORATORY TESTING SERVICES

ADHS shall require all laboratory testing sites providing services under this contract to have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver shall be limited to providing only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

48. LEGISLATIVE ISSUES

In addition to the requirements described in this contract, legislative issues which may have an impact on services provided by ADHS on or after November 1, 2005 are briefly described below:

Arizona Early Intervention Program (AzEIP): The Arizona Early Intervention (AzEIP) Program is implemented through the coordinated activities of the Arizona Department of Economic Security (DES), the Arizona Department of Health Services (ADHS), Arizona State Schools for the Deaf and Blind (ASDB), the Arizona Health Care Cost Containment System (AHCCCS), and the Arizona Department of Education (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.

AHCCCS is currently working with the Department of Economic Security to provide increased Medicaid funding to this program. This may result in additional coordination with the AzEIP program for the Contractors. Any changes will be communicated to the Contractors and may result in a future contract amendment.

E Health Connectivity: AHCCCS supports the Governor's executive order #2005-25 on Arizona Health-e Connection Roadmap. This executive order directs the development of an electronic health information data exchange (HIE) of personal health information between providers, payers and members and the deployment of necessary health information technology to facilitate electronic health records in provider offices.

AHCCCS will develop a unified approach for AHCCCS Contractors to meet the goal of the executive order and to connect AHCCCS, AHCCCS Contractors, ancillary subcontractors and registered providers into a common web based electronic health information data exchange that will meet the standards established by State and Federal governments. AHCCCS Contractors will cooperate in assisting AHCCCS with developing Health-E project plans and shall implement required data exchange interfaces as required to meet the goals of the Governor's executive order.

CMS will provide grants to state Medicaid agencies to support development of IT infrastructure and applications to achieve the goal of health information data exchange. AHCCCS Contractors will be required to:

a. Encourage lab, pharmacy and ancillary subcontractors to develop common electronic interfaces for the exchange of data in standard file formats.
b. AHCCCS may issue Minimum Subcontract language that will require subcontractors to participate in the E-Health Initiative. ADHS must amend all provider subcontracts to include the amended Minimum Subcontract provisions within six (6) months of issuance.
c. ADHS will cooperate in passing on any AHCCCS professional fee or facility reimbursement rate adjustments to primary care, nursing facility, hospital and any other providers determined by AHCCCS to be eligible for reimbursement for participation in the health information data exchange.

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

Enrollment Guarantee: AHCCCS intends to modify the rule requiring a 6 month enrollment guarantee as described in R9-22 Article 17.

Coordination of Benefits: Based on the Deficit Reduction Act of 2006, there may be changes to Coordination of Benefits requirements.

49. ADVANCE DIRECTIVES

In accordance with 42 CFR 422.128, ADHS shall maintain policies and procedures addressing advanced directives for adult behavioral health recipients that specify:

a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care, must comply with Federal and State law regarding advance directives for adult members [42 CFR 438.6(i)(l)]. Requirements include:

    1. Maintaining written policies that address the rights of adult behavioral health recipients to make decisions about medical care, including the right to accept or refuse medical care, and the right to execute an advance directive. If an agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)
    2. Provide written information to adult behavioral health recipients regarding each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].
    3. Documenting in the behavioral health recipient's medical record whether or not the adult behavioral health recipient has been provided the information and whether an advance directive has been executed.
    4. Not discriminating against a behavioral health recipient because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
    5. Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by behavioral health recipients to whom they are assigned to provide services.

b. ADHS shall ensure providers, which have agreements with the entities described in paragraph a. above, comply with the requirements of subparagraphs a. (2) through (5) above. ADHS shall also encourage health care providers specified in subparagraph a. to provide a copy of the behavioral health recipient's executed advanced directive, or documentation of refusal, to the acute care PCP for inclusion in the member's medical record.

c. ADHS shall ensure that adult behavioral health recipients are provided written information describing the following:

1. A behavioral health recipient's rights under State law, including a description of the applicable State law;
2. Policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
3. The behavioral health recipient's right to file complaints directly with AHCCCS; and
4. Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)].

50. CULTURAL COMPETENCY

ADHS shall have a Cultural Competency Plan that meets the requirements of the AHCCCS Cultural Competency Policy. An annual assessment of the effectiveness of the plan, and any modifications to the plan, must be submitted to the Division of Health Care Management, Behavioral Health Unit, no later than 45 days after the start of each contract year. This plan should address all provider types and types of staff delivering behavioral health services [42 CFR 438.206(c)(2)].

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

51. BUSINESS CONTINUITY AND RECOVERY PLAN

ADHS shall develop a Business Continuity and Recovery Plan to deal with unexpected events that may affect its ability to adequately serve members. This plan shall, at a minimum, include planning and training for:

a. Electronic/telephonic failure at ADHS' main place of business;
b. Complete loss of use of the main site;
c. Loss of primary computer system/records;
d. How ADHS shall communicate with AHCCCS in the event of a business disruption; and
e. Periodic testing.

The Business Continuity and Recovery Plan shall be reviewed annually and updated as needed. All key staff shall be trained and familiar with the Plan. ADHS shall submit a Business Continuity and Recovery Plan Summary to AHCCCS no later than 15 days after the effective date of this contract. ADHS shall adhere to all elements of the Division of Health Care Management's *Business Continuity Plan Policy*.

ADHS shall ensure subcontractors prepare adequate business continuity and recovery plans and that the subcontractors review their plans annually, updating them as needed. The subcontractor plans shall, at a minimum, address the areas listed above as they apply to the subcontractors.

52. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, and AHCCCS Contractor Operation Manual, Chapter 100, ADHS, the subcontractors or providers are required to notify the AHCCCS, Office of Program Integrity immediately and submit report within 10 business days of discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form for any and all suspected fraud or abuse [42 CFR 455.1(a)(1)]. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS members or funds.

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

ADHS agrees to permit and cooperate with any onsite review. A review by the AHCCCS Office of Program Integrity may be conducted without notice and for the purpose of ensuring program compliance. ADHS also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS Administration.

ADHS and the subcontractors must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse [42 CFR 438.608(a) and (b)]. ADHS shall have written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected member fraud, provider fraud and member abuse cases to AHCCCS, Office of Program Integrity or other duly authorized enforcement agencies [42 CFR 455.17].

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

1. The written designation of a compliance officer and a compliance committee that are accountable to ADHS' top management.
2. The Compliance Officer must be an onsite management official who reports directly to top management.
3. Effective training and education.
4. Effective lines of communication between the compliance officer and the organization's employees.
5. Enforcement of standards through well-publicized disciplinary guidelines.
6. Provision for internal monitoring and auditing.
7. Provision for prompt response to problems detected.
8. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and state standards.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with decision making authority. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), ADHS, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. ADHS must establish a process for training existing staff and new hires on the compliance program and on the items in section 10. All training must be conducted in such a manner that can be verified by AHCCCS.
12. ADHS must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions:
    a. The administrative remedies for false claims and statements;
    b. Any state laws relating to civil or criminal penalties for false claims and statements;
    c. The whistleblower protections under such laws.
13. ADHS must notify all subcontractors and providers that they are prohibited from employing or entering into a contract with an individual excluded from participation in a federal health care program. ADHS shall require that its providers screen all employees and subcontractors on a periodic basis at a frequency determined by AHCCCS by searching designated websites to determine whether they have been excluded and to immediately report such information to both ADHS and the AHCCCS Administration. ADHS shall notify AHCCCS immediately of any excluded individual to institute appropriate action in collaboration with AHCCCS.
14. Add other CMS required activities related to Program Integrity.

The ADHS documented policies must include the requirements listed above.

ADHS and the subcontractors are required to research potential overpayments identified by the AHCCCS, Office of Program Integrity [42 CFR 455.1(a)]. After conducting a cost benefit analysis to determine if such action is warranted, ADHS should attempt to recover any overpayments identified. The AHCCCS Office of Program Integrity shall be advised of the final disposition of the research and advised of actions, if any, taken by ADHS.

53. TECHNOLOGICAL ADVANCEMENT

ADHS and the subcontractors must have a website with links to the following information:

a. Formulary
b. Provider manual
c. Member handbook
d. Provider listing

ADHS must ensure that subcontractors have claims inquiry via website fully operational.

54. MEDICARE MODERNIZATION ACT (MMA)

The Medicare Modernization Act of 2003 (MMA) created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. Beginning January 1, 2006, AHCCCS will no longer cover prescription drugs that are covered under Part D for dual eligible members. AHCCCS will not cover prescription drugs for this population whether or not they are enrolled in Medicare Part D. Capitation rates do reflect this

Drugs Excluded From Medicare Part D: AHCCCS does cover those drugs ordered by an authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, contractor formularies and prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plans formulary are not considered excluded drugs and will not be covered by AHCCCS.

55. PHYSICIAN INCENTIVES

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

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

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

ADHS shall disclose to AHCCCS the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS. Please refer to the AHCCCS Physician Incentive Plan Disclosure by Contractors Policy for details on providing required disclosures.

ADHS shall also provide for compliance with physician incentive plan requirements as set forth in 42 CFR 422.208, 422.210 and 438.6(h). These regulations apply to contract arrangements with subcontracted entities.

56. PROVIDER POLICIES

ADHS shall develop and distribute provider policies to all subcontractors. At a minimum, the provider policies must contain appropriate standards, policies, requirements or information regarding the following:

a. Appointment standards
b. Americans with Disabilities Act (ADA) requirements

c. Billing and encounter submission; including but not limited to fields required for a claim or encounter to be considered acceptable by ADHS. A completed sample of each form shall be included and an explanation of which form, UB92/837I, CMS 1500/837P, or Form C/NCPDP V5.1 is to be used for services
d. Claims medical review
e. Claims re-submission policy and procedure
f. Contractor's written policies and procedures which affect the provider and the provider network–inclusive of clinical policies on SMI determination, assessment, member transitions, management of high-risk members and responsibility for clinical oversight and point of contact
g. Coordination of care and communication with AHCCCS acute Contractors and other state agencies
h. Covered behavioral health services for Title XIX and Title XXI members and information on how providers are to assist members in accessing needed covered behavioral health services that a provider is not contracted to provide
i. Cultural competency information, including Title VI of the Civil Rights Act of 1964. Providers must also be informed of how to access interpretation services to assist members who speak a language other than English or who use sign language
j. Inquiries regarding Title XIX and Title XXI eligibility and behavioral health recipient status
k. Emergency room/urgent care utilization (appropriate and non-appropriate use of the emergency room and other urgent care settings)
l. Explanation of remittance advice
m. Fraud and Abuse prevention and detection, including instructions on how to report suspected fraud or abuse
n. Grievance and request for hearing rights for members and providers including information regarding time limitations
o. Member's Rights and Responsibilities including expedited hearings
p. Introduction to ADHS and the subcontractor which explains the organization and administrative structure
q. Medical record standards
r. Prior authorization requirements
s. Provider responsibility and ADHS' expectation of the provider
t. Provider training
u. Transition of members between subcontractors
v. Statement of the Arizona Vision and the J.K. Principles
w. Information regarding member confidentiality including the provider's ability and limitations in sharing treatment and care information with the Health Plan, ALTCS Contractor and other state agencies involved in the member's care according to confidentiality guidelines contained in 42 CFR 431 and A.R.S. §36-509
x. Date of last revision
y. Information on where to refer members who are to be served by another Contractor (i.e. Elderly and Physically Disabled ALTCS members**)**
z. Formulary information, including updates when changes occur, and
aa. A statement that Title XIX and XXI covered services are funded under contract with AHCCCS.
bb. Development and/or Adoption of Best Practices (42 CFR 438.235(b)], that
    a. Are based on valid and reliable clinical evidence or a consensus of behavioral health care professionals in the particular field;
    b. Consider the needs of the Contractor's members;
    c. Are adopted in consultation with contracting behavioral health care professionals;
    d. Are reviewed and updated periodically as appropriate;
    e. Are disseminated by ADHS to all affected providers and upon request to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    f. Provide a basis for consistent decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply [42 CFR 438.236(d)].

[END OF SECTION D]

SECTION E: CONTRACT CLAUSES

1. APPLICABLE LAW

Arizona Law - The law of Arizona applies to this contract including, where applicable, the Uniform Commercial Code, as adopted in the State of Arizona.

Implied Contract Terms - Each provision of law and any terms required by law to be in this contract are a part of this contract as if fully stated in it.

2. AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by the Contractor are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and ADHS shall not be entitled to any claim under this contract based on those changes.

3. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract, including all attachments and executed amendments and modifications; AHCCCS policies and procedures.

4. CONTRACT INTERPRETATION AND AMENDMENT

No Parol Evidence - This contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any term used in this contract.

No Waiver - Either party's failure to insist on strict performance of any term or condition of the contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the non-conforming performance knows of the nature of the performance and fails to object to it.

Written Contract Amendments - The contract shall be modified only through a written contract amendment within the scope of the contract signed by the procurement officer on behalf of the State.

5. SEVERABILITY

The provisions of this contract are severable to the extent that any provision or application held to be invalid shall not affect any other provision or application of the contract, which may remain in effect without the invalid provision, or application.

6. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS [42 CFR 438.6(f)(1), 438.100(d), and 45 CFR 74, Appendix G, 14]

ADHS shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Executive Order 13166; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment, and the Rehabilitation Act of 1973. ADHS shall maintain all applicable licenses and permits.

7. RIGHT TO ASSURANCE

If AHCCCS, in good faith, has reason to believe that ADHS does not intend to perform or continue performing this contract, the procurement officer may demand in writing that ADHS give a written assurance of intent to perform. The demand shall be sent to ADHS by certified mail, return receipt required. Failure by ADHS 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.

8. AVAILABILITY OF FUNDS

Funds are not presently available for performance under this contract beyond the current fiscal year. No legal liability on the part of AHCCCS for any payment may arise under this contract until funds are made available for performance of this contract.

9. SANCTIONS AND UNALLOWABLE COSTS

AHCCCS may sanction ADHS due to noncompliance with any of the requirements of this Agreement. AHCCCS shall notify ADHS in writing regarding any non-compliance issues and the amount of and basis for any sanctions. In applying sanctions, the Administration may withhold future payments to ADHS. [Section 1932(e)(5) of the Social Security Act]

10. NON-EXCLUSIVE REMEDIES

The rights and the remedies of AHCCCS under this contract are not exclusive.

11. NON-DISCRIMINATION

ADHS shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. ADHS shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, national origin or disability.

12. AMERICANS WITH DISABILITIES ACT

People with disabilities may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility. Requests for special accommodations must be made with at least three days prior notice by contacting AHCCCS Administration.

13. EFFECTIVE DATE

The effective date of this contract shall be the date that the Contracting Officer signs the award page (page 1) of this contract.

14. TERM OF CONTRACT AND CONTRACT EXTENSION

The initial term of this contract shall be for one (1) year, with annual options to extend. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment [42 CFR 438.610(c)(3)]. When AHCCCS issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted sixty (60) days from the date of mailing by AHCCCS, even if the extension has not been signed by ADHS, unless within that time ADHS notifies AHCCCS in writing that it refuses to sign the extension. Any disagreement between the parties regarding the extension of the contract or the terms of its renewal will be considered a dispute within the meaning of Section E, Paragraph 15, Disputes, and administered accordingly.

15. DISPUTES

The exclusive manner for ADHS to assert any claim, grievance, dispute or demand against AHCCCS shall be in accordance with ARS 36-2903.01.B.4. Pending the final resolution of any disputes involving this contract, ADHS 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.

16. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCS may, at reasonable times, inspect the part of the plant or place of business of ADHS or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

17. INCORPORATION BY REFERENCE

This contract and all attachments and amendments accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

18. COVENANT AGAINST CONTINGENT FEES

ADHS warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee. For violation of this warranty, AHCCCS shall have the right to annul this contract without liability.

19. CHANGES

AHCCCS may at any time, by written notice to ADHS, 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, ADHS may assert its right to an adjustment in compensation paid under this contract. ADHS must assert its right to such adjustment within thirty (30) days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 15, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted sixty (60) days after the date of mailing by AHCCCS, even if the amendment has not been signed by ADHS, unless within that time ADHS notifies AHCCCS in writing that it refuses to sign the amendment.

20. WARRANTY OF SERVICES

ADHS warrants that all services provided under this contract will conform to the requirements stated herein. AHCCCS' acceptance of services provided by ADHS shall not relieve ADHS from its obligations under this warranty. In addition to its other remedies, AHCCCS may, at ADHS' expense, require prompt correction of any services failing to meet ADHS warranty herein. Services corrected by ADHS shall be subject to all of the provisions of this contract in the manner and to the same extent as the services originally furnished.

21. NO GUARANTEED QUANTITIES

AHCCCS does not guarantee ADHS any minimum or maximum quantity of services or goods to be provided under this contract.

22. CONFLICT OF INTEREST

ADHS 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. ADHS shall fully and completely disclose any situation that may present a conflict of interest. If ADHS is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or ADHS or an entity owning or controlling same, ADHS shall disclose this relationship prior to accepting any assignment involving such party. [Section 1932(d)(3) of the Social Security Act]

23. DISCLOSURE OF CONFIDENTIAL INFORMATION

AHCCCS and ADHS shall observe and abide by all applicable state and federal statutes, rules and regulations regarding use or disclosure of information, including, but not limited to, information concerning applicants for, and recipients of services provided by the Administration.

24. AUDITS AND INSPECTIONS [42 CFR 438.6(g)]

ADHS shall comply with all provisions specified in applicable AHCCCS Rule R9-22-521 and AHCCCS policies and procedures relating to the audit of the ADHS' records and the inspection of the ADHS' facilities. ADHS shall fully cooperate with AHCCCS staff and allow them reasonable access to the Contractor's staff, subcontractors, members, and records.

At any time during the term of this contract, ADHS' or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3) and 45 CFR 74.48].

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.

25. DATA CERTIFICATION

ADHS shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial data must be submitted concurrent with the data. Encounter data must be concurrently certified. Certification may be provided by the ADHS 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, 606].

26. LOBBYING

No funds paid to ADHS by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing 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 [45 CFR 93 Appendix A]. ADHS shall disclose if any funds paid to ADHS by AHCCCS have been used or will be used to influence the persons and entities indicated above and will assist AHCCCS in making such disclosures to CMS.

27. TERMINATION

In the event the contract, or any portion thereof, is terminated for any reason, or expires, ADHS shall assist AHCCCS in the transition of its members to other contractors. In addition, AHCCCS reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. ADHS shall make provision for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied [42 CFR 438.610(c)(3) and 434.6(a)6]. ADHS shall be responsible for providing all reports set forth in this contract and necessary for the transition process and shall be responsible for the following:

a. Notification of subcontractors and members.
b. Payment of all outstanding obligations for medical care rendered to members.
c. Until AHCCCS is satisfied that ADHS has paid all such obligations, ADHS shall provide the following reports to AHCCCS:
    1. A monthly claims aging report by provider/creditor including IBNR amounts;
    2. A monthly summary of cash disbursements;
d. Such reports shall be due on the fifth day of each succeeding month for the prior month.
e. In the event of termination or suspension of the contract by AHCCCS, such termination or suspension shall not affect the obligation of ADHS to indemnify AHCCCS for any claim by any third party against the State or AHCCCS arising from ADHS' performance of this contract and for which ADHS would otherwise be liable under this contract.
f. Any dispute by ADHS, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E, Paragraph 15, Disputes.
g. Any funds, advanced to ADHS for coverage of members for periods after the date of termination, shall be returned to AHCCCS within 30 days of termination of the contract.

[END OF SECTION E]

SECTION F - LIST OF ATTACHMENTS

Attachment A	--	Minimum ADHS Contract (Subcontract) Provisions
Attachment B	--	Encounter Submission Requirements
Attachment C	--	Periodic Reporting Requirements
Attachment D	--	[RESERVED]
Attachment E	--	Shared-Risk Methodology
Attachment F	--	Grievance and Request for Hearing Process and Standards
Attachment G	--	AHCCCS Behavioral Health Services Guide
Attachment H	--	Technical Interface Guidelines
Attachment I	--	Performance Measures Methodologies

ATTACHMENT A: MINIMUM ADHS SUBCONTRACT PROVISIONS

For the sole purpose of this Attachment, the following definitions apply:

"Subcontract" means any contract between the Contractor and a third party for the performance of any or all services or requirements specified under the Contractor's contract with AHCCCS.

"Subcontractor" means any third party with a contract with the Contractor for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS.

Subcontractors who provide services under this contract must comply with the following:

- Rules for the Behavioral Health Program are found in Arizona Administrative Code (AAC) Title 9 (Health Services), Chapter 22 (Arizona Health Care Cost Containment System Administration), Articles 2 (Scope of Services) and 12 (Behavioral Health Services) and Title 9 (Health Services), Chapter 31 (Arizona Health Care Cost Containment System Children's Health Insurance Program), Article 12 (Behavioral Health Services).

- Rules for the Acute Care Program are found in AAC Title 9, Chapter 22. AHCCCS statutes for the Acute Care Program are generally found in A.R.S. 36, Chapter 29, Article 1. Rules for the KidsCare Program are found in AAC Title 9, Chapter 31 and the statutes for KidsCare Program may be found in A.R.S. 36, Chapter 29, Article 4.

All statutes, rules and regulations cited in this attachment are listed for reference purposes only and are not intended to be all inclusive.

[The following provisions must be included in every subcontract.]

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Subcontractor under this subcontract may be assigned without the prior approval of Arizona Department of Health Services (ADHS). No assignment or delegation of the duties of this subcontract shall be valid unless prior written approval is received from ADHS. (AAC R2-7-305)

2. AWARDS OF OTHER SUBCONTRACTS

AHCCCS and/or ADHS may undertake or award other contracts for additional or related work to the work performed by the Subcontractor and the Subcontractor shall fully cooperate with such other contractors, subcontractors or state employees. The Subcontractor shall not commit or permit any act which will interfere with the performance of work by any other contractor, subcontractor or state employee. (AAC R2-7-308)

3. CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING

By signing this Subcontract, the Subcontractor certifies that it has not engaged in any violation of the Medicare Anti-Kickback statute (42 USC §§1320a-7b) or the "Stark I" and "Stark II" laws governing related-entity referrals (PL 101-239 and PL 101-432) and compensation there from. If the Subcontractor provides laboratory testing, it certifies that it has complied with 42 CFR §411.361 and has sent to AHCCCS simultaneous copies of the information required by that rule to be sent to the Centers for Medicare and Medicaid Services (42 USC §§1320a-7b; PL 101-239 and PL 101-432; 42 CFR §411.361).

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

By signing this subcontract, the Subcontractor certifies that all representations set forth herein are true to the best of its knowledge.

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

The Clinical Laboratory Improvement Amendment (CLIA) of 1988 requires laboratories and other facilities that test human specimens to obtain either a CLIA Waiver or CLIA Certificate in order to obtain reimbursement from the Medicare and Medicaid (AHCCCS) programs. In addition, they must meet all the requirements of 42 CFR 493, Subpart A.

To comply with these requirements, AHCCCS requires all clinical laboratories to provide verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in either a termination of an active provider ID number or denial of initial registration. These requirements apply to all clinical laboratories.

Pass-through billing or other similar activities with the intent of avoiding the above requirements are prohibited. The Contractor may not reimburse providers who do not comply with the above requirements (CLIA of 1988; 42 CFR 493, Subpart A).

6. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Subcontractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Subcontractor's records and the inspection of the Subcontractor's facilities. If the Subcontractor is an inpatient facility, the Subcontractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCS [ARS 41-2548; 45 CFR 74.48 (d)] [42 CFR 438.6(g)].

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Subcontractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this subcontract, without limitation to those designated within this subcontract (Requirement for FFP, 42 CFR 434.70) [42 CFR 438.6(l)].

8. CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903, 41-1959 and 46-135, AHCCCS Rules and Health Insurance Portability and Accountability Act (Public Law 107-191, 110 Statutes 1936).

9. CONFLICT IN INTERPRETATION OF PROVISIONS

In the event of any conflict in interpretation between provisions of this subcontract and the ADHS Minimum Subcontract Provisions, the latter shall take precedence.

10. CONTRACT CLAIMS AND DISPUTES

Contract claims and disputes arising under A.R.S. § Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules.

11. ENCOUNTER DATA REQUIREMENT

If the Subcontractor does not bill ADHS (e.g., Subcontractor is capitated), the Subcontractor shall submit encounter data to ADHS in a form acceptable to AHCCCS.

12. EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES

AHCCCS, ADHS or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract. (ARS 36-2903. C., (8.); ARS 36-2903.02; AAC 9-22-522)

13. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident immediately and submit report within 10 business days of discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form to AHCCCS, Office of the Director, Office of Program Integrity and the ADHS/DBHS Fraud and Abuse Unit. Incidents involving suspected member eligibility fraud should be reported to AHCCCS, Office of Program Integrity, Att: Member Fraud Unit.. (ARS 36-2918.01; AAC R9-22-511.)

14. GENERAL INDEMNIFICATION

Each party (as "Indemnitor") agrees to indemnify, defend, and hold harmless the other party (as "Indemnitee") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as "Claims") arising out of bodily injury of any person (including death) or property damage, but only to the extent that such Claims which result in vicarious/derivative liability to the Indemnitee are caused by the act, omission, negligence, misconduct, or other fault of the Indemnitor, its officers, officials, agents, employees, or volunteers.

In addition, ADHS shall cause its contractor(s) and subcontractors, if any, to indemnify, defend, save and hold harmless the State of Arizona, any jurisdiction or agency issuing any permits for any work arising out of this Agreement, and their respective directors, officers, officials, agents, and employees (hereinafter referred to as "Indemnitee") from and against any and all claims, actions, liabilities, damages, losses, or expenses (including court costs, attorneys' fees, and costs of claim processing, investigation and litigation) (hereinafter referred to as "Claims") for bodily injury or personal injury (including death), or loss or damage to tangible or intangible property caused, or alleged to be caused, in whole or in part, by the negligent or willful acts or omissions of ADHS's contractor or any of the directors, officers, agents, or employees or subcontractors of such contractor. This indemnity includes any claim or amount arising out of or recovered under the Workers' Compensation Law or arising out of the failure of such contractor to conform to any federal, state or local law, statute, ordinance, rule, regulation or court decree. It is the specific intention of the parties that the Indemnitee shall, in all instances, except for Claims arising solely from the negligent or willful acts or omissions of the Indemnitee, be indemnified by such contractor from and against any and all claims. It is agreed that such contractor will be responsible for primary loss investigation, defense and judgment costs where this indemnification is applicable.

15. INSURANCE

This section is reserved.

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state laws and regulations, the Subcontractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services.

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

The Subcontractor shall be registered with AHCCCS and shall obtain and maintain all licenses, permits and authority necessary to do business and render service under this subcontract and, where applicable, shall comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation.

18. NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, gender, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The Subcontractor shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, gender, national origin or disability. (Federal regulations, State Executive order # 99-4 & AAC R9-22-513)

19. PRIOR AUTHORIZATION AND UTILIZATION REVIEW

The Subcontractor and ADHS shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and ADHS policies. (AAC R9-22-522)

20. RECORDS RETENTION

The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to ADHS and AHCCCS and working papers used in the preparation of reports to ADHS and AHCCCS. The Subcontractor shall comply with all specifications for record keeping established by AHCCCS. All books and 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 Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCS, State or Federal government.

The Subcontractor 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.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances,

disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCS, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law (45 CFR 74.53; 42 CFR 431.17, ARS 41-2548).

21. SEVERABILITY

If any provision of these standard subcontract terms and conditions is held invalid or unenforceable, the remaining provisions shall continue valid and enforceable to the full extent permitted by law.

22. SUBJECTION OF SUBCONTRACT

The terms of this subcontract shall be subject to the applicable material terms and conditions of the contract existing between ADHS and AHCCCS for the provision of covered services.

23. TERMINATION OF SUBCONTRACT

ADHS may, by written notice to the Subcontractor, terminate this subcontract if it is found, after notice and hearing by the State, that gratuities in the form of entertainment, gifts, or otherwise were offered or given by the Subcontractor, or any agent or representative of the Subcontractor, to any officer or employee of the State with a view towards securing a contract or securing favorable treatment with respect to the awarding, amending or the making of any determinations with respect to the performance of the Subcontractor; provided, that the existence of the facts upon which the state makes such findings shall be in issue and may be reviewed in any competent court. If the subcontract is terminated under this section, unless the Contractor is a governmental agency, instrumentality or subdivision thereof, ADHS shall be entitled to a penalty, in addition to any other damages to which it may be entitled by law, and to exemplary damages in the amount of three times the cost incurred by the Subcontractor in providing any such gratuities to any such officer or employee [AAC R2-5-501; ARS 41-2616 C.; 42 CFR 434.6, a. (6)].

24. VOIDABILITY OF CONTRACT

This subcontract is voidable and subject to immediate termination by ADHS upon the Subcontractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or upon assignment or delegation of the subcontract without ADHS' prior written approval.

25. WARRANTY OF SERVICES

The Subcontractor, by execution of this subcontract, warrants that it has the ability, authority, skill, expertise and capacity to perform the services specified in this contract.

26. OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition 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.

27. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor 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 Subcontractor 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 ADHS and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that ADHS 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 Subcontractor.

[END OF ATTACHMENT A]

ATTACHMENT B: ENCOUNTER SUBMISSION REQUIREMENTS

ADHS will be assessed sanctions for noncompliance with encounter submission requirements. AHCCCS may also perform special reviews of encounter data, such as comparing encounter reports to ADHS' claims files. Any findings of incomplete or inaccurate encounter data may result in the imposition of sanctions and/or requirement of a corrective action plan.

Pended Encounter Corrections

ADHS must resolve all pended encounters within 120 days of the original processing data. Sanctions will be imposed according to the following schedule for each encounter pended for more than 120 days unless the pend is due to AHCCCS error:

0 – 120 days	121 – 180 days	181 – 240 days	241 – 360 days	361 + days
No sanction	$ 5 per month	$ 10 per month	$ 15 per month	$ 20 per month

"AHCCCS error" is defined as a pended encounter which (1) AHCCCS acknowledges to be the result of its own error, and (2) requires a change to the system programming, an update to the database reference table, or further research by AHCCCS. AHCCCS reserves the right to adjust the sanction amount if circumstances warrant.

Written preliminary results of all pended encounters will be sent to ADHS for review and comment. ADHS will have 45 days to review results and provide AHCCCS with additional documentation that would affect the final calculation of sanctions.

When ADHS notifies AHCCCS in writing that the resolution of a pended encounter depends on AHCCCS rather than ADHS, AHCCCS will respond in writing within 30 days of receipt of such notification. The AHCCCS response will report the status of each pending encounter problem or issue in question.

Pended encounters will not qualify as AHCCCS errors if AHCCCS reviews ADHS' notification and asks ADHS to research the issue and provide additional substantiating documentation, or if AHCCCS disagrees with ADHS' claim of AHCCCS error. If a pended encounter being researched by AHCCCS is later determined not to be caused by AHCCCS error, ADHS may be sanctioned retroactively.

Before imposing sanctions, AHCCCS will notify ADHS in writing of the total number of sanctionable encounters pended more than 120 days.

Pended encounters shall not be deleted by ADHS or the subcontractors as a means of avoiding sanctions for failure to correct encounters within 120 days. ADHS and the subcontractors shall document deleted encounters and shall maintain a record of the deleted CRNs with appropriate reasons indicated. ADHS and the subcontractors shall, upon request, make this documentation available to AHCCCS for review.

Encounter Validation Studies

Per CMS requirement, AHCCCS will conduct encounter validation studies of ADHS' encounter submissions, and sanction ADHS for noncompliance with encounter submission requirements. The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with ADHS' submitted encounter data. Any and all covered services may be validated as part of these studies. Encounter validation studies will be conducted at least yearly.

The following reflects AHCCCS's encounter validation study process and sanction policy. AHCCCS may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with CMS. ADHS will be notified in writing of any significant change in study methodology.

AHCCCS will conduct two encounter validation studies. Study "A" examines non-institutional services (form HCFA 1500/837P encounters), and Study "B" examines institutional services (form UB-92/837I encounters).

AHCCCS will notify ADHS in writing of the sanction amounts and of the selected data needed for encounter validation studies. ADHS will have 90 days to submit the requested data to AHCCCS. In the case of medical records requests, ADHS' failure to provide AHCCCS with the records requested within 90 days may result in a sanction of $1,000 per missing medical record. If AHCCCS does not receive a sufficient number of medical records from ADHS to select a statistically valid sample for a study, ADHS may be sanctioned up to five percent (5%) of its annual capitation payment.

The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. Refer to the AHCCCS Data Validation User Manual for further information. These criteria are defined as follows:

Timeliness: The time elapsed between the date of service and the date that the encounter is received at AHCCCS. . For all encounters for which timeliness is evaluated, a sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter record is received by AHCCCS more than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment.. It is anticipated that the sanction amount will be $1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCS determines that encounter quality has changed, or if CMS changes sanction requirements. ADHS will be notified of the sanction amount in effect for the studies at the time the studies begin.

Correctness: A correct encounter contains a complete and accurate description of AHCCCS covered services provided to a member. A sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter is incomplete or incorrectly coded. It is anticipated that the sanction amount will be $1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCS determines that encounter quality has changed, or if CMS changes sanction requirements. ADHS will be notified of the sanction amount in effect for the studies at the time the studies begin.

Omission of data: An encounter not submitted to AHCCCS or an encounter inappropriately deleted from AHCCCS's pending encounter file or historical files in lieu of correction of such record. For Study "A" and for Study "B", a sanction per encounter error extrapolated to the population of encounters may be assessed for an omission. It is anticipated that the sanction amount will be $5.00 per error extrapolated to the population of encounters for Study "A" and $10.00 per error extrapolated to the population of encounters for Study "B"; however, sanction amounts may be adjusted if AHCCCS determines that encounter quality has changed, or if CMS changes sanction requirements. ADHS will be notified of the sanction amount in effect for the studies at the time the studies begin.

For encounter validation studies, AHCCCS will select all approved and pended encounters to be studied no earlier than 240 days after the end of the month in which the service was rendered. Once AHCCCS has selected ADHS' encounters for encounter validation studies, subsequent encounter submissions for the period being studied will not be considered.

AHCCCS may review all of ADHS' submitted encounters, or may select a sample. The sample size, or number of encounters to be reviewed, will be determined using statistical methods in order to accurately estimate ADHS' error rates. Error rates will be calculated by dividing the number of errors found by the number of encounters reviewed. A ninety five percent (95%) confidence interval will be used to account for limitations caused by sampling. The confidence interval shows the range within which the true error rate is estimated to be. If error rates are based on a sample, the error rate used for sanction purposes will be the lower limit of the confidence interval.

Encounter validation methodology and statistical formulas are provided in the *AHCCCS Data Validation User Manual*. This document also provides examples which illustrate how AHCCCS determines study sample sizes, error rates, confidence intervals, and sanction amounts.

Written preliminary results of all encounter validation studies will be sent to ADHS for review and comment. ADHS will have 30 days to review results and provide AHCCCS with additional documentation that would affect the final calculation of error rates and sanctions. AHCCCS will examine ADHS' documentation and may revise study results if warranted. Written final results of the study will then be sent to ADHS and communicated to CMS, and any sanctions will be assessed.

ADHS may file a written challenge to sanctions assessed by AHCCCS not more than 35 days after ADHS receives final study results from AHCCCS. Challenges will be reviewed by AHCCCS and a written decision will be rendered no later than 60 days from the date of receipt of a timely challenge. Sanctions shall not apply to encounter errors successfully challenged. A challenge must be filed on a timely basis and a decision must be rendered by AHCCCS prior to filing a grievance pursuant to Article 8 of AHCCCS Rules. Sanction amounts will be deducted from ADHS' capitation payment.

Encounter Corrections

ADHS is 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 ADHS. ADHS shall refer to the Encounter Reporting User Manual for instructions regarding submission of corrected encounters.

[END OF ATTACHMENT B]

ATTACHMENT C: PERIODIC REPORTING REQUIREMENTS

MONTHLY REPORTS

1. ENCOUNTER REPORTING

The accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCS uses encounter data to set fee-for-service and capitation rates, determine disproportionate share payments to hospitals, and evaluate quality of care.

In order to conform to the CMS requirement that AHCCCS collect one hundred percent (100%) of encounter data for Title XIX and Title XXI services provided in the state and validate those data, ADHS shall submit encounter data for covered services via electronic file [42 CFR 438.242(b)(1) and (2)]. Encounter data shall be collected by ADHS and submitted to AHCCCS in accordance with the *Encounter Reporting User Manual* incorporated herein by reference and the *Encounter Submission Requirements* included herein as Attachment B.

ADHS will be assessed sanctions for noncompliance with encounter submission standards. AHCCCS may also perform special reviews of encounter data, such as comparing encounter reports to ADHS' claims files. Any findings of incomplete, untimely or inaccurate encounter data may result in the imposition of sanctions and/or requirement of a corrective action plan.

2. MEMBER RECONCILIATION TRANSMISSION

The Member Reconciliation Transmission is a monthly "snapshot" of the behavioral health recipient files. AHCCCS provides a file of PMMIS behavioral health recipients to allow ADHS to reconcile against their client Title XIX and Title XXI populations. Any errors or discrepancies are identified and reported for resolution by ADHS.

3. MONTHLY CAPITATION DISTRIBUTION REPORT

The Monthly Capitation Distribution Report shows the distribution of capitation to subcontractors. This report is due within forty-five days from receipt of capitation from AHCCCS.

4. MONTHLY GRIEVANCE SYSTEM REPORT (APPEALS AND CLAIM DISPUTES)

The Monthly Grievance System Report is to be submitted to the AHCCCS Division of Health Care Management and is due 75 days after the end of the reporting month. This report contains two sections: the Claims Dispute Report and the Authorization Request and Appeal Report. The Authorization Request and Appeal Report specifies the number, timeliness and outcomes of member appeals, member expedites appeals and state fair hearings. The Claim Dispute Report specifies the number of claim disputes filed during the reporting month by contractors, subcontractors, Tribal subcontractors and providers, the timeliness of decisions, the outcomes of the claim dispute and number and percentage of the top dispute categories and disputing providers. The report shall be completed in its entirety to include the disposition and status of all member appeals, member expedited appeals and claim disputes previously filed.

QUARTERLY REPORTS

1. ANALYSIS OF SUBCONTRACTOR FINANCIAL INFORMATION

ADHS shall be responsible for providing AHCCCS analysis of the following:

a. Quarterly Subcontractor Financial statements (by subcontractor, by mental health category, by Title XIX/Title XXI); and
b. Quarterly Subcontractor Viability Ratios (by subcontractor, by Title XIX/Title XXI).

The quarterly analysis shall be submitted by ADHS to AHCCCS on or before the 75th day following the end of the quarter being reported.

2. STATEMENT OF FINANCIAL POSITION

ADHS shall require subcontractors to report statement of financial position information to ADHS in the report format established by ADHS and approved by AHCCCS. ADHS shall submit the statement of financial position report to AHCCCS on or before the 55th day following the end of the quarter being reported.

3. STATEMENT OF ACTIVITIES AND CHANGES IN NET ASSETS

ADHS shall require subcontractors to report statement of activities and changes in net assets information to ADHS in the report format established by ADHS and approved by AHCCCSA. ADHS shall submit the statement of activities and changes in net assets to AHCCCSA on or before the 55th day following the end of the quarter being reported.

4. STATEMENT OF CASH FLOWS

ADHS shall require subcontractors to report statement of cash flow information to ADHS in the report format established by ADHS and approved by AHCCCS. ADHS shall submit the statement of cash flow report to AHCCCS on or before the 55th day following the end of the quarter being reported.

5. INCURRED BUT NOT REPORTED CLAIMS

ADHS shall require subcontractors to report IBNRs in the report format established by ADHS and approved by AHCCCS. An acceptable method for calculating an IBNR is with an open authorized services summary which includes services that are authorized for which a claim has not yet been received. ADHS shall submit the IBNR Report to AHCCCS on or before the 55th day following the end of the quarter being reported.

6. FINANCIAL STATEMENT FOOTNOTE DISCLOSURE

ADHS shall require subcontractors to report footnote disclosure information to supplement financial reporting to ADHS in the report format established by ADHS and approved by AHCCCS. ADHS shall submit the footnote disclosure report to AHCCCS on or before the 55th day following the end of the quarter being reported. ADHS shall require subcontractors to report the following information in the footnote disclosure report.

a. Under “Service Expenses; All Other Behavioral Health Services”:
Describe material amounts included in this category.

b. Under “Prior Period Adjustments”:
Disclose and describe any adjustments made to previously submitted financial statements including those adjustments that affect the current quarter’s financial statements.

c. Under “Claims Payable Analysis”:
Explain large fluctuations in IBNR and RBUC balances from the prior quarter.

7. RESERVED

8. RESERVED

9. SHOWING REPORT

The Quarterly Showing Report is due within 17 days after the end of the quarter. The report provides attestations from ADHS, subcontractors and Tribal subcontractors to demonstrate to the federal government compliance with certification and recertification of need requirements. ADHS shall submit timely, accurate and complete Quarterly Showing Reports.

10. QUARTERLY ADHS/DBHS FINANCIAL STATEMENT

In accordance with Section E paragraph 24 contained in this contract, ADHS shall provide AHCCCS with a quarterly financial statement for Title XIX and Title XXI no later than 60 days after the end of the reporting quarter. A reporting format pre-approved by AHCCCS should include, at a minimum: capitation revenue received, capitation amounts paid, and ADHS administrative expenditures separated by key cost categories.

11. RESERVED

12. RESERVED

SEMI-ANNUAL REPORTS

1. **SEMI-ANNUAL PERFORMANCE IMPROVEMENT REPORT**

ADHS shall submit to AHCCCS, a Semi-Annual Performance Improvement Report, in a format approved by AHCCCS, due within 60 days after the end of the semi-annual reporting period (July 1 through December 31 and January 1 through June 30).

At a minimum, the Contractor Performance Improvement Report shall include:

a. Performance and analysis, by GSA or subcontractor, on all performance measures/indicators, Children's System of Care, and status updates on performance improvement activities to cover the prior six month time period as specified in Section D – Program Requirements, Paragraph 20, Quality Management Plan, of this contract.
b. Analysis of data elements that further inform on performance measures, including member complaints, mortalities, grievances, appeals, incidents, accidents, and quality of care concerns.

AHCCCS may, upon notice to ADHS, no less than 30 days prior to the report due date, request information on additional items, as may be necessary to fully inform AHCCCS of ADHS' actions and plans related to requirements under this contract.

Additionally, ADHS shall participate in a bi-monthly meeting with AHCCCS. The topics of the bi-monthly meetings between AHCCCS and ADHS will be jointly developed.

ANNUAL REPORTS

1. PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN

The Annual Provider Network Development Plan shall be evaluated, updated annually and submitted to AHCCCS within 100 days from the start of the contract year.

The purpose of the plan is to identify the current status of the network at all levels and to identify network development and/or enhancement needs for the contract year based on the assessment of the current status of the network and multiple sources of information about current and projected network needs. At a minimum, the plan shall include the following:

A narrative analysis statewide and by subcontractor, of the sufficiency of the Title XIX and Title XXI network based on the items 1-9 below. Criteria for assessing the network should consider analysis of multiple data sources including, but not limited to: performance on appointment standards/appointment availability; problem resolutions and member complaints/grievances/appeals/requests for hearing; Title XIX and Title XXI eligibles and penetration rates; utilization data; member satisfaction surveys; provider appeals; demographic data and information on the cultural needs of the communities and analysis of national data elements.

1. a. Attestation of the current status of the ADHS network that ensures it is sufficient to provide all covered behavioral health services to TXIX and TXXI members.

b. Evidence that DBHS receives or seeks input on the status of the network from members, providers, and staff.

c. Description of network design by GSA for the general population and provisions for special populations including but not limited to SMI, the developmentally disabled, Arizona Early Intervention Program (AzEIP), the homeless and those in border communities.

2. Process for evaluating the anticipated number of TXIX and TXXI membership growth and changes in order to maintain and build a network. Evaluation should include use of national epidemiological surveys and research studies (National Co-Morbidity Study, SAMSHA statistics, and census bureau statistics, Epidemiological Catchment Area) to establish synthetic prevalence rates.

3. a. Expected utilization of service, given the characteristics of the population and the behavioral health care needs.

b. Analysis of membership access to specialty care providers/services (trauma, eating disorders, sexual offender, adolescent substance abuse, co-occurring disorders, etc.)

4. Description of methodology to address adequate access to non-emergency transportation services.

5. Number of providers not accepting new Medicaid patients.

6. Availability of weekend and after hours appointments in each GSA.

7. a. Analysis of the causes of avoidable/preventable crisis stabilization/psychiatric in-patient utilization.

b. Description of proactive strategies to reduce avoidable/preventable crisis stabilization/psychiatric in-patient utilization.

c. Describe any purchasing strategies to reduce avoidable/preventable crisis stabilization/psychiatric in-patient utilization such as:

i. Physician coverage/call availability after hours and on weekends;
ii. Same day behavioral health prescriber appointments;
iii. Nurse call-in centers, information lines, member services;
iv. Urgent Care/Crisis facilities; and
v. Expansion of support and rehabilitation services.

8. a. Description of monitoring activities that identify network gaps,

b. Plans for immediate and long term interventions to fill network gaps, and evaluation of those interventions including specific strategies of how members will receive medically necessary services if a large provider or provider group is unavailable due to closure, contract termination, natural disaster, etc.

c. Identification of barriers in network development.

d. Provider network issues that occurred over the prior year that were significant in nature requiring a corrective action plan.

9. Priorities and goals for the upcoming year.

2. SUBCONTRACTOR FINANCIAL AUDITS

Audited Financial Statement Draft

ADHS shall require subcontractors to submit to ADHS draft annual certified audited financial statements which includes supplemental schedules and a reconciliation to the fourth quarter reports in a format approved by AHCCCS. ADHS shall submit the draft financial statements to AHCCCS on or before the 100th day following the end of the fiscal year being reported.

Restated Fourth Quarter Statement of Activities

ADHS shall require subcontractors to submit to ADHS a restated fourth quarter statement of activities. ADHS shall submit the restated fourth quarter statement of activities to AHCCCS on or before the 100th day following the end of the fiscal year being reported.

Final Annual Subcontractor Financial Audits

ADHS shall require subcontractors to submit to ADHS final certified audited financial statements (including supplemental schedules and reconciliations). ADHS shall submit the final certified audited financial statements to AHCCCS on or before the 130th day following the end of the fiscal year being reported.

Subcontractor Administrative Expenditure Plan

ADHS shall require subcontractors to provide ADHS with a plan for allocating cost for Title XIX and Title XXI administrative services in accordance with 45 CFR 95.501, Subpart E. This information will be given to AHCCCS at

least 30 days after receipt from the subcontractor, but no later than September 1 of the contract year. If there are no significant changes from the previous year, a letter to that fact will be acceptable in lieu of a plan.

Analysis of Subcontractor Financial Information
ADHS shall be responsible for providing AHCCCS analysis of the following:

a. Annual Subcontractor Financial Statements (by subcontractor, by mental health category, by Title XIX/Title XXI); and
b. Annual Subcontractor Viability Ratio Analysis (by subcontractor, by Title XIX/Title XXI).

The annual analysis shall be submitted by ADHS to AHCCCS on or before the 155th day following the end of the fiscal year being reported.

ADHS shall provide AHCCCS with annual summaries of Tribal subcontractor administrative revenues and expenditures on or before the 155th day following the end of the federal fiscal year being reported.

3. SUBCONTRACTOR DISCLOSURE & RELATED PARTY TRANSACTIONS STATEMENTS

ADHS shall obtain ownership and control and related party transaction information from all subcontractors. This disclosure information will be evaluated by ADHS for reasonableness, potential adverse impact on the subcontractors, and any significant conflict of interest. This section shall not limit the ability of ADHS to investigate, examine or verify disclosures made by a subcontractor. ADHS shall submit a disclosure statement for each subcontractor annually no later than 130 days after the end of the subcontractor's fiscal year.

4. SUBCONTRACTOR OPERATIONAL AND FINANCIAL REVIEWS

ADHS or an independent external agent shall conduct an annual Operational and Financial Review of each subcontractor using protocols consistent with the CMS Protocols For External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans [42 CFR 438.230(b)(3) and (4) and 438.240(E)(2)]. At a minimum, the OFR shall include the review of the strengths and weaknesses with respect to the quality outcomes, timeliness, and access to health care services furnished to Title XIX and Title XXI behavioral health recipients; clinical and business practices and policies; and financial reporting systems and any other operational and program areas identified by ADHS. The reviews provide one venue for ADHS to understand and monitor subcontractor operational practices, recognize areas of noteworthy performance and ensure compliance with federal and state regulations and contractual requirements.

ADHS will provide a proposed review guide and proposed review schedule to AHCCCS for review and approval at least 60 days prior to commencement of the reviews. ADHS shall provide AHCCCS a summary and analysis of findings by February 1. ADHS shall utilize the findings to assist in improving subcontractor operations and the care and services delivered to members and submit a report detailing the status of corrective actions taken as a result of the OFR at least annually by August 1.

5. STATEMENT OF FINANCIAL VIABILITY RATIOS

ADHS shall establish financial viability ratios that it will use to assess the subcontractors' ability to perform under this contract. ADHS shall include a description of the financial viability ratios in their financial reporting guide..

6. QUALITY MANAGEMENT PERFORMANCE IMPROVEMENT PLAN AND EVALUATION

The Quality Management Performance Improvement (QM/PI) Plan shall be submitted by ADHS by September 15th of each contract year. ADHS must submit the QM/PI Plan to AHCCCS for review and approval at least 30 days prior to planned implementation and submit a change matrix with the plan that identifies proposed changes in those sections required by AHCCCS contract and policy. The Annual Quality Management/Performance Improvement Plan shall comply with all requirements as stated in the AHCCCS AMPM Chapter 900 and include an annual appraisal that assesses progress made by ADHS in achieving the goals and objectives identified in the previous year's QM/PI Plan. The plan must address quality of care for both clinical processes as well as administrative functions. The plan must also include the development of an effective system to monitor subcontractors' compliance with requirements. ADHS shall ensure that each subcontractor develops and adheres to a quality management/performance improvement plan

that is consistent with contract and AHCCCS requirements. The scope of this annual plan, and ADHS activities around quality management must be comprehensive and incorporate the following content areas:

a. An in-depth set of specific objectives, a work plan with timelines to support the objectives and a detailed and comprehensive description of the scope of the QM/PI program per AHCCCS AMPM Chapter 900.
b. The method(s) utilized to monitor and evaluate QM/PI activities and a demonstration of how these activities will improve the quality of services and the continuum of care in all service sites. This monitoring must, at a minimum, evaluate AHCCCS mandated performance indicators, QM/PI deliverables and other QM/PI data collected during the plan year.
c. An identifiable, structured QM/PI committee, chaired by the ADHS Medical Director or other formal structure, responsible for QM/PI functions and responsibilities. The role, structure and function of this committee must be specified in the plan.
d. Documentation of the participation and accountability of the governing or policymaking body in the approval of the QM/PI plan, oversight of quality assessment and improvement activities, and an organizational chart which delineates the reporting structure and responsibilities within the ADHS organization for QM/PI activities.
e. Documentation that appropriately qualified, trained and experienced personnel are available to effectively carry out QM/PI program functions.
f. ADHS oversight and accountability for all delegated functions is described and documented. This documentation must include policies and procedures for the monitoring and evaluation of delegated functions, reports to ADHS by delegated entities, and any corrective action plans required, ensuring quality processes within the delegated entities.
g. A description of how member rights and responsibilities are defined, implemented and monitored.
h. The ADHS standards that have been implemented to assure that the medical records and communications of clinical information for each member reflect all aspects of patient care, including ancillary services.
i. The policy and procedures utilized by ADHS for the credentialing and recredentialing process for subcontractors and providers [42 CFR 438.206(b)(6)].
j. Documentation of a process for abuse and grievance tracking and trending.
k. Documentation of performance related to AHCCCS mandated performance indicators.
l. The selection, evaluation and assessment of performance improvement projects (PIPs).
m. Documentation that its providers are credentialed.

7. MEDICAL MANAGEMENT PLAN AND EVALUATION

ADHS must develop a written MM plan which complies with all requirements as stated in the AHCCCS AMPM Chapter 1000 and includes the following activities:

a. Prior authorization (seven days a week, 24 hours per day).
b. Concurrent review.
c. Discharge planning.
d. Referral management.
e. Claims review.
f. Drug utilization patterns.
g. Case management.
h. Evidence of monitoring and evaluating under-utilization and over-utilization.
i. Developing practice guidelines.
j. Evaluating new medical technologies and new uses of existing technologies.

The initial plan and any subsequent modifications to the plan must be submitted to AHCCCS for review prior to implementation. Annually, by October 1, ADHS must submit an evaluation of the MM workplan with a newly developed or revised MM workplan which incorporates revisions as a result of the evaluation.

8. MEMBER SURVEY

ADHS shall, at a minimum, survey its Title XIX and Title XXI members every year. ADHS shall submit the proposed member survey tool, including sampling and distribution methodology, to AHCCCS for review and approval no later than 90 days prior to the intended start of the survey. The member survey results and analysis shall be submitted by June 30 of the following year. The member survey report for the survey conducted in CYE 08 is due to AHCCCS by June 30,

2009. ADHS shall ensure that subcontractors and their providers utilize member survey findings to improve care for Title XIX and Title XXI members.

9. ADHS/DBHS MEMBER HANDBOOK TEMPLATE

ADHS shall submit to AHCCCS, a Member Handbook Template that contains at a minimum, the items specified in Section D, paragraph 6, as well as documentation of the location within the template of the required items (review tool with corresponding section titles and page numbers), annually by September 15 and within 30 days of any handbook updates.

10. SUBCONTRACTOR MEMBER HANDBOOKS

ADHS shall provide copies of each subcontractors' member handbook and ADHS' review tool (with corresponding section titles and page numbers of the required items specified in Section D, paragraph 6) and feedback to each subcontractor to AHCCCS annually by December 31st and within 30 days of any handbook updates.

11. PERFORMANCE IMPROVEMENT PROJECTS PROPOSALS AND INTERIM REPORTS

ADHS shall conduct Performance Improvement Projects (PIPs) in accordance with the AHCCCS AMPM Chapter 900 and must comply with all requirements of the AHCCCS AMPM Policy 980 and 990 related to the selection of study topics and submission of all study proposals and interim/final reports.

PIPs begin 60 days after approval by AHCCCS. Baseline data will be included in the initial PIP Proposal to support the rationale for the study topic.

During the first year of the PIP, ADHS will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidenced based approaches to improving performance, as well as any unique factors such as membership, provider network, or GSA specific issues.

ADHS should utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes/interventions quickly and refine them as necessary. It is expected that this process will be implemented in as short a time frame as practical based upon the PIP topic.

AHCCCS will conduct an annual review to evaluate ADHS performance and may conduct interim reviews depending on the resources required to collect and analyze data.

ADHS will conduct a PIP until demonstration of significant improvement and the improvement has been sustained for one year or at AHCCCS' discretion.

After the first year of the PIP, ADHS will report to AHCCCS annually the interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeated measurements. ADHS will utilize the AHCCCS PIP reporting template to submit all reports. Annual reports are due December 15 each year unless otherwise stated by AHCCCS.

ADHS must submit one proposal for an additional Performance Improvement Project annually by September 15th.

12. BUSINESS CONTINUITY AND RECOVER PLAN SUMMARY

In accordance with section D, paragraph 51, ADHS shall submit a Business Continuity and Recovery Plan Summary to AHCCCS no later than 15 days after the effective date of this contract.

13. ADMINISTRATIVE EXPENDITURE PLAN

ADHS shall provide AHCCCS with a plan (annual administrative and expense budget) for allocating cost for the Title XIX and the Title XXI administrative services in accordance with 45 CFR 95.501, Subpart E. This information will be given to AHCCCS by August 15th of the contract year.

14. ANNUAL ADHS/DBHS DRAFT AND CERTIFIED FINANCIAL AUDIT REPORTS

In accordance with section E paragraph 24 contained in this contract, ADHS shall provide AHCCCS annual draft and certified audited financial reports for Title XIX and for Title XXI. The annual certified audit reports shall be prepared by a certified public accountant independent of the contractor, subcontracting entities, their officers or directors, and any affiliates. The draft audited financial statement and restated fourth quarter statement of activities will be due to AHCCCS 120 days after the contract year-end and must be approved by AHCCCS before the certified audit report is finalized. The final certified financial audit, including any management letter, is to be submitted no later than 150 days after the contract year end.

15. CULTURAL COMPETENCY PLAN

In accordance with the AHCCCS Cultural Competency Policy, ADHS must submit a Cultural Competency Plan that includes an annual assessment of the effectiveness of the previous year's plan and any modifications to the plan to the Division of Health Care Management, Behavioral Health Unit, by no later than 45 days after the start of each contract year for review and approval

16. ANNUAL REPORT AND ANALYSIS OF PREVIOUS YEAR CAPITATION RATE REPORT

ADHS shall submit to AHCCCS annually by April 1, a report as described in Section D, paragraph 28, analyzing current activity against significant or key assumptions used in development of current or previous years' capitation rates. The scope of such a report will be mutually agreed upon by ADHS and AHCCCS.

17. RESERVED

18 MEDICAL RECORDS FOR ENCOUNTER VALIDATION STUDIES

When requested by AHCCCS, ADHS must submit the selected medical records to AHCCCS within 90 days of receiving the request. Encounter validation studies are described in further detail in Attachment B.

AD HOC REPORTS

1. REPORTS OF PROVIDER AND MEMBER FRAUD AND ABUSE

As stated in Section D, Paragraph 52, Corporate Compliance, ADHS is required to report all cases of suspected (and actual) fraud and abuse involving AHCCCS members or funds by subcontractors, members or employees immediately and submit report within 10 business days upon discovery by completing the confidential AHCCCS Referral For Preliminary Investigation form

2. SUBCONTRACTOR FINANCIAL REPORTING GUIDE

ADHS shall submit the Subcontractor Financial Review Guide, or any changes to the Guide, to AHCCCS for review and approval.

3. CHANGES IN ADHS KEY STAFF

ADHS shall inform AHCCCS, Division of Health Care Management, in writing within seven days of changes in staffing for all key staff identified in Section D, Paragraph 16.

4. INTERNAL SYSTEM RECONCILIATION

As stated in Section D, Paragraph 37, ADHS shall notify AHCCCS of any problems related with the reconciliation, along with corrective action plans, within 30 days of discovering the issue.

SUMMARY OF DUE DATES

The following table is a summary of the periodic reporting requirements for ADHS 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 ADHS responsibilities in any manner. Content for all deliverables is subject to review; AHCCCS may assess sanctions if it is determined that inaccurate or incomplete data is submitted.

The deliverables listed below are due by 5:00 PM on the due date indicated, if the due date falls on a weekend or a State Holiday the due date is 5:00 PM on the next business day.

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Monthly			
Monthly Capitation Distribution Report	45 Days after receipt of capitation from AHCCCS	Section D, ¶28	Finance Manager
Monthly Grievance System Report (Appeals and Claim Disputes)	Due 75 days after the end of the reporting month	Attachment C, Monthly Reports, ¶4	Operations and Compliance Officer

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Quarterly Reports July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30			
Analysis of Subcontractor Financial Information	Due on or before the 75th day following the end of the quarter being reported)	Attachment C, Quarterly Reports, ¶1	Finance Manager
Subcontractor Financial Statements (Includes Statement of Financial Position, Statement of Activities and Changes in Net Assets, Statement of Cash Flows, Incurred But Not Reported Claims, Financial Statement Footnote Disclosure)	Due on or before the 55th day following end of quarter	Attachment C, Quarterly Reports, ¶2, 3, 4, 5 and 6	Finance Manager

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Quarterly Reports July 1 – Sept. 30 Oct. 1 – Dec. 31 Jan. 1 – March 31 April 1 – June 30			
Showing Report	Due 17 days after the end of quarter	Attachment C, Quarterly Reports, ¶9	DHCM/MM
Quarterly ADHS/DBHS Financial Statements	Due no later than 60 days after the end of the reporting quarter	Attachment C, Quarterly Reports, ¶10	Finance Manager
Quarterly Encounter Valuation	Due no later than 135 days following the quarter for which the comparison was performed	Section D, ¶26 Financial Operations	Finance Manager

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Semi-Annual Reports July 1 – Dec. 31 Jan. 1 – June 30			
Semi-Annual Performance Improvement Report Performance and analysis by GSA or subcontractor on all performance indicators. Children's System of Care, and status updates on performance improvement activities to cover the prior six month time period	Due within 60 days after the end of the semi-annual reporting period	Section D, ¶22 and Attachment C, Semi-Annual Reports, ¶1	DHCM/CQM

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Annual Reports			
Provider Network Development and Management Plan	100 days from the start of the contract year	Attachment C, Annual Reports, ¶1	Operations and Compliance Officer
Subcontractor Financial Audits **Audited Financial Statement Draft** **Restated Fourth Quarter Statement of Activities**	100 days from after the end of Fiscal Year being reported	Attachment C, Annual Reports, ¶2	Finance Manager
Final Annual Subcontractor Financial Audits	130 days following the end of the fiscal year	Attachment C, Annual Reports, ¶2	Finance Manager
Subcontractors Administrative Expenditure Plan	No later than September 1	Attachment C, Annual Reports, ¶2	Finance Manager
Analysis of Subcontractor Financial Information	155 days after end of fiscal year being reported	Attachment C, Annual Reports, ¶2	Finance Manager
Annual summaries of Tribal Subcontractor administrative revenue and expenditures	155 days after end of fiscal year being reported	Attachment C, Annual Reports, ¶2	Finance Manager
Disclosure and Related Party Transaction Statements	130 days after end of subcontractor's fiscal year	Attachment C, Annual Reports, ¶3	Finance Manager
Subcontractor Operational & Financial Reviews	Analysis and findings by February 1	Attachment C, Annual Reports, ¶4	Operations and Compliance Officer
Subcontractor OFR Tool	60 days prior to commencement of the reviews	Attachment C, Annual Reports, ¶4	Operations and Compliance Officer
Subcontractor OFR CAP Status Report (CAP update)	August 1	Attachment C, Annual Reports, ¶4	Operations and Compliance Officer
Quality Management Performance Improvement Plan and Evaluation	September 15	Attachment C, Annual Reports, ¶6	CQM Manager
Medical Management Plan and Evaluation	October 1	Attachment C, Annual Reports, ¶7	MM Manager
Member Survey Proposal	Due 90 days prior to start date of survey	Attachment C, Annual Reports, ¶8	Operations and Compliance Officer
Member Survey Results	June 30	Attachment C, Annual Reports, ¶8	Operations and Compliance Officer
ADHS/DBHS Member Handbook Template	September 15 (and within 30 days of updates)	Section D, ¶6, Attachment C, Annual Reports, ¶9	Operations and Compliance Officer
Subcontractor Member Handbooks and Review Tools	December 31 (and within 30 days of any handbook updates)	Attachment C, Annual Reports, ¶10	Operations and Compliance Officer

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Annual Reports			
Performance Improvement Project (PIP) Interim Report	December 15	Attachment C, Annual Reports, ¶11	DHCM/CQM
Performance Improvement Project (PIP) Proposal	September 15	Attachment C, Annual Reports, ¶11	DHCM/CQM
Business Continuity and Recovery Plan Summary	15 days after effective date of contract	Attachment C, Annual Reports, ¶12	Operations and Compliance Officer
ADHS Administrative Expenditure Plan	August 15 of contract year	Attachment C, Annual Reports, ¶13	Finance Manager
Rate Study - Current provider cost data, financial reports and other documentation to support updating rates	April 1	Section D, ¶33	Reimbursement Manager
Annual Report and Analysis of Previous Year Capitation Rates	April 1	Section D, ¶28, Attachment C, Annual Reports, ¶16	Finance Manager
Proposed Capitation rates & supporting documentation	April 15	Section D, ¶28	Finance Manager
Annual Evaluation & Reconciliation Analysis Report	12 months after FY ending 6/30/09 (60 days after final completed subcontractor audits)	Attachment E, Shared Risk Methodology	Finance Manager
Annual ADHS/DBHS Certified Financial Audit Report	Draft 120 days after end of contract year Final 150 days after end of contract year	Attachment C, Annual Reports, ¶14	Finance Manager
Cultural Competency Annual Plan (w/modifications) and Assessment of Effectiveness	45 days after start of contract year	Attachment C, Annual Reports, ¶15	Operations and Compliance Officer
Medical Records for Encounter Validation Studies	Within 90 days of receiving the request	Attachment C, Annual Reports, ¶18	DHCM/DAR

REPORT	WHEN DUE	SOURCE/ REFERENCE	SEND TO:
Ad Hoc Reports			
Reports of Provider and Member Fraud and Abuse	Upon discovery	Attachment C, Ad Hoc Reports, ¶1	Office of Program Integrity Manager
Subcontractor Financial Reporting Guide	Upon change by BHS	Attachment C, Ad Hoc Reports, ¶2	Finance Manager
Changes in ADHS Key Staff	Within 7 days of change	Attachment C, Ad Hoc Reports, ¶3	Operations and Compliance Officer
Unexpected changes impairing provider network	Within 1 business day of awareness	Section D, ¶18	Operations and Compliance Officer
Proposed revisions to provider selection criteria	Prior to implementation	Section D, ¶18	Operations and Compliance Officer
Advise of significant incidents/accidents	Within 1 day of awareness	Section D, ¶20	DHCM/CQM
Third Party Change Form	10 days from discovery	Section D, ¶34	TPL
Internal Systems Reconciliation	Due 30 days after discovery of a problem or issue	Section D, ¶37	Operations and Compliance Officer
Electronic termination transmittal aging out at 18	Within 1 business day of notification from Subcontractor	Section D, ¶38	Part of the daily Member match file exchange with ISD
Member Match reconciliation summary	Per schedule indicated in the Technical Interface Guidelines (TIG)	Section D, ¶38	Operations and Compliance Officer
Performance Measure Data	As requested by AHCCCS	Section D, ¶20	DHCM/CQM

[END OF ATTACHMENT C]

ATTACHMENT E: SHARED-RISK METHODOLOGY

Capitation Adjustment

AHCCCS may request ADHS to perform re-evaluations of capitation rates up to four times per year and AHCCCS will review and approve any adjustments. AHCCCS will review the capitation rates by subcontractor for the Title XIX and Title XXI programs. AHCCCS may make retrospective and prospective adjustments to the capitation rates for the Title XIX program if there is a total gain or loss of more than five percent (5%) for the subcontractors combined and for the Title XXI program if there is a total gain or loss of more than five percent (5%) for the subcontractors combined.

Annual Evaluation and Reconciliation

Sixty days after the final subcontractor audits for the fiscal year ending 2009 are completed, ADHS shall perform an analysis of the profit or loss of each subcontractor for the Title XIX and Title XXI programs. ADHS should consider the following in their review methodology: analysis of subcontractor encounters and review and analysis of subcontractor IBNRs for appropriateness. Upon completion of the analysis and submission of the report to AHCCCS, not later than 12 months after the end of the fiscal year, any profits or losses in excess of five percent (5%) for Title XIX and five percent (5%) for Title XXI will be returned to AHCCCS (profits) or reimbursed to ADHS (losses).

[END OF ATTACHMENT E]

ATTACHMENT F (1): ENROLLEE GRIEVANCE SYSTEM

ADHS shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F,Title 9 Chapter 34 of the AHCCCS Administrative Rules, and ACOM Policies. ADHS shall provide the *Enrollee Grievance System Policy* to all providers and subcontractors at the time of contract. ADHS shall also furnish this information to behavioral health recipients within a reasonable time after ADHS receives notice of the behavioral health recipient's enrollment. Additionally, ADHS 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 behavioral health recipients describing the Grievance System including the grievance process, enrollee rights, grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the subcontractor's service area and in an easily understood language and format. ADHS shall inform behavioral health recipients that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how behavioral health recipients may obtain this information.

Written documents, including but not limited to the Notice of Action, the Notice of Appeal Resolution, Notice of Extension for Resolution, and Notice of Extension of Notice of Action shall be promptly translated in the behavioral health recipient's prevalent non-English language if information is received by the Contractor, orally or in writing, indicating that an enrollee has a limited English proficiency in the prevalent non-English language. If such information is not otherwise received by the Contractor, these documents shall be translated in the prevalent non-English language(s) or shall contain information in the prevalent non-English language(s) advising the enrollee that the information is available in the prevalent non-English language(s) and in alternative formats along with an explanation of how enrollees may obtain this information. This information must be in large, bold print appearing in a prominent location on the first page of the document.

At a minimum, ADHS' Grievance System Standards and Policy shall specify:

1. That ADHS shall maintain records of all grievances and appeals.

2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes describing the right to hearing, the method for obtaining a hearing, the rules which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal.

3. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone if requested by the enrollee.

4. That the Contractor shall acknowledge receipt of each grievance and appeal, to include legal representation. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.

5. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

6. That the Contractor shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the enrollee's condition or disease.

7. The resolution timeframes for grievances, standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.

8. That if the Contractor extends the timeframe for resolution of an appeal when not requested by the enrollee, the Contractor shall provide the enrollee with written notice of the reason for the delay.

9. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.

10. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with the AHCCCS Administration.

11. That the Contractor must dispose of each grievance in accordance with the ACOM *Enrollee Grievance Policy*, but in no case shall the timeframe exceed 90 days.

12. The definition of action as the [42 CFR 438.400(b)]:

    a. Denial or limited authorization of a requested service, including the type or level of service;
    b. Reduction, suspension, or termination of a previously authorized service;
    c. Denial, in whole or in part, of payment for a service;
    d. Failure to provide services in a timely manner;
    e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
    f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

13. The definition of a service authorization request as an enrollee's request for the provision of a service [42 CFR 431.201].

14. The definition of appeal as the request for review of an action, as defined above.

15. Information explaining that a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.

16. That an enrollee may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of the Contractor to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii) when the Contractor is the only Contractor in the rural area.

17. The definition of a standard authorization request and that for standard authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's best interest [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial or an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

18. The definition of an expedited authorization request and that for expedited authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 3 business days following the receipt of the authorization request with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest.

19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the contractor must give the

enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

20. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider must be in writing.

21. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

22. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal. If a Notice of Appeal Resolution is not completed when the timeframe expires, the member's appeal shall be considered to be denied by the Contractor, and the member can file a request for hearing.

23. That if the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. The Contractor must make reasonable efforts to give the enrollee prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.

24. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.

25. That the Contractor must mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 5 days before the date of action in the case of suspected fraud; 3) at the time of any action affecting the claim when there has been a denial of payment for a service, in whole or in part; 4) within 14 days from receipt of a standard service authorization request and within three business days from receipt of an expedited service authorization request unless an extension is in effect. For service authorization decisions, the Contractor must also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail the Notice of Action no later than the date of action when:

    a. The Contractor receives notification of the death of an enrollee;
    b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
    c. The enrollee is admitted to an institution where he is ineligible for further services;
    d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address; or
    e. The enrollee has been accepted for Medicaid in another local jurisdiction.

26. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.

27. That the Notice of Action must explain: 1) the action the Contractor has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to request continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services. The Notice of Action shall comply with ACOM Policy 414.

28. That benefits shall continue until an AHCCCS hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the Contractor's action, 2) the appeal involves a) the termination, suspension, or reduction of a previously authorized course of treatment and the original period covered by the authorization has not expired, b) a denial of a previously authorized service and a licensed provider asserts the requested service or treatment is a necessary continuation of a previously authorized service, or c) a denial of a reauthorization of a previously authorized service that does not require reorder from a provider and the provider asserts that the service or treatment is a necessary continuation of a previously authorized service3) the services were ordered by an authorized provider, and 4) the enrollee requests a continuation of benefits. For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction or suspension which has been appealed.

29. That for appeals, the Contractor provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that the Contractor informs the enrollee of the limited time available in cases involving expedited resolution.

30. That for appeals, the Contractor provides the enrollee and his representative the opportunity before and during the appeals process to examine the enrollee's case file including medical records and other documents considered during the appeals process.

31. That the Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.

32. That the Contractor shall provide written Notice of Appeal Resolution to the enrollee and the enrollee's representative or the representative of the deceased enrollee's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of enrollees: a) the enrollee's right to request a State fair hearing (including the requirement that the enrollee must file the request for a hearing in writing) no later than 30 days after the date the enrollee received the Contractor's notice of appeal resolution and how to do so, b) the right to receive benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds the Contractor.

33. That the Contractor continues extended benefits originally provided to the enrollee until any of the following occurs: 1) the enrollee withdraws appeal, 2) the enrollee has not specifically requested continued benefits pending a hearing decision within 10 days of the Contractor mailing of the appeal resolution notice, or 3) the AHCCCS Administration issues a state fair hearing decision adverse to the enrollee.

34. That if the enrollee files a request for hearing, the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services (OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:

    a. Enrollee's name;
    b. Enrollee's AHCCCS I.D. number;
    c. Enrollee's address;
    d. Enrollee's phone number (if applicable);
    e. Date of receipt of the appeal;
    f. Summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution.

35. The following material shall be included in the file sent by the Contractor:

    a. The Enrollee's written request for hearing;
    b. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
    c. The Contractor's Notice of Appeal Resolution (as defined in paragraph 32, above);
    d. Other information relevant to the resolution of the appeal.

36. That if the Contractor or the State fair hearing decision reverses a decision to deny, limit, terminate, or delay services not furnished during the appeal or during the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires irrespective of whether the Contractor contests the decision.

37. That if the Contractor or the Director's Decision reverses a decision to deny, terminate, reduce or suspend 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 Contractor shall not deny the provider's request for reimbursement on the same basis as the reversed decision or for lack of prior authorization. The Contractor shall allow the provider the longer of 1) the timeframes described in ARS §36-2904 or 2) 60 days from the date of the decision to submit a clean claim to the Contractor unless the Director's Decision specifies otherwise. Contractors are also prohibited from denying claims submitted as a result of a reversed decision because the member failed to request continuation of services during the appeals/hearing process: a member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

38. That if the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor may recover the cost of those services from the enrollee. **[END OF ATTACHMENT F (1)]**

ATTACHMENT F (2): PROVIDER CLAIM DISPUTE SYSTEM STANDARDS AND POLICY

ADHS shall have in place a written claim dispute system policy for providers regarding adverse actions taken by ADHS. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claim dispute policy shall include the following provisions:

1. The provider claim dispute system policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim dispute system policy may be mailed with a remittance advice, provided the remittance is sent within 45 days of receipt of a claim.

2. The provider claim dispute system policy must specify that all claims disputes (as defined in R 9-34-402), with the exception of those challenging claim denials, must be filed with ADHS no later than 60 days from the date of the adverse action. Claim disputes challenging claim denials must be filed in writing with the ADHS no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the denial of a timely claim submission, whichever is later.

3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute system process.

4. A log is maintained for all claim disputes containing sufficient information to identify the Provider, date of receipt, nature of the claim dispute and the date the claim dispute is resolved. Separate logs must be maintained for provider claim disputes and behavioral health recipient claim disputes.

5. Within five business days of receipt, the Provider is informed by letter that the claim dispute has been received.

6. Each claim dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.

7. All documentation received by the Contractor during the claim dispute process is dated upon receipt.

8. All claim disputes are filed in a secure designated area and are retained for five years following the Contractor's decision, the Administration's decision, judicial appeal or close of the claim dispute, whichever is later, unless otherwise provided by law.

9. The Contractor shall mail a written Notice of Decision of the claim dispute to the provider no later than 30 days after the provider files the claim dispute with the Contractor unless the provider and the Contractor agree to a longer period not to exceed a total of 60 days from the date of receipt.

10. A copy of the Contractor's Notice of Decision ("Decision") will be communicated in writing to all parties. The Decision must include and describe in detail, the following:

    a. The nature of the claim dispute;
    b. The issues involved;
    c. The reasons supporting the Contractor's Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure;
    d. The Provider's right to request a hearing by filing the request for hearing to the Contractor no later than 30 days after the date the provider receives the Contractor's Decision;
    e. If the claim dispute is upheld, 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.

11. If the provider files a request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCS, Office of Administrative Legal Services, no later than five business days from the date the Contractor receives the verbal or written request from AHCCCS, Office of Administrative Legal Services. The file sent by the Contractor must contain a cover letter that includes:

a. Provider's name;
b. Provider's AHCCCS ID number;
c. Provider's address;
d. Provider's phone number (if applicable);
e. The date of receipt of the claim dispute;
f. A summary of the Contractor's actions undertaken to resolve the claim dispute and basis of the determination.

12. The following material shall be included in the file sent by the Contractor:

    a. Written request for hearing filed by the Provider;
    b. Copies of the entire file which includes pertinent records; and the Contractor's Decision;
    c. Other information relevant to the Notice of Decision of the claim dispute.

13. If the Contractor's Decision regarding a claim dispute is reversed through the appeal process, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision unless a different timeframe is specified..

[END OF ATTACHMENT F (2)]

ATTACHMENT G: BEHAVIORAL HEALTH SERVICES GUIDE

This document is also available on the AHCCCS Website at:

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

ATTACHMENT H: TECHNICAL INTERFACE GUIDELINES

This document is also available on the AHCCCS Website at:

http://www.azahcccs.gov/commercial/ContractorResources/TIG/default.htm

ATTACHMENT I: PERFORMANCE MEASURES METHODOLOGIES

The ADHS/DBHS Quality Management Performance Measures are defined as follows:

Access to Care

Description

The percent of AHCCCS members referred for or requesting behavioral health services for whom the first service was provided within 23 days of the initial assessment.

Denominators:

1) All AHCCCS-enrolled children and adolescents (up to age 21) who had an initial assessment during the measurement period
2) All AHCCCS-enrolled adults (age 21 and older) who had an initial assessment during the measurement period

Numerators:

1) All AHCCCS-enrolled children and adolescents in the denominator who received a behavioral health service within 23 days of initial assessment during the measurement period
2) All AHCCCS-enrolled adults in the denominator who received a behavioral health service within 23 days of initial assessment during the measurement period

Population: All Title XIX and Title XXI recipients

Population Exclusions: Recipients not identified as eligible under Title XIX or Title XXI

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected by DBHS from ADHS' Demographic System, and will identify AHCCCS-enrolled members as either eligible under Title XIX or Title XXI. Numerator data will be collected from encounters, according to specific service codes, as approved by AHCCCS.

Data Collection Process: DBHS will collect denominator and numerator data from its Client Information System (CIS). All recipients enrolled as "Title XIX/XXI" in ADHS' Demographic System with an assessment encounter during the measurement period will be collected for the denominator. Encounter data, allowing for a 90-day claims lag from the end of the measurement period, will be used to identify the dates of assessment and first behavioral health service in calculating the numerator for this measure.

The following codes will be used to identify an assessment:

- CPT Codes: 90801, 90802, 90885, 96100, 96101, 96102, 96103, 96110, 96111, 96115, 96116, 96117, 96118, 96119, 96120, 99241, 99242, 99243, 99244, 99245, 99271, 99272, 99273, 99274, 99275
- HCPCS Codes: H0002, H0031

Services in the following behavioral health service categories will be excluded from the numerator if they occur on the same day as the assessment:

- A.2. Assessment, Evaluation and Screening Services
- B.3. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
- B.4. Psychoeducational Services and Ongoing Support to Maintain Employment
- C.2. Laboratory, Radiolology and Medical Imaging
- C.4. Electro-Convulsive Therapy
- D.1. Case Management

- D.8. Sign Language or Oral Interpretive Services
- D.9. Non-Medically Necessary Covered Services (Flex Fund Services)
- D.10. Transportation
- G.3. Mental Health Services NOS (Room and Board)
- I. Prevention Services

Analysis Plan: ADHS/DBHS will calculate the number of days between the assessment date and the first service for each AHCCCS member. The overall rate for the measure will be calculated by dividing the number of AHCCCS-enrolled members who received clinical services 23 days or less from the initial assessment date by the total number of AHCCCS-enrolled members.

$$\frac{\text{Number of TXIX/TXXI Recipients with <=23 days from Assessment Date to Date of First Behavioral Health Service}}{\text{Total Number of TXIX/TXXI Recipients}}$$

Results will be analyzed and reported separately by DBHS to AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

Data Elements to be Reported: DBHS will report to AHCCCS denominators, numerators and percentage rates separately for Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for the child/adolescent and adult populations.

Data Validation: AHCCCS conducts data validation studies of DBHS encounters to determine the timeliness and correctness of data. The CIS contains pre-processor edits to ensure encounter data accuracy and DBHS conducts random data validation of encounters against behavioral health recipient medical charts.

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

Behavioral Health Service Plan

Description

The percent of AHCCCS members with current service plans that incorporate the needs and service recommendations identified in their assessments.

Denominators:

1) AHCCCS-enrolled children and adolescents (up to age 21) who were continuously enrolled for at least 90 days preceding the quarter in which the medical record review is conducted
2) AHCCCS-enrolled adults (age 21 and older) who were continuously enrolled for at least 90 days preceding the quarter in which the medical record review is conducted

Numerators:

1) AHCCCS-enrolled children and adolescents in the denominator with a current service plan that incorporates the needs and service provision recommendations identified in their assessment
2) AHCCCS-enrolled adults in the denominator with a current service plan that incorporates the needs and service provision recommendations identified in their assessments

Population: All Title XIX and Title XXI recipients who were continuously enrolled for at least 90 days immediately preceding the quarter in which the medical record review is conducted will be eligible for inclusion in the denominator, regardless of whether there is documentation of a current and complete assessment.

Population Exclusions:
1) Recipients not identified as eligible under Title XIX or Title XXI during all or part of the period being reviewed
2) Recipients who were not continuously enrolled for at least 90 days during the period being reviewed

Sample Selection: DBHS will select a representative random sample of Title XIX and Title XXI recipients, stratified by age group (younger than 21 years and ages 21 and older) and by GSA who meet the denominator criteria during the measurement period. The sample will be selected for each age group and GSA to provide a 90-percent confidence level and 10-percent confidence interval. Random sampling will be based on prior year study results, national benchmarks or published studies to ensure a statistically valid sample.

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected from the Client Information System (CIS) Demographic Data Set.

Numerator data will be collected through medical record reviews from the following sources:
1) The initial or annual assessment
2) The individual service plan

Data Collection Process: ADHS/DBHS will collect data for the denominator from its Client Information System (CIS) Demographic Data Set. From this sample frame, DBHS will select a statistically valid sample for the measure.

Numerator data will be collected via a two-step process:
1) ADHS/DBHS will determine which members will require medical record review, based on those recipients with current assessments in the CIS (members without current assessments will remain in the denominator, and will be counted as not meeting numerator criteria).
2) Medical record reviews will be conducted for those members who have current (initial or annual) assessments.

The ADHS/DBHS Office of Monitoring and Oversight will conduct the review of medical records. Service plan data will be collected using a standardized review tool and will be stored in an electronic database.

Using the standardized tool, reviewers with appropriate clinical knowledge and training in data collection procedures will determine whether:
1) the assessment is complete, and
2) the service plan incorporates the needs and service recommendations identified in the assessment.

Both criteria must be met in order to meet numerator criteria for this measure.

Data will be collected quarterly for AHCCCS members enrolled with Regional Behavioral Health Authorities (RBHAs) who met the sample frame criteria. Data for AHCCCS members enrolled with Tribal Behavioral Health Authorities (T/RBHAs) will be collected semiannually.

Analysis Plan: The rate for this measure will be calculated by dividing the number of charts reviewed that contained documentation of the needs and service recommendations identified in the assessment by the total number of charts reviewed.

$$\frac{\text{Number of Charts with a Service Plan Containing Documentation of Needs and Service Recommendations as Identified in the Assessment}}{\text{Total Number of Charts Reviewed}}$$

Results will be analyzed and reported separately by DBHS to AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

Data Elements to be Reported: DBHS will report to AHCCCS denominators, numerators and percentage rates separately for Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for the child/adolescent and adult populations.

As part of its analysis, DBHS also should report the number of members in the denominator who did not meet numerator criteria because they did not have current assessments.

Data Validation: DBHS will continue to conduct inter-rater reliability (IRR) studies for all staff involved in data collection after each review to ensure consistency in scoring and validity of data. DBHS will continue to provide retraining for any staff whose IRR scores deviate significantly from the mean or standard established for the criteria rated. Results of IRR studies are subject to review by AHCCCS.

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

Behavioral Health Service Provision

Description

The percent of AHCCCS members who received the services that were recommended in their service plans.

Denominators:
1) AHCCCS-enrolled children and adolescents (up to age 21) with current service plans that incorporated the needs and service recommendations identified in their assessments (Behavioral Health Service Plan numerator #1)
2) AHCCCS-enrolled adults (age 21 and older) with current service plans that incorporated the needs and service recommendations identified in their assessments (Behavioral Health Service Plan numerator #2)

Numerators:
1) AHCCCS-enrolled children and adolescents in the denominator who received all the services recommended in their most recent service plan
2) AHCCCS-enrolled adults in the denominator who received all the services recommended in their most recent service plan

Population: All Title XIX or Title XXI recipients who met the numerator criteria for the Behavioral Health Service Plan measure

Population Exclusions:
Recipients who did not meet the numerator criteria for the Behavioral Health Service Plan measure

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected from the numerator for the Behavioral Health Service Plan measure.

Numerator data will be collected from encounters for behavioral health services.

Data Collection Process: ADHS/DBHS will collect data for the denominator from the electronic database used to determine numerator compliance for the Behavioral Health Service Plan measure.

Numerator data will be collected from encounters for each recipient. DBHS will map fields and values for services recommended in the service plan to the appropriate CPT and HCPCS codes for behavioral health services, in order to match recommended services with encounter data. To meet numerator criteria, all services recommended in the service plan must have been provided during the measurement year, with dates of service on or after the date the service plan was completed.

Analysis Plan: The rate for this measure will be calculated by dividing the number of AHCCCS members who received all the services recommended in their most recent service plan, as documented through encounter data, by the total number of members with current and complete service plans.

$$\frac{\text{Number of AHCCCS Members who Received All Services Recommended in their Most Recent Service Plan}}{\text{Total Number of Members with Current Service Plans (Behavioral Health Service Plan Numerator)}}$$

Results will be analyzed and reported separately by DBHS to AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

Data Elements to be Reported: DBHS will report to AHCCCS denominators, numerators and percentage rates separately for Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for the child/adolescent and adult populations.

Data Validation: ADHS/DBHS will validate encounter data through review of a statistically valid sample of members' corresponding medical records.

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

Coordination of Care #1 (Disposition of Referral)

Description

The percent of AHCCCS members for whom disposition of the referral is communicated to the PCP or Health Plan within 45 days of initial assessment or, if behavioral health services are declined, within 45 days of the referral.

Denominators:
1) AHCCCS-enrolled children and adolescents (up to age 21) who were referred for services from ADHS/DBHS during the measurement period
2) AHCCCS-enrolled adults (age 21 and older) who were referred for services from ADHS/DBHS during the measurement period

Numerators:
1) AHCCCS-enrolled children and adolescents in the denominator for whom disposition of the referral was communicated to the PCP or Health Plan within 45 days of initial assessment or, if behavioral health services were declined, within 45 days of the referral
2) AHCCCS-enrolled adults in the denominator for whom disposition of the referral was communicated to the PCP or Health Plan within 45 days of initial assessment or, if behavioral health services were declined, within 45 days of the referral

Population: All Title XIX and Title XXI recipients who were referred by an AHCCCS PCP or Health Plan during the measurement period

Population Exclusions:
Recipients not identified as eligible under Title XIX or Title XXI
Recipients with missing or erroneous data in the Referral Source field on the Referral Log
Recipients with missing or erroneous data in the Referral Date field on the Referral Log

Sample Selection: Based on the current number of referrals from PCPs and AHCCCS health plans, all members meeting denominator criteria will be included in the measure. If the number of referrals increases to a level that warrants sampling, DBHS may select a representative random sample of Title XIX and Title XXI recipients, stratified by age group (younger than 21 years and ages 21 and older) and by GSA who were referred for behavioral health services during the measurement period. The sample will be selected for each age group and GSA to provide a 90-percent confidence level and 10-percent confidence interval. Random sampling may be based on prior year study results.

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected by DBHS from ADHS' Demographic System, via RBHA-submitted referral logs (Referral Source Code 35), and will identify AHCCCS-enrolled members as either eligible under Title XIX or Title XXI. Numerator data will be collected from chart reviews.

Data Collection Process: DBHS will provide a list of sample members to each RBHA, which will conduct medical record reviews for members in the sample to determine if there is evidence that the disposition of the referral was sent to the referring PCP or Health Plan as required. RBHAs will submit the results to DBHS electronically using a report template developed by DBHS and approved by AHCCCS.

To meet numerator criteria, at least one of the following must be evidenced in the record:
1) ADHS/DBHS PM Form 4.3.1, Communication Document, completed in its entirety
2) Progress Note, dated and typed or legibly written, that clearly identifies the occurrence of required communication with the AHCCCS PCP/Health Plan, including the date, time and place of the scheduled intake appointment or, if the person declines behavioral health services, the reason why.

Analysis Plan: The overall rate for the measure will be calculated by dividing the number of AHCCCS-enrolled members with documentation in their medical charts that disposition of the referral was communicated to the PCP or Health Plan within 45 days of initial assessment or, if behavioral health services were declined, within 45 days of the referral, by the total number of AHCCCS-enrolled members in the denominator.

$$\frac{\text{Number of Charts Containing Documentation that Disposition of Referral was Communicated to AHCCCS PCP or Health Plan}}{\text{Total Number of Charts Reviewed}}$$

Results will be analyzed and reported separately by DBHS to AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

DBHS also should report to AHCCCS the number of records with missing or erroneous data for the following fields:

- Title XIX/Title XXI – Number of records with "Unknown" values separately by child/adolescent and adult populations
- Referral Source - Number of records with missing or erroneous data separately by child/adolescent and adult populations
- Referral Date - Number of records with missing or erroneous data separately by child/adolescent and adult populations

Data Validation: ADHS/DBHS will continue to review T/RBHA-submitted referral logs for completeness and accuracy of data submitted. Errors will be identified as erroneous or missing data in any of the referral log fields, except BHS Client ID. Error rates cannot exceed 5% per GSA.

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

Coordination of Care #2 (Communication)

Description

The percent of AHCCCS members for whom behavioral health service providers communicate behavioral health clinical and contact information with the member's Primary Care Physician (PCP) and/or Health Plan

Denominators:
1) AHCCCS-enrolled children and adolescents (up to age 21) with an Axis III diagnosis who were referred by an AHCCCS PCP or Health Plan during the measurement period
2) AHCCCS-enrolled adults (age 21 and older) with an SMI and/or Axis III diagnosis who were referred by an AHCCCS PCP or Health Plan during the measurement period

Numerators:
1) AHCCCS-enrolled children and adolescents in the denominator whose records contain documentation of communication of behavioral health clinical and contact information with his or her Primary Care Physician (PCP) and/or Health Plan during the measurement period
2) AHCCCS-enrolled adults in the denominator whose records contain documentation of communication of behavioral health clinical and contact information with his or her Primary Care Physician (PCP) and/or Health Plan during the measurement period

Population: Title XIX and Title XXI Children with an Axis III diagnosis and Title XIX and Title XXI Adults with an SMI and/or Axis III diagnosis who were referred by an AHCCCS PCP or Health Plan during the measurement period

Population Exclusions:
Recipients not identified as eligible under Title XIX or Title XXI
Recipients with missing or erroneous data in the Referral Source field on the Referral Log
Recipients with missing or erroneous data in the Referral Date field on the Referral Log

Sample Selection: DBHS will select a representative random sample of Title XIX and Title XXI recipients, stratified by age group (younger than 21 years and ages 21 and older) and by GSA who met the denominator criteria during the measurement period. The sample will be selected for each age group and GSA to provide a 90-percent confidence level and 5-percent confidence interval. Random sampling will be based on prior year study results, national benchmarks or published studies to ensure a statistically valid sample.

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected by DBHS from ADHS' Demographic System, via RBHA-submitted referral logs (Referral Source Code 35), and will identify AHCCCS-enrolled members as either eligible under Title XIX or Title XXI. Numerator data will be collected from chart reviews.

Data Collection Process: DBHS will provide a list of sample members to each RBHA, which will conduct record reviews for members in the sample to determine if there is evidence that behavioral health service providers communicated information to the member's Primary Care Physician (PCP) and/or Health Plan, as required by ADHS. RBHAs will submit the results to DBHS electronically using a report template developed by DBHS and approved by AHCCCS.

To meet numerator criteria, at least one of the following must be evidenced in the record:
1) ADHS/DBHS Referral for Behavioral Health Services PM Form 4.3.1, Communication Document, completed in its entirety or another form that is required/approved by ADHS/DBHS
2) Progress Note, dated and typed or legibly written, that clearly documents the occurrence of required communication of behavioral health clinical information, including diagnosis(es) and strength and dosage of prescribed medication(s) and behavioral health provider contact(s)

Analysis Plan: The overall rate for the measure will be calculated by dividing the number of AHCCCS-enrolled members with documentation of communication with the member's Primary Care Physician (PCP) and/or Health Plan by the total number of AHCCCS-enrolled members in the denominator.

$$\frac{\text{Number of Charts Containing Documentation of Communication with AHCCCS PCP/Health Plan}}{\text{Total Number of Charts Reviewed}}$$

Results will be analyzed and reported separately by DBHS to AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

Data Validation: AHCCCS may identify a statistically significant random sample of recipients who meet the numerator criteria and either request DBHS to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on-site visits.

Follow Up after Hospitalization for Mental Illness

Description
The percent of discharges for members age 6 years and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit or partial hospitalization with a behavioral health practitioner, based on Healthcare Effectiveness Data and Information Set (HEDIS) criteria. Two rates will be reported:
1) Members who received follow up within 30 days of discharge
2) Members who received follow up within seven days of discharge

Denominators:

1) The total number of discharges among AHCCCS-enrolled children and adolescents (up to age 21) who were continuously enrolled with ADHS/DBHS during the measurement period and were discharged from an acute inpatient setting with a principal mental health diagnosis during the measurement period
2) The total number of discharges among AHCCCS-enrolled adults (age 21 and older) who were continuously enrolled with ADHS/DBHS during the measurement period and were discharged from an acute inpatient setting with a principal mental health diagnosis during the measurement period

Note: The denominators for this measure are based on discharges, not unduplicated members; all discharges meeting denominator criteria will be included

Numerators:
1) The number of outpatient visits, intensive outpatient encounters and/or partial hospitalizations among AHCCCS-enrolled children and adolescents in the denominator that occurred on the date of discharge or within 30 days of discharge
2) The number of outpatient visits, intensive outpatient encounters and/or partial hospitalizations among AHCCCS-enrolled children and adolescents in the denominator that occurred on the date of discharge or within 7 days of discharge
3) The number of outpatient visits, intensive outpatient encounters and/or partial hospitalizations among AHCCCS-enrolled adults in the denominator that occurred on the date of discharge or within 30 days of discharge
4) The number of outpatient visits, intensive outpatient encounters and/or partial hospitalizations among AHCCCS-enrolled adults in the denominator that occurred on the date of discharge or within 7 days of discharge

Note: Codes to identify mental health diagnoses and non-acute services are included in current HEDIS technical specifications

Population: Title XIX and Title XXI AHCCCS members continuously enrolled with ADHS/DBHS during the measurement period

Population Exclusions:
Recipients not identified as eligible under Title XIX or Title XXI
Recipients who were not continuously enrolled with ADHS/DBHS during the measurement period (i.e., had any gap in enrollment)
Recipients who were readmitted or directly transferred to a non-acute facility for any principal health diagnosis within the 30-day follow-up period.

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected from AHCCCS recipient data and from encounters to identify discharges and the related qualifying diagnoses, according to HEDIS specifications. Numerator data will be collected from encounters, according to HEDIS specifications.

Data Collection Process: Data will be collected through the AHCCCS Data Decision Support (ADDS) data warehouse using the MeasureBase program.

Analysis Plan: The overall rate for the measure will be calculated by dividing the number of discharges among AHCCCS-enrolled members in the denominator with encounters for qualifying follow-up services within 30 days and within 7 days of discharge, by the total number of AHCCCS-enrolled members in the denominator.

$$\frac{\text{Number with Qualifying Follow-up Services within 30 Days of Discharge}}{\text{Total Number of Discharges (Children/Adolescents or Adults)}}$$

$$\frac{\text{Number with Qualifying Follow-up Services within 7 Days of Discharge}}{\text{Total Number of Discharges (Children/Adolescents or Adults)}}$$

Results will be analyzed and reported separately for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by geographic service area (GSA).

Data Validation: AHCCCS conducts data validation studies of DBHS' encounter data to determine the overall completeness and accuracy of encounters. AHCCCS also may identify a statistically significant random sample of recipients who meet the numerator criteria and either request DBHS to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on-site visits.

Treatment of Depression

Description:
The percent of continuously enrolled AHCCCS members diagnosed with major depressive disorder of mild subtype who received an antidepressant medication or psychotherapy during the measurement period

Denominators:
1) The number of AHCCCS-enrolled children and adolescents (up to age 21) who were continuously enrolled with ADHS/DBHS and who had a current diagnosis of major depression that is mild (296.21) and not chronic during the measurement period
2) The number of AHCCCS-enrolled adults (age 21 and older) who were continuously enrolled with ADHS/DBHS and who had a current diagnosis of major depression that is mild (296.21) and not chronic during the measurement period

Numerators:
1) The number of AHCCCS-enrolled children and adolescents in the denominator who received an antidepressant medication or psychotherapy during the measurement period
2) The number of AHCCCS-enrolled adults in the denominator who received an antidepressant medication or psychotherapy during the measurement period
Note: Services provided through Acute-care health plans will be counted in the numerator

Population: Title XIX and Title XXI AHCCCS members continuously enrolled with ADHS/DBHS during the measurement period

Population Exclusions:
Recipients who did not meet diagnosis criterion during the measurement period.
Recipients not identified as eligible under Title XIX or Title XXI
Recipients who were not continuously enrolled with ADHS/DBHS during the measurement period (i.e., had a gap in enrollment that resulted in less than 11 member months of enrollment with a T/RBHA))

Measurement Period: July 1, 2009, through June 30, 2010

Data Sources: Denominator data will be collected from AHCCCS recipient data and from encounters to identify the qualifying diagnosis. Numerator data will be collected from pharmacy data and encounters.

Data Collection Process: : Data will be collected through the AHCCCS Data Decision Support (ADDS) data warehouse

Analysis Plan: The overall rate for the measure will be calculated by dividing the number of AHCCCS-enrolled members in the denominator with encounters for qualifying services during the measurement period, by the total number of AHCCCS-enrolled members in the denominator.

$$\frac{\text{Number of Members with Antidepressant Medications or Psychotherapy Services}}{\text{Total Number of Members with Qualifying Diagnosis}}$$

Results will be analyzed and reported separately by AHCCCS for the child/adolescent and adult populations. Results also will be analyzed and reported by Title XIX and Title XXI eligibility for the child/adolescent population, and by T/RBHA by geographic service area (GSA) for both the child/adolescent and adult populations.

Data Validation: AHCCCS conducts data validations studies of DBHS' encounter data to determine the overall completeness and accuracy of encounters. AHCCCS also may identify a statistically significant random sample of recipients who meet the numerator criteria and either request DBHS to provide medical chart or other hard copy documentation for validation purposes, or perform such validation through on-site visits.