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

SECTION A. CONTRACT AMENDMENT

AMENDMENT NUMBER:	CONTRACT NUMBER:	EFFECTIVE DATE OF AMENDMENT:	PROGRAM:
34	AHCCCS # **YH6-0014** DES # **E 2005004**	**July 1, 2009**	**ALTCS/DDD**

CONTRACTOR'S NAME AND ADDRESS: Brian Lensch - ALTCS Liaison
DES/DDD, Site Code 791-A
Arizona Department of Economic Security
1789 W. Jefferson Street
Phoenix, AZ 85007

PURPOSE OF AMENDMENT: To renew the contract term for an additional 12 months effective July 1, 2009 and to amend Section B Capitation Rates , Section D, Program Requirements and Section F, Atachment B(1), Enrollee Grievance System, and Attachment D, Chart of Deliverables.

THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

7. The contract referenced above is amended as follows:

   A. SECTION B - CAPITATION RATES: Rates have been revised for the new contract term, July 1, 2009 through June 30, 2010. See Section B, Capitation Rates for details.

   B. SECTION C - DEFINITIONS: No change.

   C. SECTION D - PROGRAM REQUIREMENTS: In accordance with Section E, Paragraph 26 "Changes", various changes in contract requirements in Section D are indicated in this contract restatement. Paragraph 25, Staff Requirements and Support Services contains revised language. "All staff" has been changed to "all key staff and case managers" in the Staff Training and Meeting Attendance section. Paragraph 26, Written Policies, Procedures and Job Descriptions has been revised to include the submittal of a quarterly update of progress made for incorporating Administrative Directives into DDD's Policy Manual. Paragraph 28, Network Development has had the paragraph that references the AzEIP program removed as this does not apply to DDD. Paragraph 36, Hospital Subcontracting and Reimbursement contains a technical correction (change UB92 to UB04). Paragraph 44, Claims Payment/Health Information System contains a new paragraph concerning the reversal of a decision by DES/DDD or the Director's Decision to deny, terminate, reduce or suspend authorization of services. Additionally, Paragraph 44 has had the submittal of the monthly Claims Dashboard Report removed and replaced with claims information that DES/DDD will submit quarterly. Also in Paragraph 44 the outdated report of claims requirements due to AHCCCS within the first 6 months of the CYE 09 Contract Year has been removed. Paragraph 57 was revised to require DES/DDD to submit to AHCCCS the budget submittal they provide to the Office of Strategic Planning and Budget.

   D. SECTION E – CONTRACT TERMS AND CONDITIONS: No change.

   E. SECTION F – LIST OF ATTACHMENTS: Attachment B(1), Enrollee Grievance System contains revised language in items 36 and 37 to conform with Section D, 44. Attachment D, Chart of Deliverables has been updated to reflect current work units and revised due dates for the Draft and Final Audited Financial Statements and the quarterly Administrative Directives report.

Note: *Please sign, date and return one original to:*

Jamey Schultz
AHCCCS Contracts & Purchasing
701 E. Jefferson, MD5700
Phoenix, Arizona 85034

EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT. IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.

CONTRACTOR: DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES SIGNATURE OF AUTHORIZED REPRESENTATIVE:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM SIGNATURE OF AHCCCS CONTRACTING OFFICER:
TYPED NAME: **ELIZABETH G. CSAKI**	TYPED NAME: **MICHAEL VEIT**
TITLE: **PROCUREMENT MANAGER**	TITLE: **CONTRACTS & PURCHASING ADMINISTRATOR**
DATE:	DATE:

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SECTION B - CAPITATION RATES

DES/DDD shall provide services as described in this contract. In consideration for the provision of services, DES/DDD will be paid in as shown below for the term July 1, 2009 through June 30, 2010.

CAPITATION RATES
(Per Member Per Month)

DDD Rate

A. Long Term Care	$3,499.67
B. Behavioral Health	$100.64 (Blended Rate)
C. Targeted Case Management Rate	$139.57

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

SECTION C - DEFINITIONS

A.A.C.	Arizona Administrative Code. State regulations established pursuant to relevant statutes. Referred to in Contract as "AHCCCS Rules".
ABUSE (OF MEMBER)	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.
ABUSE (BY PROVIDER)	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
ACOM	*AHCCCS Contractor Operations Manual* available on the AHCCCS website at www.azahcccs.gov
ADHS	Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
ADJUDICATED CLAIM	Claims which have been received and processed by the Program Contractor which resulted in payment or denial of payment.
ADMINISTRATION	The Arizona Health Care Cost Containment System Administration, its agents, employees, and designated representatives, as defined in 9 A.A.C. 22, Article 1.
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 in A.R.S. § 36-2902, et seq.
AHCCCS	Arizona Health Care Cost Containment System Administration
AIHP	The American Indian Health Program that delivers health care to the eligible Native American population living on reservations through the Indian Health Service (IHS). Formerly known as AHCCCS IHS FFS Program
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by A.R.S. § 36-2932.
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.
AMPM	AHCCCS Medical Policy Manual available on the AHCCCS website at www.azahcccs.gov.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.

AT RISK	Refers to the period of time that a member is enrolled with a contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.
A.R.S.	Arizona Revised Statutes.
BBA	The Balanced Budget Act of 1997
BIDDERS' LIBRARY	A repository of manuals, statutes, rules and other reference material referred to in this document, located on the AHCCCS website at www.azahcccs.gov.
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
BORDER COMMUNITIES	Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring counties, due to service availability or distance. (R9-22-201.F, R9-22-201.G, R9-22-101.B)
CAPITATION	Payment to a contractor by AHCCCS of a fixed monthly payment per person in advance for which the contractor provides a full range of covered services as authorized under A.R.S. § § 36-2931 and 36-2942.
CATS	Client Assessment and Tracking System, a component of the Administration's data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from DES/DDD.
CLAIM DISPUTE	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
CMS	Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services which administers the Medicare, Medicaid and State Children's Health Insurance Program.
CYE	Contract Year Ending; Corresponds to federal fiscal year (Oct. 1 through Sept. 30). For example, Contract Year 01 is 10/1/00 - 9/30/01.
CONTRACTOR	An organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with contract requirements, AHCCCS statue and rules and federal laws and regulations.
CONVICTED	A judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.
CO-PAYMENT	A monetary amount specified by the Director that the member pays directly to a contractor or provider at the time covered services are rendered, as defined in 9 A.A.C. 22, Article 1.

COST AVOIDANCE	The process of identifying and utilizing all sources of first or third party benefits before services are rendered by DES/DDD or before payment is made by DES/DDD. (This assumes DES/DDD can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party contracted provider renders the service so that DES/DDD is only liable for coinsurance and/or deductibles.)
COVERED SERVICES	The health and medical services to be delivered by the DES/DDD as defined in 9 A.A.C. 28, Article 2; A.A.C. 31, Article 2, Section D of this contract and the AMPM. [42 CFR 438.210(a)(4)]
CRS	Children's Rehabilitative Services administered by ADHS, as defined in 9 A.A.C. 22, Article 1.
CRS ELIGIBLE	An individual who has completed the CRS application process, as delineated in the *CRS Policy and Procedure Manual*, and has met all applicable criteria to be eligible to receive CRS related Services.
DAYS	Calendar days unless otherwise specified.
DELEGATED AGREEMENT	A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Program Contractor pursuant to this contract.
DES/DDD	Department of Economic Security/Division of Developmental Disabilities.
DD	Developmentally disabled.
DIRECTOR	The Director of AHCCCS.
DISENROLLMENT	The discontinuance of a member's ability to receive covered services through a contractor.
DME	Durable medical equipment, is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury as defined in 9 A.A.C. 22, Article 1.
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 (or, with respect to a pregnant woman, the health of the woman or her unborn child) health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. (42 USC 13960-2) [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	A record of a health care related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a contractor on the date of service.
ENROLLEE	A Medicaid recipient who is currently enrolled with a Contractor. [42 CFR

	438.10(a)]
ENROLLMENT	The process by which an eligible person becomes a member of a contractor's plan as defined by 9 A.A.C. 28, Article 4.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment services for eligible persons or members less than 21 years of age as defined in 9 A.A.C. 22, Article 2.
FFS	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
FFP	Federal financial participation (FFP) refers to the contribution that the federal government makes to the Title XIX and Title XXI programs portion of AHCCCS as defined in 42 CFR 400.203.
FQHC	Federally Qualified Health Center, an entity which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
FIRST PARTY LIABILITY	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Administration, contractor, or member.
FFY	Federal Fiscal Year, October 1 through September 30.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law, as defined in 42 CFR 455.2.
FREEDOM 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 deduction, is at or below 250% of the FPL and who are not eligible for any other Medicaid program.
GRIEVANCE SYSTEM	A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes and access to the state fair hearing system.
HCBS	Home and community-based services, as defined in A.R.S. § § 36-2931 and 36-2939.
HIPAA	The Health Insurance Portability and Accountability Act (P.L. 104-191); also known as the Kennedy-Kassebaum Act, signed August 21, 1996.
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a: health care institution defined in ARS § 36-401; residential care institution defined in ARS § 36-401; community residential facility defined in ARS § 36-551; or behavioral health service facility defined in A.A.C. 20, Article 1.
IBNR	Incurred But Not Reported liabilities, for services rendered for which claims have not been received.

IHS	Indian Health Service, authorized as a federal agency pursuant to 25 U.S.C. 1661.
LIABLE PARTY	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.
LIEN	A legal claim filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality and medical management and the coordination of care.
MANAGEMENT SERVICE AGREEMENTS	A type of subcontract agreement with an entity in which the owner of the Program Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Program Contractor.
MANAGEMENT SERVICES SUBCONTRACTOR	A person or organization who agrees to perform any administrative service for DES/DDD related to securing or fulfilling DES/DDD's obligations to AHCCCS under the terms of the contract.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.
MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MAJOR UPGRADE	Any upgrade or changes that may result in a disruption to the following: Loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.
MEDICAID	A federal/state program authorized by Title XIX of the Social Security Act, as amended.
MEDICAL MANAGEMENT (MM)	Is an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICARE	A federal program authorized by Title XVIII of the Social Security Act, as amended.

MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Plan (MAP), Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
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. There are certain drugs that are excluded from coverage by Medicare, and 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 Plan's formulary are not considered excluded drugs, and will not be covered by AHCCCS.
MEMBER	An eligible person who is enrolled in AHCCCS, as defined in A.R.S. § 36-2931, 36-2901, 36-2901.01 and A.R.S. §36-2981.
NPI	National Provider Identifier assigned by the CMS contracted national enumerator.
NON-CONTRACTING PROVIDER	A person or entity that provides services as prescribed in A.R.S. § 36-2939 and A.R.S. §36-2981 who does not have a subcontract with an AHCCCS contractor.
PAS	Pre-admission screening; is a process of determining an individual's risk of institutionalization at a NF or ICF-MR level of care as specified in 9 A.A.C. 28, Article 1.
PAY AND CHASE	Recovery method used by DES/DDD to collect from legally liable first or third parties after DES/DDD pays the member's medical bills. The service may be provided by a contracted or noncontracted provider. Regardless of who provides the service, pay and chase assumes that DES/DDD will pay the provider, then seek reimbursement from the first or third party.
PCP	Primary Care Provider/ Practitioner, an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's or eligible person's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
PIP	Performance Improvement Projects, formerly referred to as Quality Improvement Projects (QIPs)
PMMIS	AHCCCS' Pre-paid 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 enrolled with a contractor [42 CFR 438.10(a)].
PROGRAM CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCS to provide the goods and services specified by this contract in conformance with stated contract requirements, AHCCCS statute and rules and federal law and regulations, as defined in A.R.S. § 36-2931.
QMB	Qualified Medicare Beneficiary**,** a person, eligible under A.R.S. §36-2971(6), who is entitled to Medicare Part A insurance and meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB, who is also eligible for Medicaid, is commonly referred to as a QMB dual eligible.
REINSURANCE	A risk-sharing program provided by the AHCCCS to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a monetary threshold, as defined in 9 A.A.C. 22, Article 1.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence DES/DDD, or a party that is, or may be, controlled or significantly influenced by DES/DDD. "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.
RFP	The Request For Proposals, a document prepared by AHCCCS that describes the services required and that instructs prospective Offerors how to prepare a response (proposal), as defined in 9 A.A.C. 22, Article 1.
RBHA	Regional Behavioral Health Authority, an organization under contract with ADHS to administer covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a tribal regional behavioral health authority (TRBHA) for the provision of behavioral health services to Native American members living on-reservation.
RBUC	Reported But Unpaid Claims; Liability for services rendered for which claims have been received but not paid.
RHC	Rural Health Clinic, a clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of DHHS as medically underserved or having insufficient number of physicians, which meets the requirements under 42 CFR 491.
ROOM AND BOARD (or ROOM)	The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF/MR). Medicaid funds cannot be expended for room and board when a member resides in an alternative residential setting (e.g. Assisted Living Home, Behavioral Health Level 2) or an apartment like setting that may provide meals.

SERVICE LEVEL AGREEMENT	A type of agreement with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Program Contractor specifically related to fulfilling the Program Contractor's obligations to AHCCCS under the terms of this contract, as defined in R9-28-101.
SFY	State Fiscal Year, July 1 through June 30.
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 generally required by members.
STATE	The State of Arizona.
STATE PLAN	The written agreement between the State of Arizona and CMS which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by a contractor with any of the following: a provider of health care services who agrees to furnish covered services to a member or with any other organization or person who agrees to perform any administrative function or service for a contractor specifically related to fulfilling the contractor's obligations to the Administration under the terms of this contract, as defined in 9 A.A.C. 22, Article 1.
SUBCONTRACTOR	(1) A provider of health care who agrees to furnish covered services to members. (2)A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities (3) A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.
SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS	Eligible individuals receiving income through federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or disabled and have household income levels at or below 100% of the FPL.
THIRD PARTY LIABILITY	See Liable Party.
TITLE XIX	Means Medicaid as defined in 42 U.S.C. 7.19.
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), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Medicare Cost Sharing groups, Breast and Cervical Cancer Treatment program and Freedom to Work.

TITLE XXI	Title XXI of the Social Security Act, State Children's Health Insurance Program, known in Arizona as KidsCare. 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. The Arizona version of SCHIP is referred to as "KidsCare"
VENTILATOR DEPENDENT	For the purposes of ALTCS eligibility, an individual who is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, residing in their own home or a HCBS approved alternative residential setting for 30 consecutive days, as defined in 9 A.A.C. 28, Article 1.
638 TRIBAL FACILITY	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.
WWHP	Well Woman Health Check Program (WWHP), administered by the Arizona Department of Health Services and funded by the Centers for Disease Control and Prevention. (see AMPM Chapter 300, Section 320)

[END OF DEFINITIONS]

SECTION D - PROGRAM REQUIREMENTS

1. PURPOSE AND APPLICABILITY:

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

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

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

2. INTRODUCTION

AHCCCS' Mission and Vision

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

The AHCCCS Administration supports a program that promotes the values of:

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

ALTCS Guiding Principles

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

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

3. ENROLLMENT AND DISENROLLMENT

AHCCCS is solely responsible for enrolling and disenrolling ALTCS members and for providing notification of same to DES/DDD. At the time of approval for ALTCS, active DD clients shall be enrolled with DES/DDD. An ALTCS applicant screened as a potential DD client at the time of application for ALTCS shall be referred to DES/DDD for a DD eligibility determination. DES will be allowed 30 days in which to determine DD eligibility and to notify the ALTCS local office. If a response is not received by ALTCS by the 30th day and the applicant is otherwise eligible for ALTCS, the ALTCS member will be considered an active DD client and shall be enrolled with DES/DDD.

DES/DDD may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. If an applicant or member is or would meet the DES/DDD Division developmental disability criteria but does not cooperate with DES/DDD, the applicant or member cannot be assessed for ALTCS eligibility as an EPD applicant.

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

The effective date of enrollment with DES/DDD shall be retroactive to the effective date of ALTCS DD eligibility except when a member is enrolled with an acute health plan at the time of the ALTCS decision of approval. When this occurs, enrollment with DES/DDD will become effective the date the ALTCS enrollment action is processed by PMMIS (referred to as the "PMMIS update"). The disenrollment from the acute health plan will be effective the day before the DES/DDD effective enrollment date. Disenrollment from DES/DDD takes effect per the Division of Member Services Eligibility Policy Manual.
DES/DDD must continue to provide services until disenrollment from DES/DDD becomes effective. This includes reinstatement of ALTCS eligibility and DES/DDD enrollment pending a decision on the member's eligibility appeal with AHCCCS. Services must be continued whether or not DES/DDD has determined that the member no longer meets DES/DDD eligibility requirements.

4. RESERVED

5. RESERVED

6. RESERVED

7. RESERVED

8. TRANSITION ACTIVITIES

Member Transition:

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

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

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

DES/DDD shall designate an executive staff person to act as the Transition Coordinator. This staff person shall interact closely with the AHCCCS Transition staff and staff from other Program Contractors and Acute Health Plans to ensure a safe and orderly transition.

When relinquishing members, DES/DDD is responsible for timely notification of the receiving Contractor regarding pertinent information related to any special needs of transitioning members. DES/DDD, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with DES/DDD and service information, emergency numbers and instructions of how to obtain services.

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

Other Transition Activities: When an ALTCS member resides in an AHCCCS registered setting with no contract at the time of enrollment, DES/DDD must give at least 7 days advance written notice advising the member that he or she must move to a facility contracting with DES/DDD. The reasons for the transfer must be included in the notice to the member and/or the member's representative. Medical Assistance to members who do not move to a contracting facility is limited to acute care services only. If a member's condition does not permit transfer to another facility, DES/DDD should compensate the registered non-contracting provider's service rates or another reasonable alternative payment method until the member can be transferred.

9. AHCCCS GUIDELINES, POLICIES and MANUALS

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS Internet website located at www.azahcccs.gov.

DES/DDD is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS rules, Statutes and other resources are also available to all interested parties through the AHCCCS website at www.azahcccs.gov. Upon adoption by AHCCCS, updates will be made available to Program Contractors. The Program Contractor shall be responsible for implementing and maintaining current copies of updates.

10. COVERED SERVICES

DES/DDD, either directly or through subcontractors, shall, at a minimum, be responsible for providing the following acute, long term, behavioral health and case management services in accordance with the *AHCCCS Medical Policy Manual (AMPM), AHCCCS Behavioral Health Services Guide,* ACOM and as approved by the AHCCCS Director [42 CFR 438.210(a)(1)][42 CFR 438210(a)(4) and 438.224]. DES/DDD must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the service is furnished. [42 CFR 438.210(a)(3)(i)(iii)] The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the enrollee. [42 CFR 438.210(a)(3)(ii)] DES/DDD may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can be reasonably expected to achieve their purpose.

DES/DDD shall ensure that its providers are not restricted or inhibited in any way from communicating freely with members regarding the members' health care, medical needs and treatment options even if a service is not covered by AHCCCS or DES/DDD. [42 CFR 438.102]

DES/DDD shall ensure that its providers, acting within the lawful scope of their practice are not prohibited or otherwise restricted from advising or advocating, on behalf of a member who is his or her patient, for:

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

DES/DDD must notify AHCCCS if, on the basis of moral or religious grounds, it elects to not provide, reimburse for, or provide coverage of a covered counseling or referral service. Notification must be submitted prior to entering into a contract with AHCCCS or prior to adopting the policy during the term of the contract [42 CFR 438.102(a)(2) and (b)(1)]. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to members during their initial appointment; and must be provided to members at least 30 days prior to the effective date of the policy.

Members must be notified on how to access the services. The notification and policy must be consistent with the provisions of 42 CFR 438.10, must be provided to members during their initial appointment, and must be provided to members at least 30 days prior to the effective date of the policy.

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

Authorization of Services: For the processing of requests for initial and continuing authorizations of services, DES/DDD must have in place, and follow, written policies and procedures. DES/DDD must have mechanisms in place to ensure consistent application of review criteria for authorization decisions. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested,

must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. [42 CFR 438.210(b)]

Notice of Action: DES/DDD must notify the requesting provider, and give the member written notice of any decision by DES/DDD to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of42 CFR 438.404, AHCCCS Rules and ACOM Notice of Action Policy. The notice to the provider must also be in writing as specified in Attachment B (1). [42 CFR 438.210(c)] See Attachments B (1).

ACUTE CARE SERVICES

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

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

***Audiology*:** DES/DDD shall provide audiology services to members under age 21 including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through other than medical or surgical means (i.e. hearing aids). Only the identification and evaluation of hearing loss are covered for members 21 years of age and older unless the hearing loss is due to an accident or injury-related emergent condition. Pursuit to A.A.C. R9-22-212, hearing aids are not covered for members 21 and older.

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

***Behavioral Health*:** DES/DDD shall provide behavioral health services as described in Section D, Paragraph 12, Behavioral Health Services. Services are described in detail in the *AMPM* and the *AHCCCS Behavioral Health Services Guide* available from AHCCCS, Division of Health Care Management or on the AHCCCS website, at: http://www.azahcccs.gov/Publications/GuidesManuals/.

For DES/DDD members who are in Acute Care Only status , behavioral health services shall include emergency behavioral health services, individual, group and family therapy and counseling, inpatient hospital, laboratory and radiology services for psychotropic medication regulation and diagnosis, emergency and non-emergency transportation, psychotropic medication, and psychotropic adjustment and monitoring.

Children's Rehabilitative Services (CRS): The program for children with CRS-covered conditions is administered by the Arizona Department of Health Services (ADHS) for children who meet CRS eligibility criteria. DES/DDD shall refer children to the CRS program who are potentially eligible for services related to CRS covered conditions, as specified in 9 A.A.C. 28, Article 2 and A.R.S. § 35-Ch. 3, § 2. See Section D, Paragraph 13. Children's Rehabilitative Services.

Chiropractic Services: DES/DDD shall provide chiropractic services to members under age 21, when prescribed by the member's PCP and approved by DES/DDD in order to ameliorate the member's medical condition. Medicare approved chiropractic services for any member shall also be covered, subject to limitations specified in CFR 410.22, for Qualified Medicare Beneficiaries if prescribed by the member's PCP and approved by DES/DDD.

Dialysis: DES/DDD shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified end stage renal disease

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

***Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*:** DES/DDD shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings for members under age 21. DES/DDD shall ensure that these members receive required health screenings, including developmental/behavioral health screenings, in compliance with the AHCCCS periodicity schedule (Exhibit 430-1 in the *AMPM*) and to submit to AHCCCS, Division of Health Care Management, all EPSDT reports as noted in Attachment D. For members under age 21, chiropractic services shall be covered. DES/DDD is required to meet specific participation/ utilization rates for EPSDT members; these are described in the *AMPM* and Section D, Paragraph 20, Quality Management..

The Contractor is encouraged to assign EPSDT-aged members to providers that are trained on and who use AHCCCS approved developmental screening tools.

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

Emergency services: DES/DDD shall have and/or provide the following at a minimum:

a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, 7-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule 9 A.A.C. 22, Article 1. Emergency medical services are covered without prior authorization. DES/DDD is encouraged to contract with emergency service facilities for the provision of emergency services. DES/DDD shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. DES/DDD shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a "prudent layperson" is a person who possesses an average knowledge of health and medicine.
b. All medical services necessary to rule out an emergency condition and
c. Emergency transportation and

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 services:

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

DES/DDD may not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition 42 CFR 438.114.

2. A representative of DES/DDD (an employee or subcontracting provider) instructs the member to seek emergency medical services.

Additionally, DES/DDD may not:

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

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

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

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

Family Planning: DES/DDD shall provide Family Planning services in accordance with the *AMPM*, Section 420, for all members who choose to delay or prevent pregnancy. These include medical, surgical, pharmacological and laboratory services, as well as contraceptive devices. Information and counseling, which allow members to make informed decisions regarding family planning methods, shall also be included. If DES/DDD does not provide family planning services, it must contract for these services through another health care delivery system.

The Contractor shall provide services to members enrolled in the Family Planning Services Extension Program, a program that provides family planning services only, for a maximum of two consecutive 12-month periods, to women whose SOBRA eligibility has terminated. The Contractor is also responsible for notifying AHCCCS when a SOBRA woman is sterilized to prevent inappropriate enrollment in the SOBRA Family Planning Services Extension Program. Notification should be made at the time the newborn is reported or after the sterilization procedure is completed.

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

Immunizations: DES/DDD shall provide immunizations for adults (21 years of age and older) to include but not limited to: diphtheria-tetanus, influenza, pneumococcus, rubella, measles, hepatitis-B and others as

medically indicated. EPSDT immunization requirements include but not limited to: diphtheria, tetanus, pertussis vaccine (DTaP), inactivated polio vaccine (IPV), measles, mumps, rubella vaccine (MMR), H. influenza, type B (HIB), hepatitis B (Hep B), pneumoccacal conjugate (PCV) and varicella zoster virus (VZV) vaccine. (Please refer to the AMPM for current immunization requirements. See also Section D Paragraph 62 Pediatric Immunizations and the Vaccine for Children Program)

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

Indian Health Service (IHS): DES/DDD may choose to subcontract with and pay an IHS or 638 tribal facility as part of their provider network for covered services provided to members. AHCCCS will reimburse IHS or a 638 tribal facility for claims for acute care services provided to Title XIX members who receive medically necessary covered services through IHS or a 638 tribal facility.

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

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

Maternity: DES/DDD shall provide pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants, nurse practitioners or certified midwives. Members may select or be assigned to a PCP specializing in obstetrics. Members anticipated to have a low-risk delivery may elect to receive labor and delivery services in their home from their maternity provider if this setting is included in allowable settings for DES/DDD, and DES/DDD has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by certified nurse midwives if they are in DES/DDD's provider network. Members receiving maternity services from a certified nurse midwife must also be assigned to a PCP for other health care and medical services.

DES/DDD shall allow women and their newborns to receive 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96-hour stay.

DES/DDD shall inform all ALTCS DES/DDD enrolled pregnant women of voluntary HIV testing and the availability of counseling if the test is positive. DES/DDD shall provide information in the member handbook to encourage pregnant women to be tested and instructions on where to be tested. Semi-annually, DES/DDD shall report to AHCCCS, Division of Health Care Management, the number of pregnant women who have been identified as HIV/AIDS positive. This report is due no later than 30 days after the end of the second and fourth quarters.

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

Medical Supplies, Durable Medical Equipment (DME), Orthotic and Prosthetic Devices: These services are covered when prescribed by the member's PCP, other attending physician or practitioner, or by a dentist. Medical equipment may be rented or purchased only if other sources are not available which provide the items at no cost. The total cost of the rental must not exceed the purchase price of the item. Reasonable repairs or adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

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

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

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

Podiatry: DES/DDD shall provide podiatry services to include bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease which prohibits care by a nonprofessional person.

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

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

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

Pursuant to 42 CFR 422.113(c)(3), DES/DDD financial responsibility for post-stabilization care services that have not been pre-approved ends when:

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

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

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

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

Medicare Part D: AHCCCS covers those drugs ordered by a PCP, attending physician, dentist or other authorized prescriber and dispensed under the direction of a licensed pharmacist subject to limitations related to prescription supply amounts, and the Contractor's prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS.

Primary Care Provider (PCP): PCP services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a coordinator in referring the member for specialty medical services and behavioral health. [42 CFR 438.208(b)]. The PCP is responsible for maintaining the member's primary medical record which contains documentation of all health risk assessments and health care services of which they are aware, whether or not they were provided by the PCP. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the periodicity schedule.

Radiology and Medical Imaging: These services are covered when ordered by the member's PCP, attending physician or dentist and are provided for diagnosis, prevention, treatment or assessment of a medical condition. Services are generally provided in hospitals, clinics, physician offices and other health care facilities.

Rehabilitation Therapy: DES/DDD shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation.

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

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

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

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

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

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

LONG TERM CARE SERVICES

A more detailed description of services can be found in 9 A.A.C. 28, Article 2 and Chapter 1200 00 of the *AMPM*.

Attendant Care: A service provided by a trained attendant for members who reside in their own homes and is a combination of services which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development. Attendant care services are not considered duplicative of hospice services.

Spouses as Paid Caregivers: A service option within Attendant Care. Implementation for this option began on October 1, 2007. See AMPM Chapters 1200 and 1600 for requirements pertaining to Self-Directed Attendant Care.

Behavior Management Services: A service that assists the member in carrying out daily living tasks and other activities essential for living in the community.

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

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

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

Homemaker: Assistance in the performance of routine household activities such as shopping, cooking, running errands, etc.

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

Hospice: A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with DES/DDD. DES/DDD is required to pay nursing facilities 100% of the class specific contracted rate when a member elects the hospice benefit. Medicaid services provided to members receiving Medicare hospice services that are duplicative of Medicare hospice benefits (i.e., personal care and homemaker services) will not be covered. Only when the service need is not related to the hospice diagnosis can the service be covered by Medicaid

Partial Care: A service that provides structured, coordinated programs designed to provide therapeutic activities that promote coping, problem solving and socialization.

Personal Care: A service that provides intermittent assistance with personal physical needs such as washing hair, bathing and dressing.

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

Respite Care: A service that provides short-term care and supervision to relieve primary caregivers. It is available for up to 24-hours per day and is limited to 720 hours per year.

LONG TERM CARE - INSTITUTIONAL SETTINGS

Behavioral Health Level I: A behavioral health service facility licensed by ADHS, as defined in 9 A.A.C. 20, to provide a structured treatment setting with 24-hour supervision, on-site medical services and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services (other than psychiatric hospitalization). Some Level I facilities are IMDs.

Institution for Mental Disease (IMD)*:* A Medicare certified hospital, special hospital for psychiatric care, behavioral health facility or nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. ADHS, Office of Behavioral Health Licensure licensed Level I facilities with more than 16 beds are considered IMDs. Reimbursement for services provided in an IMD to Title XIX persons age 21 through 64 years is limited to 30 days per inpatient admission, not to exceed a total of 60 days per contract year. For Title XIX members under age 21 and 65 years of age or over, there is no benefit limitation. A Title XIX member 21 - 64 will lose eligibility for covered services if an IMD stay extends beyond 30 days per admission or 60 cumulative days per year (July 1 through June 30). A Title

XIX member who is receiving services in an IMD who turns 21 may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first. AHCCCS provider types B6 and 71 are IMDs.

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

Intermediate Care Facility for Mentally Retarded (ICF-MR): A facility whose primary purpose is to provide health, habilitative and rehabilitative services to individuals with developmental disabilities.

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

LONG TERM CARE - HCBS ALTERNATIVE RESIDENTIAL SETTINGS

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

Adult Developmental Home: An alternative residential setting for developmentally disabled adults (18 or older) which is licensed by DES to provide room, board, supervision and coordination of habilitation and treatment for up to three residents.

Behavioral Health Therapeutic Home: Adult – licensed by ADHS/OBHL. A behavioral health service agency that is the licensee's residence where behavioral health adult therapeutic home care services are provided to at least one, but no more than three individuals as defined in 9 A.A.C. 20, Articles 1 and 15, who reside at the residence, have been diagnosed with behavioral health issues, and are provided with food and are integrated into the licensee's family.

Child – licensed by DES as a professional foster care home as defined in 6 A.A.C. 5, Article 5850 for one or two children. A Foster Care Home may be larger to accommodate sibling groups."

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

a. *Adult Foster Care:* An ALTCS HCBS approved alternative residential setting that provides supervision and coordination of necessary services within a family type environment for up to four adult residents.

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

c. *Assisted Living Centers*: An ALTCS approved alternative residential setting, as defined in A.R.S. §36-401, that provides supervision and coordination of necessary services to more than 10 or more residents. Under A.R.S. §36-2939 members residing in Assisted Living Centers must be offered the choice of single occupancy.

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

Behavioral Health Level III: A behavioral health service agency licensed by ADHS to provide a residential setting with 24-hour supervision and supportive protective oversight, behavior management or psycho-social rehabilitation and assure that members receive required medications, obtain needed treatment and have transportation to outside treatment agencies if necessary. Life skills training, social and recreational activities may be provided directly or by referral to outside treatment agencies.

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

Group Home for Developmentally Disabled: A community residential facility for up to six residents that provides room, board, personal care, supervision and habilitation. The DD Group Home provides a safe, homelike, family atmosphere, which meets the physical and emotional needs for ALTCS members who cannot physically or functionally live independently in the community. ALTCS covers services except for room and board.

Rural Substance Abuse Transitional Agency: An agency that provides behavioral health services as defined in 9 A.A.C. 20, Article 14.

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

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

11. THERAPEUTIC LEAVE AND BED HOLD

For therapeutic leave and bed hold definitions, refer to the *AHCCCS Medical Policy Manual*, Chapter 100.

12. BEHAVIORAL HEALTH SERVICES

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

a. Behavior Management (behavioral health personal assistance, family support/home care training, self-help/peer support)
b. Behavioral Health Case Management Services (with limitations)
c. Behavioral Health Nursing Services
d. Emergency Behavioral Health Care
e. Emergency and Non-Emergency Transportation
f. Evaluation and Assessment

g. Individual, Group and Family Therapy and Counseling
h. Inpatient Hospital Services - (DES/DDD may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative settings will be considered in capitation rate development.) (with limitations)
i. Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities)
j. 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 %

k. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
l. Opioid Agonist Treatment
m. Partial Care (Supervised day program, therapeutic day program and medical day program)
n. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
o. Psychotropic Medication
p. Psychotropic Medication Adjustment and Monitoring
q. Respite Care (with limitations)
r. Rural Substance Abuse Transitional Agency Services
s. Screening
t. Behavioral Health Therapeutic Home Care Services

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

Training: DES/DDD is responsible for training case managers and providers to identify and screen for members' behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services, how to access them, including the petitioning process, how to involve the member and their family in decision-making and service planning, and information regarding initial and quarterly behavioral health consultation requirements. Training for case managers and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. Training must be provided in sufficient detail and frequency to ensure that case managers and providers appropriately identify and refer members with behavioral health needs. DES/DDD shall maintain documentation of the behavioral health trainings in a central file.

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

AHCCCS registered behavioral health provider. DES/DDD shall ensure that all behavioral health services provided are medically necessary as determined by a qualified behavioral health professional.

DES/DDD shall contract with behavioral health providers who meet Arizona Department of Health Services (ADHS) licensure standards and who are registered as behavioral health providers with AHCCCS. DES/DDD shall ensure each provider is qualified to provide the services for which they are contracting. DES/DDD may, at its option, contract with ADHS or Regional Behavioral Health Authorities for the provision of behavioral health services. If such contracts are used, DES/DDD shall be responsible for ensuring compliance with AHCCCS appointment standards for behavioral health services, provision of case management and all medically necessary covered services and the quality of care provided to DES/DDD ALTCS members. DES/DDD shall ensure that all HCBS members who are referred for behavioral health services receive a screening and evaluation within seven days of referral. If DES/DDD's behavioral health subcontractor fails to provide medically necessary behavioral health services within the prescribed timeframes, DES/DDD shall ensure services are provided to the member directly or through corrective action with their subcontractor.

EPSDT: DES/DDD shall ensure that PCPs screen for behavioral health needs at each EPSDT visit, and when appropriate, initiate a behavioral health referral. DES/DDD shall develop a tracking mechanism to ensure that a referral is made when a behavioral health need is identified and that when the PCP has initiated a behavioral health referral, the member receives appropriate medically necessary behavioral health services.

Referral for behavioral health services may be made by the Primary Care Provider, case manager, facility staff, family, legal guardian, school, the member or other referral sources. DES/DDD shall develop, monitor and continually evaluate its processes for timely referral, screening, evaluation and treatment planning for behavioral health services. DES/DDD is responsible for training case managers and providers to identify and screen for members' behavioral health needs. Training for case managers and providers may be provided through employee orientation, clinical in-services and/or information sharing via newsletters, brochures, etc. Training must be provided in sufficient detail and frequency to ensure that case managers and providers appropriately identify and refer members with behavioral health needs. At a minimum, training shall include information regarding covered behavioral health services and how to access them, the importance of including the member and family in assessing needs and service planning and information regarding initial and quarterly behavioral health consultation requirements. DES/DDD shall maintain documentation of the behavioral health trainings in a central file.

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

DES/DDD shall have procedures in place for ensuring that members' behavioral health services are appropriately provided, coordinated with the PCP and behavioral health providers, tracked by the case manager and documented in the member's record. DES/DDD shall also have procedures in place for ensuring communication occurs between the case manager, PCP and behavioral health providers and that care is coordinated with other agencies and involved parties. Quality management for behavioral health services must be included in DES/DDD's Quality Management Plan and shall meet the quality management requirements of AHCCCS as specified in the *AMPM*, Chapter 900.

Additional Requirements: DES/DDD shall conduct an annual case review of the behavioral health care provided to its members and submit an analysis of the findings to AHCCCS no later than August 30. To meet this requirement, DES/DDD may independently perform the review, subcontract with ADHS or Regional Behavioral Health Authorities, or subcontract with a Professional Review Organization approved by AHCCCS. If applicable, DES/DDD shall have oversight responsibility to assure that the subcontractor performs the review as required and the results are accurate. DES/DDD shall ensure reviews are conducted on

a sample of member records for both children and adults served for each geographic service area based on a sampling methodology approved by AHCCCS.

DES/DDD shall submit a proposed sampling methodology and case file review tool with instructions to AHCCCS for review and approval no later than 60 days prior to implementation. At a minimum, the case review should assess the following indicators or aspects of care:

a. Treatment goals are jointly established with the member, member's family, and other involved parties;
b. Individuals requiring specialty providers are referred for and receive specialty services;
c. There is evidence that behavioral health care has been coordinated with the member's PCP;
d. For persons with multi-agency involvement, treatment recommendations are collaboratively developed and implemented;
e. Individuals receive timely access to services;
f. Measures of quality outcomes.

DES/DDD shall monitor and provide feedback on all corrective action plans written as a result of the findings in the case file review to ensure improved performance.

For more information, refer to the AHCCCS Behavioral Health Services Guide that is available from the Office of Managed Care, Behavioral Health Unit or on the AHCCCS web site at: http://www.azahcccs.gov/Publications/GuidesManuals/.

13. CHILDREN'S REHABILITATIVE SERVICES

The program for children with CRS-covered conditions is administered by the Arizona Department of Health Services (ADHS) for children who meet CRS eligibility criteria. DES/DDD shall refer children to the CRS program who are potentially eligible for services related to CRS covered conditions, as specified in R9-22, Article 2 and A.R.S. Title 36, Chapter 2, Article 3. DES/DDD is responsible for care of members until those members are determined eligible by Children's Rehabilitation Services Administration (CRSA). In addition, DES/DDD is responsible for covered services for CRS eligible members unless and until the Contractor has received written confirmation from CRSA that CRSA will provide the requested service. DES/DDD shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Program. For detailed information regarding eligibility criteria, referral practices and Program Contractor CRS coordination issues, refer to the CRS Policy and Procedures Manual for Covered Services and Limitations located on the Arizona Department of Health Services website at http://www.azdhs.gov/phs/ocshcn/crs/crs_policy_az.htm and the related ACOM Policy.

DES/DDD shall respond to requests for services potentially covered by CRSA in accordance with the related ACOM Policy. DES/DDD is responsible for addressing prior authorization requests if CRSA fails to comply with the timeframes specified in the related ACOM Policy. DES/DDD remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition and emergency services related to a CRS condition rendered outside of CRS network And AHCCCS covered services denied by CRSA for the reason that it is not a service related to the CRS condition.

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

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

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

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

DES/DDD shall submit a written request to AHCCCS Division of Health Care Management ALTCS Unit before placing a member outside the state to facilitate a coordinated review with the Division for any potential eligibility impact.

15. ALTCS TRANSITIONAL PROGRAM

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

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

DES/DDD compliance will be monitored through AHCCCS, Division of Health Care Management.

16. CASE MANAGEMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DES/DDD shall ensure adequate staffing to meet case management requirements. DES/DDD's case management plan shall also describe their methodology for assigning and monitoring case management caseloads. Program Contractors must obtain authorization from the Division of Health Care Management prior to implementing caseloads whose values exceed those outlined below.

Caseload Ratios:

Prior to July 1, 2006 the average DDD ALTCS case management caseload was 1:40. Effective July 1, 2006 a 1:35 caseload ratio will be in effect for any membership above the number of enrolled members as of June 30, 2006 (17,910). AHCCCS will annually determine an average weighted caseload based on 1:40 and 1:35 case manager ratios, the membership as of June 30, 2006 and the number of members above the June 30, 2006 baseline.

If caseloads exceed the annually determined average of 1:39.5, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must also be sufficient to cover case manager absenteeism, turnover and out-of-state members.

17. MEMBER HANDBOOK and MEMBER COMMUNICATIONS

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

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

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

All written notices informing members of their right to interpretation and translation services in a language shall be translated when DES/DDD is aware that 1,000 or 5% (whichever is less) of DES/DDD's members speak that language and have LEP. [4 CFR 438.10(c)(3)]

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

DES/DDD 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 AHCCCS *Member Information Policy*. Regardless of the format chosen by DES/DDD, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. [42 CFR 438.10(b)(1) and (b)(3)] DES/DDD must notify its members that alternative formats are available and how to access them. [42 CFR 438.10(d)]

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

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

I. A m*ember handbook* which, at a minimum, shall include the items listed in the ACOM *Member Information Policy.*

   DES/DDD shall review and update the Member Handbook at least once a year. The handbook must be submitted to AHCCCS, Division of Health Care Management for approval by May 15th of each contract year, or within four weeks of receiving the annual renewal amendment, whichever is later.

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

II. A description of DES/DDD's provider network, which at a minimum, includes those items listed in the ACOM *Member Information Policy.*

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

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

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

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

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

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

DES/DDD 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.

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

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

18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS electronic Member Change Report must be used by DES/DDD to notify the ALTCS eligibility offices and AHCCCS of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, mailing address, temporary absence from the state, demographic information, refusal of HCBS services, contract type changes, living arrangements, share of cost, income or resources; a change in medical condition which could affect eligibility, admission to Arizona State Hospital; no long term care services provided; demographic changes or the member's death. DES/DDD shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS.

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

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

20. QUALITY MANAGEMENT

DES/DDD shall provide quality medical care to members, regardless of payer source or eligibility category. DES/DDD shall promote improvement in the quality of care provided to enrolled members through established quality management and performance improvement processes DES/DDD shall execute processes to monitor, assess, plan, implement, evaluate and, as mandated, report quality management and performance improvement activities, as specified in the AMPM. [42 CFR 438.240(a)(1) and (e)(2)]:

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

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

1. A written Quality Assessment and Performance improvement (QA/PI) plan, an evaluation of the previous year's QA/PI program, and 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 include Peer Review and Quality Management Committees chaired by the Contractor's Chief Medical Officer.
3. Protection of medical records and any other personal health and enrollment information that identifies a particular member or subset of members in accordance with Federal and State privacy requirements.
4. Member rights and responsibilities.
5. Uniform provisional credentialing, initial credentialing, re-credentialing and organizational credential verification [42 CFR 438.206(b)(6)]. The Contractor shall demonstrate that its providers are credentialed and reviewed through the Contractor's Credentialing Committee that is chaired by the Contractor's Medical Director [42 CFR 438.214]. The Contractor should refer to the AMPM and Attachment D, Chart of Deliverables, for reporting requirements. The process:
    a. Shall follow a documented process for provisional credentialing, initial credentialing, recredentialing and organizational credential verification of providers who have signed contracts or participation agreements with the Contractor;
    b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

c. Shall not employ or contract with providers excluded from participation in Federal health care programs.

6. Tracking and trending of member and provider issues, which includes investigation and analysis of quality of care issues, abuse, neglect and unexpected deaths. The resolution process must include:
   a. Acknowledgement letter to the originator of the concern;
   b. Documentation of all steps utilized during the investigation and resolution process;
   c. Follow-up with the member to assist in ensuring immediate health care needs are met;
   d. Closure/resolution letter that provides sufficient detail to ensure that the member has an understanding of the resolution of their issue, any responsibilities they have in ensuring all covered, medically necessary care needs are met, and a Contractor contact name/telephone number to call for assistance or to express any unresolved concerns;
   e. Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
   f. Analysis of the effectiveness of the interventions taken.
7. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.
8. Participation in community initiatives including applicable activities of the Medicare Quality Improvement Organization (QIO).
9. Performance Improvement Programs including performance measures and performance improvement projects.

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

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

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

I. Performance Measures:

The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Complete descriptions of the AHCCCS clinical quality Performance Measures can be found in the most recently published reports of acute-care performance measures located on the AHCCCS website. AHCCCS uses Healthcare Effectiveness Data and Information Set (also known as the Health Plan Employer Data and Information Set, or HEDIS) technical specifications from the National Committee for Quality Assurance (NCQA) for all DES/DDD clinical quality performance Measures except the measure titled "EPSDT Participation". AHCCCS bases the measurement of EPSDT Participation on the methodology established in CMS "Form 416," which can be found on the CMS website (www.cms.hhs.gov).

Contractors 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.

AHCCCS intends to implement a hybrid methodology for collecting and reporting Performance Measure rates, as allowed by NCQA, for selected HEDIS measures. Contractors shall collect data from medical records and provide these data with supporting documentation, as instructed by AHCCCS, for each hybrid measure as requested. The number of records that each Contractor will be required to collect will be based on HEDIS sampling guidelines and may be affected by the Contractor's previous rate for the measure being collected. AHCCCS may begin implementation of the hybrid methodology with the measure of Adolescent Immunizations. AHCCCS may implement hybrid methodology for collecting and reporting additional measures in this, or future, contract years.

In addition, the Contractor 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. The Contractor's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration. It also will report this Performance Measure data to AHCCCS in conjunction with its Quarterly EPSDT and Adult Monitoring Report.

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

> ***Minimum Performance Standard*** – A Minimum Performance Standard (MPS) is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, the Contractor will be required to submit a corrective action plan and may be subject to a sanction for each deficient measure.
>
> ***Goal*** – If the Contractor has already met or exceeded the AHCCCS Minimum Performance Standard for any measure, the Contractor must strive to meet the established Goal for the measure(s).

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

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

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

AHCCCS has established standards for the measures listed below.

Performance Measures	CYE 10 Minimum Performance Standard	Goal (1)
EPSDT Participation	**55%**	**80%**
Immunization of two-year-olds		
4:3:1:3:3:1:4 Series	**43%**	**80%**
4:3:1:3:3:1 Series	**82%**	**80%**

DTaP - 4 doses	**85%**	**90%**
Polio - 3 doses (*)	**90%**	**90%**
MMR - 1 dose (*)	**90%**	**90%**
Hib - 3 doses (*)	**86%**	**90%**
HBV - 3 doses (*)	**90%**	**90%**
Varicella - 1 dose (*)	**86%**	**90%**
Adolescent Immunizations (2)	**TBD**	**90%**
Dental Visits	**41%**	**57%**
Well-child Visits 3 - 6 Years	**44%**	**80%**
Adolescent Well-care Visits	**31%**	**50%**
Children's Access to PCPs		
12 – 24 months (3)	**78%**	**97%**
25 months – 6 years	**70%**	**97%**
7 – 11 years	**70%**	**97%**
12 – 19 years	**70%**	**97%**

(1) Goals are based on Healthy People 2010 objectives or other appropriate goals or benchmarks
2) NCQA is in the process of making revisions to the measure, and current AHCCCS data is not yet available.
(3) AHCCCS may not report rates for Children's Access to PCPs at 12 – 24 Months.
(*) AHCCCS will continue to measure and report results of these individual antigens; however, the Contractor may not be held accountable for specific Performance Standards unless AHCCCS determines that completion of a specific antigen or antigens is affecting overall completion of the childhood immunization series.

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

In addition, AHCCCS shall measure and report the Contractor's EPSDT Participation Rate, utilizing the CMS 416 methodology. The Contractor must take affirmative steps to increase member participation in the EPSDT program. The EPSDT participation rate is the number of children younger than 21 years receiving at least one medical screen during the contract year, compared to the number of children expected to receive at least one medical screen. The number of children expected to receive at least one medical screen is based on the AHCCCS EPSDT periodicity schedule and the average period of eligibility.

The Contractor must monitor rates for postpartum visits and low/very low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. These activities will be monitored by AHCCCS during the Operational and Financial Review.

II. Performance Improvement:

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

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

DES/DDD 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)]

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

III. Data Collection Procedures:

When requested, DES/DDD 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 data. DES/DDD is responsible for collecting valid and reliable data, including data collected by subcontracted acute-care health plans, and for using qualified staff and personnel to collect the data. Data collected for Performance Measures and/or Performance Improvement Projects must be returned by DES/DDD 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 DES/DDD.

21. MEDICAL MANAGEMENT

DES/DDD shall execute processes to assess, plan, implement and evaluate Medical Management (MM) activities, as specified in the *AMPM* Chapter 1000 that include at least the following:

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee;
2. Prior authorization and Referral Management;
    a. For the processing of requests for initial and continuing authorizations of services DES/DDD shall:
        1) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
        2) Consult with the requesting provider when appropriate [42 CFR 438210(b)(2)]
        3) Monitor and ensure that all enrollees with special health care needs have direct access to care
3. Develop and/or Adoption of Practice Guidelines [42 CFR 438.235(b)], that
    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
    b. Consider the needs of DES/DDD's members;
    c. Are adopted in consultation with contracting health care professionals;
    d. Are reviewed and updated periodically as appropriate;
    e. Are disseminated by DES/DDD to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)]
4. Concurrent review;
    a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services and other areas to which the guidelines apply;

b. Discharge planning;
5. Continuity and coordination of care;
6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438.240(b)(3)];
7. Evaluation of new medical technologies, and new uses of existing technologies;
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the UM Committee; and
9. Quarterly Utilization Management Report (details in the AMPM)
10. DES/DDD must review all prior authorization requirements for services, items or medications and submit a report to AHCCCS providing the rationale for the requirements by June 30, 2010. AHCCCS shall determine and provide a format for the report.

DES/DDD and their subcontractor's medical coverage decisions must comply with all DES/DDD or their subcontractor's coverage criteria. On an ongoing routine basis DES/DDD must assess and monitor the appropriateness of coverage criteria decisions including timeliness and appropriateness of the language in the Notices of Action letter sent to members. The outcomes of the monitoring must be reported at least quarterly to or acted upon by the MM Committee.

DES/DDD shall have a process to report MM data and management activities through a MM Committee. DES/DDD's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. DES/DDD shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs [42 CFR 438240(b)(4)].DES/DDD shall maintain a written MM plan that addresses its plan for monitoring MM activities described in the *AMPM* Chapter 1000. The plan must be submitted for review by AHCCCS Division of Health Care Management (DHCM) within timelines specified in Attachment D.

22. GRIEVANCE SYSTEM

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

DES/DDD may delegate the grievance system process to subcontractors, however, DES/DDD must ensure that the delegated entity complies with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. DES/DDD shall remain responsible for compliance with all requirements. DES/DDD shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to state fair hearing, the method for obtaining a state fair hearing, the rules that govern representation at the hearing, the right to file grievances, appeals and claim disputes, the requirements and timeframes for filing grievances, appeals and claim disputes, the availability of assistance in the filing process, the toll-free numbers that the enrollee can use to file a grievance or appeal by phone, that benefits will continue when requested by the enrollee in an appeal or state fair hearing request concerning certain actions which are timely filed, that the enrollee may be required to pay the cost of services furnished during the appeal/hearing process if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent. Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 17, Member Handbook and Member Communications, and Section D, Paragraph 69, Cultural Competency.

DES/DDD shall be responsible to provide the necessary professional, paraprofessional and clerical services for the representation of DES/DDD 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, DES/DDD shall be responsible for all attorney fees and costs awarded to the claimant in a judicial process.

The Program Contractor will provide reports on the Grievance System as required in the Grievance System Reporting Guide available on the AHCCCS website.

23. RESERVED

24. RESERVED

25. STAFF REQUIREMENTS AND SUPPORT SERVICES

The Program Contractor shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements. For the purposes of this contract, the Contractor shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b)].

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

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

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

The Contractor 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 staff is required:

Key Staff Positions

a. **Administrator/CEO/COO** or their designee must be available during working hours to fulfill the responsibilities of the position and to oversee the entire operation of the Program Contractor. The Administrator shall devote sufficient time to the Program Contractor's operations to ensure adherence to program requirements and timely responses to the AHCCCS Administration.
b. **Medical Director/CMO** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all major clinical and QM and MM components of the Program Contractor. The Medical Director shall devote sufficient time to the Program Contractor's operations to ensure timely medical decisions, including after-hours consultation as needed (see Paragraph 27).
c. **Chief Financial Officer/CFO** to oversee the budget, accounting systems and financial reporting implemented by the Program Contractor.
d. **Pharmacy Coordinator/Director** who is an Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or contractor of the Plan.
e. **Dental Director/Coordinator** that is responsible for coordinating dental activities of the Program Contractor and providing required communication between the Contractor and AHCCCS. The Dental Director/Coordinator may be an employee or contractor of the plan and must be licensed in Arizona if they are required to review or deny dental services.
f. **Compliance Officer** who will implement and oversee the Program Contractor's compliance program. The compliance officer shall be a management official, available to all employees, with designated and recognized authority to access records and make independent referrals to AHCCCS, Office of Program Integrity. See paragraph 70 for more information.
g. **Grievance Manager** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for hearing and provider claim disputes.
h. **A Business Continuity Planning and Recovery Coordinator** as noted in the ACOM Business Continuity and Recovery Planning Policy.
i. **Contract Compliance Officer** who will serve as the primary point-of-contact for all Contractor operational issues. The primary functions of the Contract Compliance Officer may include but are not limited to coordinate the tracking and submission of all contract deliverables; field and coordinate responses to AHCCCS inquiries, coordinate the preparation and execution of contract requirements such as OFRS, random and periodic audits and ad hoc visits.
j. **Quality Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality. The QM Coordinator must have experience in quality management and quality improvements.
k. **Performance/Quality Improvement Coordinator** who will have a minimum qualification as a Certified Professional in Healthcare Quality (CPHQ) or comparable education and experience in data and outcomes measurement.
l. **Maternal Health/EPSDT (child health) Coordinator** who shall be an Arizona licensed nurse, physician, or physician's assistant; or have a Master's degree in health services, public health, or health care administration or other related field and/or a Certified Professional in Health Care Quality (CPHQ). Staffing under this position should be sufficient to meet quality and performance measure goals.
m. **Medical Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determination.
n. **Behavioral Health Coordinator** who shall be a behavioral health professional as described in Health Services Rule, 9 A.A.C. 20. The Behavioral Health Coordinator shall devote sufficient time to assure the Contractor's Behavioral Health Program is implemented per AHCCCS requirements.
o. **Provider Services Manager** and staff to coordinate communications between the Program Contractor and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt

resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program.

p. **Claims Administrator** to develop, implement and administer a comprehensive claims processing system capable of paying claims in accordance with state and federal requirements.
q. **Provider Claims Educator** (full-time equivalent employee for a Contractor with over 100,000 members) to educate contracted and non-contracted providers (i.e.: professional and institutional) regarding appropriate claims submission requirements, coding updates, electronic claims transactions and electronic fund transfer, and available Contractor resources such as provider manuals, website, fee schedules, etc. In addition, this position identifies trends and guides the development and implementation of strategies to improve provider satisfaction; communicates (i.e.: telephonic and on-site) with providers to assure the effective exchange of information and gain feedback regarding the extent to which providers are informed about appropriate claims submission practices; and identifies trends and guides the development and implementation of strategies to improve provider satisfaction
r. **Case Management Administrator/Manager** to oversee the case management functions and who shall have the qualifications of a case manager as defined in Section D, Paragraph 16.

Additional Required Staff

s. **Prior Authorization staff** to authorize health care 24 hours per day, 7 days per week. This staff shall include an Arizona-licensed nurse, physician or physician's assistant. The staff will work under the direction of an Arizona-licensed registered nurse, physician or physician's assistant.
t. **Concurrent Review staff** to conduct inpatient concurrent review. This staff shall consist of an Arizona-licensed nurse, physician, physician's assistant. The staff will work under the direction of an Arizona licensed registered nurse, physician or physician's assistant.
u. **Clerical and support staff** to ensure proper functioning of the Program Contractor's operation.
v. **Provider Services staff** to enable providers to receive prompt responses and assistance (See Section D, Paragraph 29, Network Management, for more information).
w. **Claims Processing staff** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
x. **Encounter Processing staff** to ensure the timely and accurate processing and submission to AHCCCS of encounter data and reports.
y. **Case Management Supervisor(s)** to oversee case management staff who shall have the qualifications of a case manager as defined in Section D, Paragraph 16.
z. **Case Managers** to coordinate the provision of services to members in HCBS and institutional settings.

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

1. An organization chart complete with the "**key staff"** positions (include the person's name, title and telephone number).
2. A functional organization chart of the key program areas, responsibilities and the areas which report to that position.
3. A listing of all functions and their locations; and a list of any functions that have moved outside of the State of Arizona in the past contract year.

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

In State Positions

- Administrator/CEO/COO
- Medical Director/CMO
- Compliance Officer
- Grievance Manager
- Contract Compliance Officer

- Quality Management Coordinator
- Maternal Health/EPSDT (child health) Coordinator
- Medical Management Coordinator
- Behavioral Health Coordinator
- Provider Services Manager
- Provider Claims Educator
- Concurrent Review Staff
- Clerical and Support Staff
- Provider Services Staff
- Case Management Administrator/Manager
- Case Management Supervisors
- Case Managers

Staff Training and Meeting Attendance:

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

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

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

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

26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

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

All Administrative Directives developed by DES/DDD shall be incorporated into DES/DDD's Policy Manual as outlined on the AHCCCS approved workplan. DES/DDD shall submit a quarterly report to AHCCCS by the 10th day following the end of each quarter which will include the status of Administrative Directives applicable to ALTCS not yet incorporated into DES/DDD's Policy Manual.

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

27. MEDICAL DIRECTOR

DES/DDD shall have on staff a Medical Director who is currently actively licensed as a physician in Arizona through the Arizona Medical Board or the Arizona Osteopathic Board. The Medical Director must have at least 3 years of training and/or experience appropriate to the needs of the population being served. For example, if the program is mainly focused on the medical needs of members, then training/experience should be in a medical specialty. If the program is mainly focused on the behavioral health needs of members, then the training/experience should be in a psychiatric specialty. For those programs with a significant overlap in need (behavioral and medical), then the Medical Director should have sufficient training/experience to be able to comfortably and competently deal with issues in both areas. If not, then DES/DDD must clearly identify a physician who will be available and accountable for those areas in which the Medical Director's training/experience may be lacking. The Medical Director shall be responsible for:

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

During periods when the Medical Director is not available, DES/DDD shall have adequate back-up physician staff to provide competent medical direction.

28. NETWORK DEVELOPMENT

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

- Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles of (as defined in Section D, paragraph 2):
    - *Member-Centered Case Management*

- *Consistency of Services*
- *Available and Accessible Services*
- *Most Integrated Setting*
- *Collaboration with Stakeholders*

- Support of the member's informal support system (e.g., family caregivers) through respite services, day programs, etc.
- Development of HCB services and settings to meet the needs of members who have behavioral health needs and other special medical needs.
- To provide not only linguistic services but also develop services that are able to address, as needed, the culture, race, ethnic and religious facets in the process of meeting the needs of members as described in the ACOM C*ultural Competency Policy* and Paragraph 69, Cultural Competency.

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

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

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

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

Program Contractors make up the largest payer group for paraprofessionals in the long term care market and must leverage this to ensure adequate resources in the future. Successful efforts to recruit, retain and maintain a long-term care workforce are necessary to meet the needs of the anticipated growth in the ALTCS membership. DES/DDD must have as part of their network development plan a component regarding paraprofessional work force development in alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. DES/DDD supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care. See the Citizens Workgroup on the Long-Term Care Workforce Report, April 2005, in the Bidder's Library.

DES/DDD's network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix or Tucson do not have to travel more than 5 miles to visit a PCP or pharmacy. A member residing outside the metropolitan boundary area, but within Maricopa or Pima County, must not have to travel more than 10 miles to see such providers if a provider resides within 10 miles and is willing to contract with DES/DDD. Any exceptions to the Network Standards must be prior approved by AHCCCS, Division of Health Care Management.

DES/DDD shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 4389.12(a)(1) and (2)]. In addition, DES/DDD shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit DES/DDD from limiting provider participation to the extent necessary to meet the needs of DES/DDD's members. This provision also does not interfere with measures established by DES/DDD to control costs consistent with its responsibilities under this contract nor does it preclude DES/DDD from using different reimbursement amounts for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)]. If DES/DDD declines to include individuals or groups of providers in its network, it must give the affected providers timely written notice of the reason for its decision [42 CFR 438.12(a)(1)]. DES/DDD may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)].

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

Ball v Biedess (Rodgers): In order to fulfill the settlement in the Ball v. Biedess (Rodgers) case DES/DDD is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. DES/DDD shall resolve gaps in critical services within two hours of a gap being reported.

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

DES/DDD shall implement policies and procedures to identify, correct, and track gaps in service; see the ACOM Gap in Service Policy. These policies shall, at a minimum, cover the following areas:

- Information to members on their right to receive services as authorized.
- Information to members on how to contact DES/DDD or its Subcontractor when one of the above stated services is not provided as scheduled.
- At the time of the initial and quarterly reassessment case managers are required to assess a member’s needs, including a member’s service preference level if a gap in services were to occur and develop a contingency plan in the event of a gap in a member’s services.
- DES/DDD’s process for providing services in the event of a gap in service. This shall include guidelines on how timely DES/DDD or its Subcontractor shall be in providing services in the event of a gap in service.
- Tracking and trending gaps in service and grievances as a result of gaps.

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

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

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

DES/DDD must make resources available to assist homeless clinics with administrative issues such as obtaining Prior Authorization, and resolving claims issues.

AHCCCSA will convene meetings, as necessary, with the Contractors and the homeless clinics to resolve administrative issues and perceived barriers to the homeless members receiving care. Contractor representatives must attend these meetings.

***E-Prescribing*:** The Contractor must work in collaboration with the Administration to implement E-Prescribing.

29. NETWORK MANAGEMENT

DES/DDD shall have policies on how DES/DDD will:

a. Communicate with the network regarding contractual and/or program changes and requirements;
b. Monitor network compliance with policies and rules of AHCCCS and DES/DDD, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member’s care is not compromised during the grievance/appeal processes;
c. Evaluate the quality of services delivered by the network;
d. Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;

e. Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and
f. Process expedited and temporary credentials.
g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling
h. Provide training for its providers and maintain records of such training
i. Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;
j. Ensure that provider calls are acknowledged within 3 business days of receipt; resolved and/or state the result communicated to the provider within 30 business days of receipt. If not resolved in 30 days the Contractor must document why the issue goes unresolved; however, the issue must be resolved within 90 days.

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

DES/DDD may be required to conduct meetings with providers to address issues (or to provider general information, technical assistance, etc.) related to federal and state requirements, changes in policy, reimbursement matters, prior authorization and other matters as identified or requested by the Administration.

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

All material changes in DES/DDD's provider network must be approved in advance by AHCCCS, Division of Health Care Management. The Contractor must submit the request for approval of material change, including draft notification to affected members, 60 days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. If AHCCCS does not respond within 30 days the request and the notice are deemed approved. A material change in Contractor network requires 30 days advance written notice to affected members. For emergency situations, AHCCCS will expedite the approval process.

A material change to the network is defined as one which affects, or can reasonably be foreseen to have an impact on more than 5% or more of the members and/or providers, the AHCCCS Program or may significantly impact the delivery of services by DES/DDD. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. DES/DDD shall notify AHCCCS, Division of Health Care Management, within one business day of any unexpected changes that would impair its provider network [42 CFR 438.207(c)]. This notification shall include (1) information about how the change will affect the delivery of covered services, and (2) DES/DDD's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.

30. PROVIDER MANUAL

DES/DDD shall develop, distribute and maintain a provider manual as described in the ACOM *Provider Network Information Policy*.

31. PROVIDER REGISTRATION

DES/DDD shall ensure that each of its subcontractors register with AHCCCS as an approved service provider. A Provider Participation Agreement must be signed by each provider who is not an AHCCCS registered provider. The original shall be forwarded to AHCCCS. The provider registration process must be completed in order for DES/DDD to report services a provider renders to enrolled members and for DES/DDD to be paid reinsurance.

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

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

32. NETWORK SUMMARY

DES/DDD shall submit a listing of independent and agency HCBS and therapy providers with the Network Management and Development Plan, see Section D, Paragraph 28. This network summary should include a waiting list for therapy and HCBS services. An update of the network and waiting list shall be submitted by October 15 and May 15. The AHCCCS Division of Health Care Management will notify DES/DDD if there is a change in the submitted frequency.

33. SUBCONTRACTS

DES/DDD shall be legally responsible for contract performance whether or not subcontracts are used [42 CFR 438.230(a) and 434.6(c). No subcontract shall operate to terminate the legal responsibility of DES/DDD to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by DES/DDD pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing [42 CFR 438.6(1)]. See the ACOM *Contractor Claims Processing by Health Plan Subcontracted Providers Policy.*

All subcontracts entered into by DES/DDD are subject to prior review and written approval by AHCCCS, Contracts and Purchasing, and shall incorporate by reference the applicable terms and conditions of this contract. The following types of Administrative Services subcontracts shall be submitted to AHCCCS Division of Health Care Management for prior approval at least 30 days prior to the beginning date of the subcontract:

Administrative Services Subcontracts:

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

DES/DDD shall submit by September 1, 2008 to the AHCCCS Division of Health Care Management copies of all current Administrative Services subcontracts. DES/DDD shall submit to AHCCCS copies of Administrative Services subcontracts request for proposals (RFPs) at the time they are formally issued to the Public.

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

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

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor, DES/DDD must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If DES/DDD delegates duties or responsibilities to a subcontractor, then DES/DDD shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance in inadequate. In order to determine adequate performance, DES/DDD 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)]

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

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

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

DES/DDD shall promptly inform AHCCCS, Division of Health Care Management, in writing if a subcontractor is in significant non-compliance that would affect their abilities to perform the duties and responsibilities of the subcontract.

DES/DDD 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 enrollee.

Provider Agreements

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

DES/DDD or its subcontractors shall require any ADHS licensed or certified provider to submit their most recent ADHS licensure review, copies of substantiated complaints and other pertinent information that is available and considered to be public information from oversight agencies. DES/DDD shall ensure contracted providers comply with quality assurance measures such as supervisory visits by a Registered Nurse when a home health aide is providing services.

DES/DDD must enter into a written agreement with any provider DES/DDD reasonably anticipates will be providing services at the request of DES/DDD more than 25 times during the contract year [42 CFR 438.206(b)(1)]. Exceptions to this requirement include the following:

a. If a provider who provides services more than 25 times during the contract year refuses to enter into a written agreement with DES/DDD, DES/DDD shall submit documentation of such refusal to AHCCCS Division of Health Care Management within seven days of its final attempt to gain such agreement.
b. If a provider performs emergency services such as an emergency room physician or an ambulance company, a written agreement is not required.
c. Individual providers as detailed in the *AMPM*
d. Hospitals, as discussed in Section D, Paragraph 36, Hospital Subcontracting and Reimbursement
e. If a provider primarily performs services in an inpatient setting
f. If upon the Medical Director's review, it is determined that DES/DDD or members would not benefit by adding the provider to the contracted network.

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

All subcontracts must contain language that is in compliance with State contracting regulations. In addition, each provider subcontract must contain the following [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 patient capacity, to be covered by the subcontractor.
d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation. Program Contractors shall give hospitals and physician groups 90 days notice prior to a contract termination without cause. Contracts between the Contractor and single practitioners are exempt from this requirement.
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 DES/DDD.
h. A description of the subcontractor's patient, medical, dental and cost record keeping system.
i. Specification that the subcontractor shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.
j. A provision stating that a merger, reorganization or change in ownership of an Administrative Services subcontractor of DES/DDD shall require a contract amendment and prior approval of AHCCCS.
k. A provision that indicates that AHCCCS is responsible for enrollment, re-enrollment and disenrollment of the covered population.
l. A provision that the subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage obligations which arise under this subcontract, for itself and its employees, and that AHCCCS shall have no responsibility or liability for any such taxes or insurance coverage.
m. A provision that the subcontractor must obtain any necessary authorization from DES/DDD or AHCCCS for services provided to eligible and/or enrolled members.
n. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
o. Provision(s) that allow DES/DDD to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.
p. For Nursing Facility subcontracts, a provision that the subcontractor must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e) 3 and (g) 2. The provision must also require the subcontractor to ensure these registry personnel are fingerprinted as required by ARS 36-411.

q. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee (42 CFR 438.210(e))

Subcontractor Compliance with Contract Requirements **-** DES/DDD shall be held fully liable for the performance of all contract requirements and shall develop and maintain a system of regular and periodic assessment of all subcontractors' compliance with its terms.

DES/DDD shall conduct onsite monitoring and performance measurement analysis of significant subcontractors, such as those subcontractors responsible for member assignment to providers, development of provider networks, prior authorization and/or claims payments (i.e., acute care subcontractors, claims processing subcontractors, behavioral health subcontractors). For these subcontractors, DES/DDD shall forward to AHCCCS, Office of Managed Care, copies of any operational and financial reviews or audits conducted by DES/DDD for the purpose of, but not limited to, ensuring program compliance. Oversight activities shall include, but are not limited to:

a. Review of subcontractor's adherence to contract provisions through chart review, review of reports, review of QM/UM findings and reports;
b. Review of provider credentials;
c. Review and assessment of adequacy of network;
d. Review and assessment of claims payment process; and
e. Review and analysis of subcontractor's financial viability

DES/DDD shall promptly advise AHCCCS, Division of Health Care Management, in writing of the subcontractor's non-compliance and of corrective actions taken.

34. ADVANCE DIRECTIVES

DES/DDD shall maintain policies and procedures addressing directives for adult members that specify [42 CFR 422.128]:

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

b. DES/DDD shall require subcontracted PCP's to comply with the requirements of subparagraph a.(2) through a.(5) above. DES/DDD shall also encourage health care providers specified in subparagraph (a). To provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

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

35. SPECIALTY CONTRACTS

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

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

Currently, AHCCCS only has specialty contracts for transplant services and anti-hemophiliac agents and pharmaceutical related services. AHCCCS shall provide at least 60 days advance written notice to DES/DDD prior to the implementation of any specialty contract. See Section D, Paragraph 58, Reinsurance, for further details.

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

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

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

***For Out-of-State Hospitals**:* The Contractor shall reimburse out-of-state hospitals in accordance with 9 A.A.C. 28, Article 7. A Contractor serving border communities (excluding Mexico) are strongly encouraged to establish contractual agreements with bordering out-of-state hospitals.

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

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

37. PRIMARY CARE PROVIDER STANDARDS

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

DES/DDD shall assess the PCP's ability to meet AHCCCS appointment availability and other standards when determining the appropriate number of its members to be assigned to a PCP. DES/DDD should also consider the PCP's total panel size (e.g., AHCCCS and non-AHCCCS patients) when making this determination. AHCCCS members shall not comprise the majority of a PCP's panel of patients. AHCCCS shall inform DES/DDD when a PCP has a panel of more than 1,800 AHCCCS members, to assist in the assessment of the size of their panel. This information will be provided on a quarterly basis. DES/DDD will adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards.

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

The Contractor shall ensure that providers serving EPSDT-aged members utilize the AHCCCS-approved standard developmental screening tools and are trained in the use of the tools. The Contractor is encouraged to assign EPSDT-aged members to providers that are trained in the use of, and have expressed willingness to use, AHCCCS-approved developmental screening tools.

To the extent required by this contract, DES/DDD shall offer members freedom of choice within its network in selecting a PCP [42 CFR 438.6(m) and 438.52(d)]. DES/DDD may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to DES/DDD, DES/DDD shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of DES/DDD's receipt of notification of assignment by AHCCCS. DES/DDD shall include with the enrollment notification a list of all DES/DDD's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the ACOM *Member Information Policy*. DES/DDD shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

a. Supervision, coordination and provision of care to each assigned member (except for well woman exams and children's dental services when provided without a PCP referral);
b. Initiation of referrals for medically necessary specialty care;
c. Maintaining continuity of care for each assigned member; and
d. Maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral services.

DES/DDD will work with AHCCCS to develop a methodology to reimburse school based clinics. AHCCCS and DES/DDD will identify coordination of care processes and reimbursement mechanisms. DES/DDD will be responsible for payment of these services directly to the clinics.

DES/DDD shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty and referral services provided to assigned members by specialty physicians, and other health care professionals. DES/DDD policies and procedures shall be subject to approval by AHCCCS, Division of Health Care Management, and shall be monitored through operational audits.

38. APPOINTMENT STANDARDS

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

DES/DDD shall have monitoring procedures in place that ensure:

For **PCP appointments**, DES/DDD shall be able to provide:
a. Emergency appointments the same day or within 24 hours of the member's phone call or other notification, or as medically appropriate
b. Urgent care appointments within two days
c. Routine care appointments within 21 days

For **specialty referrals**, DES/DDD shall be able to provide:
a. Emergency appointments within 24 hours of referral
b. Urgent care appointments within 3 days of referral
c. Routine care appointments within 45 days of referral

For **behavioral health services,** DES/DDD shall be able to provide appointments as follows:
a. Emergency appointments within 24 hours of referral.
b. Routine appointments within 30 days of referral.

For **dental appointments**, DES/DDD shall be able to provide:
a. Emergency appointments within 24 hours
b. Urgent appointments within 3 days of request
c. Routine care appointments within 45 days of request

For **maternity care**, DES/DDD shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:
a. First trimester- within 14 days of request
b. Second trimester within 7 days of request
c. Third trimester within 3 days of request

d. High risk pregnancies within 3 days of identification of high risk by DES/DDD or maternity care provider, or immediately if an emergency exists

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

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

For **medically-necessary non-emergent transportation,** DES/DDD shall require its transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; does not have to wait more than one hour after calling for transportation after the conclusion of the appointment to be picked up; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor to be picked up prior to the completion of treatment.

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

DES/DDD shall establish processes to monitor and reduce the appointment "no-show" rate for PCPs, dentists and transportation providers. As best practices are identified, AHCCCS may require implementation by the Contractor.
DES/DDD shall have written policies and procedures about educating its provider network about appointment time requirements. DES/DDD must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. DES/DDD is encouraged to include the standards in the provider subcontracts.

39. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

Physician Incentives

Reporting of Physician Incentive Plans has been suspended by CMS until further notice. No reporting to CMS is required until the suspension is lifted. However, AHCCCS requires the Contractor to disclose the information on physician incentive plans listed in 42 CFR 417.479(h)(1) through 417.479(I) upon contract renewal, prior to initiation of a new contract, or upon request from AHCCCS or CMS.

The DES/DDD 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. DES/DDD is required to disclose all physician incentive agreements to AHCCCS and to AHCCCS members who request them.

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

1. A complete copy of the contract
2. A plan for the member satisfaction survey
3. Details of the stop-loss protection provided

4. A summary of the compensation arrangement that meets the substantial financial risk definition.

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

Value Driven Healthcare/Pay for Performance

AHCCCS may explore opportunities to develop and implement system-wide Value Driven Healthcare programs and pay for performance initiatives. The Contractor shall participate in the development and implementation of such programs as requested by AHCCCS. Should the Contractor's individual pay for performance program conflict with AHCCCS programs, the Contractor may be required to close out the individual program. AHCCCS may require the Contractor to provide PCP assignment information. The Contractor shall provide this information in a format specified by AHCCCS upon request.

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

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

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

Public Reporting of Contractor Cost Management, Satisfaction and Quality Performance
AHCCCS is in the process of developing a cost management, satisfaction, and quality score card as part of the AHCCCS value driven decision support initiative. The score card information will be made available to beneficiaries, legislators and the public. These reports will be posted on the AHCCCS website. Contractors are also encouraged to provide quality and cost information on network hospitals and providers to help enrollees choose among high performing value driven providers and hospitals.

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

DES/DDD shall have adequate written procedures regarding referrals to specialists, to include, at a minimum, the following:

a. Use of referral forms clearly identifying the Contractor
b. PCP referral shall be required for specialty physician services, except that women shall have direct access to in-network GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services [42 CFR 438.206(b)(2)]. In addition, for members with special health care needs determined to need a specialized course of treatment or regular care monitoring, DES/DDD must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. Any waiver of this requirement by DES/DDD must be approved in advance by AHCCCS.
c. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.
d. A process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services
e. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services
f. Referral to Medicare Managed Care Plan
g. Allow for a second opinion from a qualified health care professional within the network, or if one is not available in network, arrange for the member to obtain one outside the network, at no cost to the member [42 CFR 438.206(b)(3)].

DES/DDD shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act and their implementing regulations which include but are not limited to 42 CFR Part 411, Part 424, Part 435 and Part 455. Sections 1903(s) and 1877 of the Act prohibits

physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services include:

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

41. MAINSTREAMING OF ALTCS MEMBERS

To ensure mainstreaming of ALTCS members, DES/DDD shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information or physical or mental handicap, except where medically indicated. DES/DDD must take into account a member's literacy and culture, when addressing members and their concerns, and must take reasonable steps to encourage subcontractors to do the same. DES/DDD must also make interpreters, including assistance for the visual and hearing impaired, available to members to ensure appropriate delivery of covered services.

Examples of prohibited practices include, but are not limited to, the following, in accordance with Title VI of the US Civil Rights Act of 1964, 42 USC, Section 2001, Executive Order 13144 and rules and regulation promulgated according to, or as otherwise provided by law:

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

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

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

42. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHCS)

DES/DDD is encouraged to use FQHCs/RHCs in Arizona to provide covered services. AHCCCS requires DES/DDD to negotiate rates of payment with FQHCs/RHCs for non-pharmacy services that are comparable to

the rates paid to providers that provide similar services. AHCCCS reserves the right to review a Contractor's negotiated rates with an FQHC/RHC for reasonableness and to require adjustments when negotiated rates are found to be substantially less than those being paid to other, non-FQHC/RHC providers for comparable services.

DES/DDD is required to submit member month information for Title XIX members for each FQHC/RHC on a quarterly basis to AHCCCS Division of Health Care Management. AHCCCS will perform periodic audits of the member information submitted. DES/DDD should refer to the AHCCCS reporting Guide for ALTCS Program Contractors for further guidance. THE FQHCs/RHCs registered with AHCCCS are listed on the AHCCCS website at www.azahcccs.gov.

43. RESERVED

44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

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

DES/DDD will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least 6 months before the anticipated implementation date, the contractor shall provide the system change plan to AHCCCS for review and comment.

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

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

In addition to the above required audit, the Contractor shall develop and implement an internal claims audit function that will include the following:

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

The findings of the audits described above must be documented and any deficiencies noted in the resulting reports must be met with corrective action.

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

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

- Correct Coding Initiative (CCI) for Professional and Outpatient services;
- Multiple Surgical Reductions;
- Global Day Bundling;
- Multi Channel Lab Test Bundling;

The Contractor claims payment system must be able to assess and/or apply the following data related edits:

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

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

- an adequate description of all denials and adjustments,
- the reasons for such denials and adjustments,
- the amount billed,
- the amount paid,
- application of COB and SOC and
- provider rights for claim disputes.

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). The remittance advice sent related to an EFT must be mailed, or sent to the provider, no later than the date of the EFT. If the remittance is made through EFT, a notice of the provider's right for claim dispute must be sent to the provider concurrently.

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

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

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

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

If DES/DDD 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.

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

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

Unless a shorter time period is specified in contract, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or pay a clean claim submitted more than 12 months after date of service except as directed by AHCCCS or otherwise noted in this contract. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at DES/DDD's specified claims mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the claim end date or the effective date of eligibility posting, whichever is later as stated in A.R.S. 36-2904H.

DES/DDD must have procedures for either pre-payment or post payment claims review that includes review of supporting documentation such as medical records, home health visit notes, in addition to authorizations.

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

- DES/DDD must be able to offer Electronic Claims Submission and Electronic Claims transfer to all providers. Additionally, DES/DDD shall continue to develop and implement processes to continue to increase the proportion of:

    a. claims received electronically, and
    b. claim payments via electronic funds transfer

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

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

DES/DDD shall submit a claims dashboard report quarterly that includes:

a. Number of claims received
b. Number of claims adjudicated as clean
c. Number of claims on error/pend
d. Number and percent of clean claims adjudicated within 30 days of receipt
e. Number and percent of clean claims adjudicated within 60 days of receipt

The quarterly report must be received by the AHCCCS, Division of Health Care Management, no later than 15 days from the end of each quarter.

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

45. RESERVED

46. RESERVED

47. RESERVED

48. ACCUMULATED FUND DEFICIT

DES/DDD shall fund any accumulated fund deficit through capital contributions in a form acceptable to AHCCCS within 60 days after receipt by AHCCCS of the final audited financial statement. The amount of any accumulated fund deficit will be determined in accordance with DES/DDD's annual audited financial statements.

49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLANS

If DES/DDD has subcontracted for management services, the management service agreement must be approved in advance by AHCCCS, Division of Health Care Management. If there is a cost allocation plan as part of the management services agreement, it is subject to review by AHCCCS upon request. AHCCCS reserves the right to perform a thorough review of actual management fees charged and/or cost allocations made. If there is a change in ownership of the entity with which the Contractor has contracted for management services, AHCCCS must review and provide prior approval of the assignment of the subcontract to the new owner. AHCCCS may offer open enrollment to the members assigned to the Contractor should a change in ownership occur. AHCCCS will not permit two Contractors to utilize the same management service company in the same GSA.

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

50. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

DES/DDD shall not, without the prior approval of AHCCCS, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line of business within its organization. DES/DDD shall not, without prior approval of AHCCCS, make advances to its providers in excess of $50,000. All requests for prior approval and notifications are to be submitted to the AHCCCS Division of Health Care Management. Refer to the ACOM *Provider and Affiliate Advance Request Policy* for further information.

51. RESERVED

52. FINANCIAL PERFORMANCE GUIDELINES

DES/DDD must comply with the AHCCCS established financial performance guidelines. These guidelines will be monitored by AHCCCS on a quarterly basis as part of AHCCCS' due diligence in financial statement monitoring. Sanctions may not be imposed if DDD does not meet the performance guidelines, however, if guidelines are consistently not met, additional monitoring, such as monthly reporting, may be required.

Performance Guidelines

Medical Expense Ratio Total medical expense (including case management) divided by total payments received by AHCCCS less premium tax	Standard: At least 85%
Total Administrative Cost Percentage Total administrative expenses (excluding case management, premium tax and income taxes) divided by total payments received from AHCCCS less premium tax.	Standard: No greater than 8%

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

53. RESERVED

54. RESERVED

55. RELATED PARTY TRANSACTIONS

Any proposed subcontract involving a related party or entity requires prior approval from AHCCCS, Division of Health Care Management. The minimum information required on ownership and control in related party transactions is set by federal law (42 CFR 455.100 through 455.106) and DES/DDD shall disclose all required information, justify all related party transactions reported, and certify the accuracy and completeness of the disclosures made. DES/DDD shall demonstrate that transactions occurring between the provider and a related party-in-interest are reasonable, will not adversely affect the fiscal soundness of DES/DDD, and do not present a conflict of interest.

56. COMPENSATION

Capitation Payments: DES/DDD shall be compensated on a capitated basis using a cost-based rate blending the Ventilator and Non-Ventilator populations. The capitation rates will be effective for the period July 1, 2008 through June 30, 2009. Actuaries established the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purposes of rebasing the capitation rates:

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

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis of the capitation rates.

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary to maintain actuarially sound rates. DES/DDD may cover services for members that are not covered under the State Plan; however those services are not included in the data provided to actuaries for setting capitation rates.

The capitation rate includes an assumed cost per member per month for DES/DDD to provide reinsurance to its subcontracted health plans. This will be considered full reimbursement for all reinsurance cases of $100,000 or less. For reinsurance claims of over $100,000, DES/DDD will be reimbursed at 75% of the allowable charges over the deductible limit of $100,000. Reinsurance covers acute hospitalizations only. AHCCCS will use inpatient encounter information to determine the reinsurance payable to DES/DDD.

Subject to the availability of funds, AHCCCS shall make payments to DES/DDD in accordance with the terms of this contract provided that DES/DDD's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of ARS Title 36. Capitation payments will be made no later than the fifth business day of the month for which the payment is due, dependent on the availability of sufficient state match funds.

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

Behavioral Health Services: AHCCCS will transfer to ADHS, on behalf of DES/DD, the capitation rate for behavioral health services to Title XIX DES/DD ALTCS members. ADHS shall be responsible for the state match for Title XIX ALTCS behavioral health expenditures. AHCCCS shall provide DES/DD with a copy of each transfer of federal funds made to ADHS, as well as a roster of those eligible persons for which capitation payments were made. DES/DD shall use the daily and monthly behavioral health rosters provided by AHCCCS to review and validate eligible persons.

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

Requests for Federal Financial Participation (FFP): Requests for federal financial participation (FFP) from DES/DDD and the pass through of these funds to DES/DDD from AHCCCS shall both adhere to the mandatory Cash Management Improvement Act (CMIA) of 1990 as established by the General Accounting Office of the Arizona Department of Administration (GAO/ADOA).

DES/DDD receives legislative appropriations for DD Title XIX services and a 100% state-funded DD services program. DES/DDD shall, by July 1st on an annual basis, transfer to AHCCCS the total amount appropriated for the state match for Title XIX ALTCS expenditures, the DES/DDD share of Medicare phase-down payments to CMS as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and the total estimated amount sufficient to provide the required state match for Title XIX eligible targeted case management expenditures. This transfer shall be made, in its entirety, prior to the first Title XIX disbursement. AHCCCS shall deposit the monies transferred into an Intergovernmental Agreement (IGA) Fund of which AHCCCS shall have sole disbursement authority.

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

AHCCCS also will use monies in the IGA Fund to make monthly disbursements to CMS for the DES/DDD share of Medicare phase-down payments made in accordance with the MMA for drug benefit costs assumed by Medicare for full dual eligible members. Payment amounts will be made in a manner specified by CMS and will be funded prior to monthly capitation if insufficient funds are remaining in the IGA Fund.

If AHCCCS determines that additional monies are required, AHCCCS shall notify DES/DDD 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 ARS § 35-190 - 191, monies remain in the IGA Fund, AHCCCS shall notify DES/DDD and transfer these monies back to DES/DDD. If it is determined that excessive funds exist in the IGA Fund, DES/DDD may request a withdrawal of monies prior to the end of a state fiscal year and/or prior to the close of the administrative adjustment period.

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

DES/DDD or its subcontractors shall collect any required copayment from members but service will not be denied for inability to pay the copayment. Except for permitted copayments, DES/DDD or its subcontractors shall not bill or attempt to collect any fee from, or for, a member for the provision of covered services. Any required copayments collected shall belong to DES/DDD or its subcontractors.

Effective July 1, 2008 the HIV – AIDS Supplement will be incorporated into the capitation rate.

Liability for Payment: Except for permitted copayments and calculated share of costs, DES/DDD or its subcontractors must ensure that members are not held liable for:

a. DES/DDD or subcontractor's debts in the event of DES/DDD or subcontractor's insolvency;
b. covered services provided to the member, for which AHCCCS does not pay DES/DDD and DES/DDD does not pay subcontractors; or
c. payments to DES/DDD or subcontractors for covered services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount the member would owe if DES/DDD or the subcontractor provided the services directly.

Medicare Part D Copay Funding: Beginning October 1, 2006, AHCCCS also will use monies in the IGA Fund to pay the prescription drug copayment and administrative fee for DES/DDD members who are low income individuals qualifying for both Medicare and Medicaid. No FFP is available for these payments. Payment amounts will be made to the AHCCCS Pharmacy Benefit Manager (PBM) responsible for coordinating with Medicare Part D drug pharmacy providers and will consist of a copayment per prescription of $1, $2, $3 or $5 and a PBM administrative fee. Payments to the PBM will be funded after Medicare phase-down payments but prior to monthly capitation if insufficient funds are remaining in the IGA Fund."

57. ANNUAL SUBMISSION OF BUDGET

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

If at any time during the term of this contract DES/DDD determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. DES/DDD, with AHCCCS, may request additional money from the Governor's Office of Strategic Planning and Budgeting.

58. REINSURANCE

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

DES/DDD will be reimbursed at 75% of the allowable charges over the deductible limit of $100,000 for regular inpatient reinsurance claims. Reinsurance covers acute inpatient hospitalizations only. Reimbursement for these reinsurance benefits will be made to DES/DDD each month.

Catastrophic Reinsurance: Catastrophic Reinsurance encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with hemophilia, Von Willebrand's Disease, Gaucher's Disease. For additional detail and restrictions refer to the *AHCCCS Reinsurance Claims Processing* Manual and the *AMPM*. There are no deductibles for catastrophic reinsurance cases. For members receiving Biotech drugs outside of specific conditions mentioned in this paragraph, AHCCCS will reimburse at 85% of the cost of the drug only. For those members diagnosed with hemophilia, Von Willebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement

at 85% of the AHCCCS allowed amount or DES/DDD's paid amount, whichever is lower, depending on the subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCCS contracted amount or DES/DDD's paid amount, whichever is lower. All catastrophic claims are subject to medical review by AHCCCS.

AHCCCS holds a single-source specialty contract for anti-hemophilic agents and related services for hemophilia. Non-hemophilia related services are not covered under this specialty contract. Non-hemophilia-related care is defined as any care that is provided not related to the hemophilia services.

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

DES/DDD must notify AHCCCS, Division of Health Care Management, Medical Management Unit, of cases identified for catastrophic reinsurance coverage excluding coverage of Biotech drugs outside of those conditions mentioned in this paragraph, within 30 days of initial diagnosis and/or enrollment with DES/DDD, and annually 30 days prior to the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCS. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria: 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona for the type of case under consideration.

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

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

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

Biotech Drugs: Catastrophic reinsurance is available to cover the cost of certain biotech drugs when medically necessary. These drugs, collectively referred to as Biotech Drugs, are the responsibility of the Contractor unless the member is CRS enrolled, the medications are related to the management of a CRS covered condition, and CRS is providing coverage. Catastrophic reinsurance will cover the drug cost only. The drugs covered are Cerazyme, Aldurazyme, Fabryzyme, Myozyme, Elaprase, and Ceprotin. The Biotech Drugs covered under reinsurance will be reviewed by AHCCCS at the start of each contract year. AHCCCS reserves the right to require the use of a generic equivalent where applicable. AHCCCS will reimburse at the lesser of the Biotech Drug or its generic equivalent for reinsurance purposes.

Transplants: This program covers members who are eligible to receive covered major organ and tissue transplantation including bone marrow, heart, heart/lung, lung liver kidney and other organ transplantation. Bone grafts and cornea transplantation services are not eligible for transplant reinsurance coverage but are eligible under the regular inpatient reinsurance program. Refer to the *AMPM* for covered services for organ and tissue transplants. Reinsurance coverage for transplants received at an AHCCCS contracted facility is to be paid at the less or of 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of DES/DDD's paid amount. Reinsurance coverage for transplants received at a non-AHCCCS contracted facility is paid the lesser of 85% of the lowest AHCCCS contracted rate, for the same organ or tissue, or the Contractor paid amount. The AHCCCS contracted transplantation rates may be found on the AHCCCS website. When a member is referred to a transplant facility for an AHCCCS covered organ

transplant, DES/DDD shall notify AHCCCS, Division of Health Care Management, Medical Management Unit as specified in the AMPM Chapter 300, Policy 310 Attachments A and B.

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

Encounter Submission and Payments for Reinsurance

a) Encounter Submission: All reinsurance associated encounters must reach a clean status within fifteen months from the end date of service, or date of eligibility posting, whichever is later. Encounters for reinsurance claims that have passed the fifteen month deadline and are being adjusted due to a claim dispute or hearing decision must be submitted and pass all encounter and reinsurance edits within 90 calendar days of the date of the claim dispute decision or hearing decision or Director's decision, whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss in any related reinsurance dollars.

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

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

c) Payment of Transplant Reinsurance Cases: Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the DES/DDD's paid amount, subject to coinsurance percentages. Effective for dates of service on or after October 1, 2004, DES/DDD is required to submit all supporting service encounters for transplant services. Reinsurance payments will be linked to transplant encounter submissions. In order to receive reinsurance payment for transplant stages, billed amounts and health plan paid amounts for adjudicated encounters must agree with related claims and/or invoices. Timeliness for each stage payment will be calculated based on the latest adjudication date for the complete set of encounters related to the stage. Please refer to the *Reinsurance Claims Processing Manual* for appropriate billing of transplant services.

Reinsurance Audits

***Pre-audit*:** Medical audits on prospective and prior period coverage reinsurance cases will be determined based on statistically valid retrospective random sampling or on targeted cases/encounters selected on utilization trend information. For closed contracts, a 100% audit may be conducted. AHCCCS, Division of Health Care Management, Reinsurance Unit, will generate the cases and/or encounters selected and will notify DES/DDD of documentation needed for the medical audit process to occur. The Reinsurance Unit may select cases based on encounter data received during the existing contract year to ensure timeliness of the audit process.

***Audits*:** AHCCCS will give DES/DDD at least 45 days advance notice of any on-site audit. DES/DDD shall have all requested medical records and financial documentation on-site and available to the nurse auditors. Any documents not requested in advance by AHCCCS shall be made available upon request of the Audit Team during the course of the audit. A DES/DDD representative shall be available to the Audit Team at all times during AHCCCS on-site audit activities. If an audit should be conducted on-site, DES/DDD shall provide the Audit Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

Audits may also be completed without an on-site visit. For these audits, DES/DDD will be asked to send the required documentation to AHCCCS. The documentation will then be reviewed by AHCCCS.

Audit Considerations: Reinsurance consideration will be given to inpatient facility contracts and hearing decisions rendered by the Office of Legal Assistance. Pre-hearing and/or hearing penalties discoverable during the review process will not be reimbursed under reinsurance.

Audit Determinations: DES/DDD will be furnished a copy of the Reinsurance Post-Audit Results letter approximately 45 days after the audit and given an opportunity to comment and provide additional medical or financial documentation on any audit findings. AHCCCS may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by DES/DDD. A recoupment of reinsurance reimbursements made to DES/DDD may occur based on the results of the medical audit.

In the event that a reinsurance case is reduced or denied, DES/DDD shall be notified in writing by AHCCCS and will be informed of the cause for the reduction or denial determination and the applicable grievance and appeal process available. AHCCCS reserves the right to sanction DES/DDD for reinsurance audit exceptions.

59. CAPITATION ADJUSTMENTS

Except for changes made specifically in accordance with this contract, the rates set forth in Section B shall not be subject to re-negotiation or modification during the contract period. AHCCCS may, at its option, review the effect of a program change and determine if a capitation adjustment is needed. In these instances the adjustment will be prospective with assumptions discussed with DES/DDD prior to modifying capitation rates. DES/DDD may request a review of a program change if it believes the program change was not equitable; AHCCCS will not unreasonably withhold such a review.

If DES/DDD is in any manner in default in the performance of any obligation under this contract, AHCCCS may, at its option and in addition to other available remedies, adjust the amount of payment until there is satisfactory resolution of the default. DES/DDD shall reimburse AHCCCS and/or AHCCCS may deduct from future monthly capitation for any portion of a month during which DES/DDD was not at risk due to, for example:

a. death of a member
b. inmate of a public institution
c. duplicate capitation paid for the same member
d. adjustment based on change in member's contract type

e. voluntary withdrawal

Upon becoming aware that a member may be an inmate of a public institution, the Contractor must contact AHCCCS for an eligibility determination.

If a member is enrolled twice with DES/DDD, recoupment will be made as soon as the double capitation is identified. AHCCCS reserves the right to modify its policy on capitation recoupments at any time during the term of this contract.

60. MEMBER SHARE OF COST

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

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

61. COPAYMENTS

ALTCS members are not required to make copayments for ALTCS covered services [42 CFR 438.108].

62. PEDIATRIC IMMUNIZATION AND THE VACCINE FOR CHILDREN PROGRAM

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

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

Arizona State law requires the reporting of all immunizations given to children under the age of 19. Immunizations must be reported at least monthly to the ADHS. Reported immunizations are held in a central

database known as ASIIS (Arizona State Immunization Information System), which can be accessed by providers to obtain complete, accurate immunization records. Software is available from ADHS to assist providers in meeting this reporting requirement. Contractors must educate their provider network about these reporting requirements and the use of this resource and monitor to ensure compliance.

63. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. DES/DDD shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by DES/DDD are cost avoided or recovered from a liable party. DES/DDD 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. DES/DDD shall use these methods as described in A.A.C. R9-22-1001 et seq and federal and state law. (See also Section D, Paragraph 64, Medicare Services and Cost Sharing).

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

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

If a third-party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, DES/DDD is responsible for making these payments, even if the services are provided outside of the DES/DDD network. DES/DDD is not responsible for paying coinsurance and deductibles that are in excess of what DES/DDD would have paid for the entire service per a written contract with the provider performing the service, or the AHCCCS FFS payment equivalent when no contract exists. If DES/DDD refers the member for services to a third-party insurer, other than Medicare, and the insurer requires payment in advance of all co-payments, coinsurance and deductibles, DES/DDD must make such payments in advance.

If DES/DDD knows that the third party insurer will not pay the claim for a covered service due to untimely claim filing or as a result of the underlying insurance coverage (e.g. the service is not a covered benefit), DES/DDD shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. DES/DDD shall communicate any known change in health insurance information, including Medicare, to AHCCCS Administration, Division of Member Services, not later than 10 days from the date of discovery using the approved AHCCCS correspondence. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80. If DES/DDD does not know whether a particular service is covered by the third-party, and the service is medically necessary, DES/DDD shall contact the third-party and determine whether or not such service is covered rather than requiring the member to do so. In the event that the service is not covered by the third-party, DES/DDD shall arrange for the timely provision of the service. (See also Section D, Paragraph 64, Medicare Services and Cost Sharing.)

The requirement to cost-avoid applies to all AHCCCS covered services. For prenatal care and preventive pediatric services, AHCCCS may require DES/DDD to provide such service and then coordinate payment with the potentially liable third-party ("pay and chase"). In emergencies, DES/DDD shall provide the necessary services and then coordinate payment with the third-party payer. DES/DDD shall also provide medically necessary transportation so the member can receive medical benefits. Further, if a service is medically necessary, DES/DDD shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member shall not be required to pay any coinsurance or deductibles for use of the other insurer's providers.

Members with CRS condition:
A member with private insurance or Medicare coverage is not required to utilize CRSA. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. If the member uses the private insurance network for a CRS covered condition, the Contractor is responsible for all applicable deductibles and copayments. However, if the member has Medicare coverage, the AHCCCS Policy 201- *Medicare Cost Sharing for Members in Traditional Fee for Service Medicare* and Policy 202 - *Medicare Cost Sharing for Members in Medicare Managed Care Plans* shall apply. When the private insurance or Medicare is exhausted, or certain annual or lifetime limits are reached with respect to CRS covered conditions, the Contractor shall refer the member to CRSA for determination for CRS services. If the member with private insurance or Medicare chooses to enroll with CRS, CRS becomes the secondary payer responsible for all applicable deductibles and copayments. The Contractor is not responsible to provide services in instances when the CRS eligible member, who has no primary insurance or Medicare, refuses to receive CRS covered services through the CRS Program. If the Contractor becomes aware that a member with a CRS covered condition refuses to participate in the CRS application process or refuses to receive services through the CRS Program, the member may be billed by the provider in accordance with AHCCCS regulations regarding billing for unauthorized services.

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

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

Other Recoveries: DES/DDD shall identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 799.9 and 800 to 999.9 (excluding code 994.6) and other procedures. DES/DDD shall not pursue recovery in the following circumstances unless the case has been referred to DES/DDD by AHCCCS or AHCCCS' authorized representative:

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

Upon identification of any of the above situations, the Program Contractor shall promptly report any cases involving the above circumstances to AHCCCS' authorized representative for determination of a "total plan" case. A total plan case is a case where payments for services rendered to the member are exclusively the responsibility of the Program Contractor; no reinsurance or fee-for-service payments are involved. By contract, a "joint" case is one where fee-for-service payments and/or reinsurance payments are involved. In joint cases, the Program Contractor shall notify AHCCCS' authorized representative within 10 business days of the identification of a liable party case with reinsurance or fee-for-service payments made by AHCCCS.

Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions. The Program Contractor shall cooperate with AHCCCS' authorized representative in all collection efforts.

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

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

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

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

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

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

Other Reporting Requirements: If a Contractor discovers the probable existence of a liable party that is not known to AHCCCS, the Contractor must report the information to the AHCCCS contracted vendor not later than 10 days from the date of discovery. In addition, the Contractor shall notify AHCCCS of any known changes in coverage within deadlines and in a format prescribed by AHCCCS in the *Technical Interface Guidelines*. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 80, Sanctions.

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

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

64. MEDICARE SERVICES and COST SHARING

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

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

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

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

1. Program Contractors must ensure that member placement information on the CA 161 screen is timely and as accurate as possible. Information regarding members placed in medical institutions funded by Medicaid for a full calendar month will be submitted to CMS.

2. Program Contractors will complete the ALTCS Medical Institution Notification form for Dual Eligibles members who are placed in the medical institutions listed below to the AHCCCS Member Database Management Administration, via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month:

   a. Acute hospital
   b. Psychiatric Hospital – Non IMD
   c. Psychiatric Hospital – IMD

65. RESERVED

66. SURVEYS

DES/DDD may be required to perform its own annual general or focused member survey. All such surveys, along with a timeline for the project, must be approved in advance by AHCCCS. Results, analysis and improved strategies shall be communicated to AHCCCS Division of Health Care Management, ALTCS Operations Unit within 45 days of completion. AHCCCS may require inclusion of certain questions. DES/DDD is required to include questions related to case manager performance, appointment waiting time, transportation wait times and culturally competent treatment on member surveys and to use personnel other than the case manager to administer the survey.

AHCCCS may periodically conduct a survey of a representative sample of DES/DDD's membership. AHCCCS will consider suggestions from DES/DDD for questions to be included in this survey. The results of these surveys will become public information and available to all interested parties upon request.

67. PATIENT TRUST ACCOUNT MONITORING

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

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

68. AMERICAN WITH DISABILITIES ACT (ADA) COMPLIANCE

DES/DDD shall meet all applicable ADA requirements when providing services to members.

69. CULTURAL COMPETENCY

DES/DDD shall have a Cultural Competency Plan which meets the requirement of the ACOM Cultural Competency Policy. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the AHCCCS Division of Health Care Management, ALTCS Operations Unit, no later than 45 days after the start of each contract year. The Plan should address all services and settings, *i.e.*, attendant care, assisted living facilities, *etc*. [42 CFR 438.206(c)(2)]

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

70. CORPORATE COMPLIANCE

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

As stated in A.R.S. 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.

DES/DDD 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. DES/DDD also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by the AHCCCS Administration. The Contractor agrees to provide documents, including original documents, to representatives of the Office of Program Integrity upon request. The OPI shall allow a reasonable time for the Contractor to copy the requested documents, not to exceed 20 business days from the date of the OPI request.

DES/DDD shall be in compliance with 42 CFR 438.608. DES/DDD must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. DES/DDD 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.

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

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to and processes for complying with all applicable federal and state standards.
2. The written designation of a compliance committee who are accountable to DES/DDD's top management.
3. The Compliance Officer must be an onsite management official who reports directly to DES/DDD's top management. Any exceptions must be approved by AHCCCS.
4. Effective training and education.
5. Effective lines of communication between the compliance officer and the organization's employees.
6. Enforcement of standards through well-publicized disciplinary guidelines.
7. Provision for internal monitoring and auditing.
8. Provision for prompt response to problems detected.
9. A Compliance Committee which shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.
10. Pursuant to the Deficit Reduction Act of 2005 (DRA), DES/DDD, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. The Program Contractor 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. The Contractor must require, through documented policies and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions;
    a. The administrative remedies for false claims and statements;
    b. Any state laws relating to civil or criminal penalties for false claims and statements;
    c. The whistleblower protections under such laws.

DES/DDD is required to research potential overpayments identified by the AHCCCS, Office of Program Integrity. After conducting a cost benefit analysis to determine if such action is warranted, DES/DDD 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 DES/DDD.

71. RECORDS RETENTION

DES/DDD shall maintain books and records relating to covered services and expenditures including reports to AHCCCS and documentation used in the preparation of reports to AHCCCS. DES/DDD 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.

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

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

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

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

72. DATA MANAGEMENT

DES/DDD shall have the capability for all required technical interfaces with AHCCCS. Refer to the *AHCCCS Technical Interface Guidelines* in the Bidder's Library for further information. A copy of these guidelines are available online at www.azahcccs.gov.

73. DATA EXCHANGE REQUIREMENT

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

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

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

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

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

DES/DDD shall be provided with a DES/DDD -specific security code for use in all data transmissions made in accordance with contract requirements. Each data transmission by the DES/DDD shall include DES/DDD's security code. DES/DDD agrees that by use of its security code, it certifies that any data transmitted is accurate

and truthful, to the best of DES/DDD's Chief Executive Officer, Chief Financial Officer or designee's knowledge [42 CFR 438.606].

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

Health Insurance Portability and Accountability Act (HIPAA): DES/DDD 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 DES/DDD by the dates required by the implementing Federal regulation as well as all subsequent requirements and regulations as published.

74. ENCOUNTER DATA REPORTING

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

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

Encounter data must be provided to AHCCCS as outlined in the HIPAA *Transaction Companion Documents & Trading Partner Agreements* and the AHCCCS *Encounter Reporting User Manual* and should be received by AHCCCS no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with DES/DDD, whichever date is later. Requirements for encounter data are described in the *AHCCCS Encounter Manual* and the. AHCCCS Encounter *Companion Document*.
The Contractor will be assessed sanctions for noncompliance with encounter submission requirements.

Encounter Reporting:
An Encounter Submission Tracking Report (ESTR) must be maintained and made available to AHCCCS upon request. The Tracking Report's purpose is to link each claim to an adjudicated or pended encounter returned to DES/DDD. Further information regarding the Encounter Submission Tracking Report may be found in *The AHCCCS Encounter Reporting User's Manual*.

In addition to the Encounter Submission Tracking Report, the Contractor must maintain a report which reconciles financial fields of a claim (health plan paid, billed amount, health plan allowed, etc.) with the financial fields of adjudicated encounters. This report shall be available to AHCCCS upon request.

At least twice each month AHCCCS provides DES/DDD with full replacement files containing provider and medical procedure coding information. These files should be used to assist DES/DDD to ensure accurate Encounter Reporting. Refer to the AHCCCS *Encounter Reporting User Manual* for further information.

Pended Encounter Corrections:
The Contractor must resolve all pended encounters within 120 days of the original processing date. 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/or (2) requires a change to the system programming, an update to the database reference table, or further research by AHCCCS. Upon completion of any changes to the AHCCCS system programming or updates to the database reference tables, sanctions may be imposed from date of resolution. AHCCCS reserves the right to adjust the sanction amount if circumstances warrant.

Before imposing sanctions, AHCCCS will notify the Contractor, in writing, of the total number of sanctionable encounters pended more than 120 days. Pended encounters shall not be voided by the Contractor as a means of avoiding sanctions for failure to correct encounters within 120 days. The Contractor shall document voided encounters and shall maintain a record of the voided Claim Reference Number(s) (CRN) with appropriate reasons indicated. The Contractor shall, upon request, make this documentation available to AHCCCS for review. Refer to the *AHCCCS Encounter Reporting User Manual* for further information.

***Encounter Corrections*:**
Contractors are required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission as described below. This includes corrections as a result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCS or the Contractor. The Contractor must void encounters for claims that are recouped in full. For recoupments that result in a reduced claim value or adjustments that result in an increased claim value, replacement encounters must be submitted. For those recoupments requiring approval from AHCCCS, replacement encounters must be submitted within 120 days of the recoupment approval from AHCCCS. Refer to the AHCCCS *Encounter Reporting User Manual* for instructions regarding the submission of corrected encounters.

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

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

AHCCCS will notify the Contractor in writing of the sanction amounts and of the selected data needed for encounter validation studies. The Contractor will have 90 days to submit the requested data to AHCCCS. In the case of medical records requests, the Contractor's 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 the Contractor to select a statistically valid sample for a study, the Contractor may be sanctioned up to 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.

AHCCCS may also perform special reviews of encounter data, such as comparing encounter reports to the Contractor's claims files. Any findings of incomplete or inaccurate encounter data may result in the imposition of sanctions or requirement of a corrective action plan.

75. REPORTING REQUIREMENTS

AHCCCS, under the terms and conditions of its CMS grant award, requires reports, encounter data, and other information from DES/DDD. DES/DDD will comply with all reporting requirements in a manner similar to all other program contractors. DES/DDD will be sanctioned if DES/DDD fails to comply with stated contractual reporting requirements. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in Section D, Paragraph 80, Sanctions and Attachment D, Chart of Deliverables. Standards applied for determining adequacy of required reports are as follows:

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

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

DES/DDD shall be responsible for continued reporting beyond the term of the contract.

76. REQUESTS FOR INFORMATION

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

77. DISSEMINATION OF INFORMATION

Upon request, DES/DDD 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 DES/DDD. All advertisements, publications and printed materials which are produced by DES/DDD and refer to covered services shall state that such services are funded under contract with AHCCCS.

78. RESERVED

79. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS requirements and AHCCCS Rule 9 A.A.C. 28, Article 5, AHCCCS, or an independent agent, will conduct regular operational and financial reviews for the purpose of (but not limited to) identifying best practices and ensuring program compliance [42 CFR 438.204]. The type and duration of the review will be solely at the discretion of AHCCCS. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give DES/DDD at least three weeks advance notice of the scheduled Operational and Financial Review. AHCCCS reserves the right to conduct reviews without notice. AHCCCS may conduct a review without notice in the event DES/DDD undergoes reorganization, or makes changes in three or more key staff positions within a 12-month period, or to investigate complaints received by AHCCCS.

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

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

The operations review is conducted by an AHCCCS review team comprised of staff from the Division of Health Care Management, the Office of Legal Assistance and other AHCCCS staff as necessary. The team will evaluate DES/DDD's performance and compliance with AHCCCS policies, rules and the terms of this contract. The review may look at any aspects of DES/DDD operations. DES/DDD shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report nor final report to other AHCCCS Program Contractors or Health Plans. DES/DDD may share the Operational and Financial Review Tool with their subcontracted acute care plans.

DES/DDD will be furnished a copy of the draft Operational and Financial Review report and given the opportunity to comment on any review findings prior to AHCCCS issuing the final report. Recommendations made by the Review Team to bring DES/DDD into compliance with federal, state, AHCCCS, and/or contract requirements, must be implemented by DES/DDD. AHCCCS may conduct a follow-up review or require a corrective action plan to determine DES/DDD's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial review and may be conducted without prior notice to DES/DDD.

DES/DDD shall submit a corrective action plan to improve areas of non-compliance identified in the review. Once the corrective action plan is approved by AHCCCS, it shall be implemented by DES/DDD. Modifications to the corrective action plan must be approved in advance by AHCCCS. Unannounced follow-up reviews may be conducted to determine DES/DDD's progress in implementing recommendations and achieving compliance.

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

80. SANCTIONS

AHCCCS may impose monetary sanctions, suspend, deny, refuse to renew, or terminate this contract or any related subcontracts in accordance with AHCCCS Rules R9-22-606, ACOM Sanction Policy and the terms of this contract and applicable Federal or State law and regulations [42 CFR 422.208.42; 42 CFR 438.700, 702, 704, and CFR 92.36(i)(1); 45 CFR 74.48]. Written notice will be provided to DES/DDD specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of the sanction. AHCCCS will prepare the AHCCCS side of the (GAO-614) transfer documents and forward them to DES/DDD 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 DES/DDD to account for their state match sanction expenditure funded by a state match source chosen by DES/DDD. A copy of the transfer document will be sent with the monthly capitation payment to notify DES/DDD that the sanction has taken place. DES/DDD may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. 9-34-401 et seq. Intermediate sanctions may be imposed, but are not limited to the following actions:

a. Substantial failure to provide medically necessary services that the DES/DDD is required to provide under the terms of this contract to its enrolled members.
b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
c. Discrimination among enrollees on the basis of their health status or need for health care services.
d. Misrepresentation or falsification of information furnished to CMS or AHCCCS.
e. Misrepresentation or falsification of information furnished to an enrollee, potential enrollee, or provider.
f. Failure to comply with the requirement for physician incentive plan as delineated in Paragraph 39, Physician Incentive/Pay for Performance.
g. Distribution directly, or indirectly through any agent or independent contractor, of marketing materials that have not been approved by AHCCCS or that contain false or materially misleading information.
h. Material deficiencies in the DES/DDD's 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 comply with any provisions contained in this contract
n. Failure to report third party liability cases as defined in paragraph 63, Coordination of Benefits/Third Party Liability..

AHCCCS may impose the following types of intermediate sanctions:

a. Civil monetary penalties
b. Appointment of temporary management for a Program Contractor as provided in 42 CFR 438.706 and A.R.S.§36-2903 (M).
c. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
d. Additional sanctions allowed under statue or regulation that address areas of noncompliance.

Cure Notice Process: Prior to the imposition of a sanction for non-compliance, AHCCCS shall provide a written cure notice to the DES/DDD regarding the details of the non-compliance. The cure notice will specify the period of time during which the DES/DDD must bring its performance back into compliance with contract requirements. If, at the end of the specified time period, the DES/DDD has complied with the cure notice requirements, AHCCCS will take no further action. If, however, the DES/DDD has not complied with the cure notice requirements, AHCCCS may proceed with the imposition of sanctions.

81. MEDICAID SCHOOL BASED CLAIMING PROGRAM, (MSBC)

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

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

The Contractor's evaluations and determinations of medical necessity shall be made independent of the fact that the child is receiving MSBC services. If a request is made for services that also are covered under the

MSBC program for a child enrolled with the Contractor, the request shall be evaluated on the same basis as any request for a covered service.

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

82. PENDING LEGISLATION AND PROGRAM CHANGES

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

Electronic Case Management Assessments and Planning System: The AHCCCS Administration is exploring the feasibility of developing a statewide Information Technology (IT) universal Case Management Assessment and Planning (CMAP) system. Currently the Administration has limited case management and care planning data to perform various analyses of ALTCS members. Current data is limited to encounter, member placement and home and community based service cost-effectiveness study information. A full array of assessment, care planning and other data can provide program contractors and the Administration with the necessary information to improve the management of individual member needs and the overall ALTCS population.

An ideal and cost-effective system will not just collect case management assessment data but will eventually have the ability to integrate data from several sources. The ideal design would be able to incorporate such data from eligibility assessments, health service encounters, prescription medications, case management assessments and care plans. Outputs from a system rich in data would provide the opportunity for AHCCCS and contracted managed care organizations to more effectively manage this population. This type of system could be developed on a web-based platform and also incorporate opportunities for members, practitioners and case managers to share data and communicate as needed.
Ball vs. Biedess (Rodgers): This Federal court case is pending on appeal. It is not known if there will be any additional requirements of the AHCCCS and DES/DDD.

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.

Member Incentives: AHCCCS may explore opportunities to develop member incentive programs to increase the use of preventive health services and compliance with guidelines for recommended care and services for specific health conditions. The Contractor shall participate in the development and implementation of such programs as directed by AHCCCS.

Eligibility Privatization: AHCCCS is currently conducting an RFP process to evaluate the potential of awarding a contract to a private vendor for the determination of eligibility for KidsCare and HIFA Parents. A similar RFP process will be conducted for the Title XIX eligibility determination process as well.

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

Arizona E Health Connectivity: In February of 2007, AHCCCS was awarded a CMS Transformation Grant of $11.7 million to build a health information exchange (HIE) and a web based suite of applications for accessing electronic health records (EHR). The HIE will serve to provide real time patient health information and clinical care automation for AHCCCS contracted health care providers, in accordance with the Governor's executive order #2005-25 on Arizona Health-e Connection Roadmap.

AHCCCS will develop a unified approach for AHCCCS 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 health plans and Program Contractors will cooperate in assisting AHCCCS with developing the Health-E project plan and shall implement required data exchange interfaces as required to meet the goals of the Governor's executive order.

AHCCCS Contractors will be required to:

1) Encourage lab, pharmacy and ancillary subcontractors to develop common electronic interfaces for the exchange of data using standards based transactions.

2) AHCCCS may issue Minimum Subcontract language that will require subcontractors to participate in the e-Health Initiative. DES/DDD must amend all provider subcontracts to include the amended Minimum Subcontract provisions within six (6) months of issuance.

3) DES/DDD 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.

AHCCCS will continually work to enhance the functionality of the health information exchange, electronic health records electronic prescribing and web based applications. The AHCCCS Contractor is expected to deploy upgrades and enhancements as necessary to contracted providers.

Arizona Direct Care Workforce Initiative: In April 2005 the Citizens Workgroup on the Long Term Care Workforce (CWG), created by Governor Napolitano, issued a report recommending, among others the:

> "implementation of a standardized, uniform and universal training curriculum for direct support professional that is portable and addresses the needs of the specific populations."

To that end, the CWG's Core Curriculum and Expansion Subcommittee has developed a certificate program for direct support professionals that focuses on providing the basic knowledge and skills central to providing support to specific populations of individuals.

During CYE 09 policies and procedures will be developed to implement the Program with rollout to begin October 1, 2009 and full implementation by September 30, 2010.

83. BUSINESS CONTINUITY AND RECOVERY PLAN

DES/DDD shall adhere to all elements of the ACOM *Business Continuity and Recovery Policy*. This plan is currently under review and will be placed in the Bidder's Library upon completion. DES/DDD 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:

- Electronic/telephonic failure at DES/DDD's main place of ALTCS business
- Complete loss of use of the main site and satellite offices out of state

- Loss of primary computer system/records
- Communication between DES/DDD and AHCCCS in the event of a business disruption
- Periodic testing

The Business Continuity and Recovery Plan shall be updated annually. All staff shall be trained and familiar with the Plan. DES/DDD shall submit a summary of the plan as specified in the ACOM, *Business Continuity and Recovery Planning Policy* to AHCCCS 15 days after the start of the contract year. All staff shall be trained and familiar with the Plan.

84. MEDICAL RECORDS

The member's medical record is the property of the provider who generates the record. Each member is entitled to one copy of his or her medical record free of charge. The DES/DDD shall have written policies and procedures to maintain the confidentiality of all medical records.

The DES/DDD is responsible for ensuring that a medical record is established when information is received about a member. If the PCP has not yet seen the member, such information may be kept temporarily in an appropriately labeled file, in lieu of establishing a medical record, but must be associated with the member's medical record as soon as one is established.

The DES/DDD shall have written policies and procedures for the maintenance of medical records so that those records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information.

The DES/DDD shall have written standards for documentation on the medical record for legibility, accuracy and plan of care, which comply with the *AMPM*.

The DES/DDD shall have written plans for providing training and evaluating providers' compliance with the DES/DDD medical records standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

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

Information related to fraud and abuse may be released so long as protected HIV-related information is not disclosed (A.R.S. §36-664(I)).

85. ENROLLMENT AND CAPITATION TRANSACTION UPDATES

AHCCCS produces daily enrollment transaction updates identifying new members and changes to members' demographic, eligibility and enrollment data, which the DES/DDD shall use to update its member records. The daily enrollment transaction update, that is run immediately prior to the monthly enrollment and capitation transaction update, is referred to as the "last daily" and will contain all rate code changes made for the prospective month, as well as any new enrollments and disenrollments as of the first of the prospective month.

AHCCCS also produces a daily Manual Payment Transaction, which identifies enrollment or disenrollment activity that was not included on the daily enrollment transaction update due to internal edits. The DES/DDD shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction will be produced to provide contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.

The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for the DES/DDD as of the first day of the next month. These updates contain the information used by AHCCCS to produce the monthly capitation payment for the next month. The DES/DDD will reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor will record the results of the reconciliation, which will be made available upon request, and will resume posting daily updates beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation into the next month. If the DES/DDD detects an error through the monthly update process, the DES/DDD shall notify AHCCCS, Information Services Division.

Refer to Paragraph 73, Data Exchange Requirements, for further information.

86. SPECIAL HEALTH CARE NEEDS

DES/DDD must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions of the member which require a course of treatment or regular care monitoring [42 CFR 438.240(b)(4)]. The assessment mechanisms must use appropriate health care professionals [42 CFR 438.240(c)(2)] [42 CFR 438.208(c)(2)]. DES/DDD shall share with other entities providing services to that member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3) and (c)(3)]. Members enrolled in the ALTCS Program who are elderly or physically disabled or are developmentally disabled are automatically identified as having special health care needs.

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, DES/DDD must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 208(c)(4)].

DES/DDD shall ensure that populations with ongoing medical needs, including but not limited to dialysis, radiation and chemotherapy, have coordinated, reliable, medically necessary transportation to ensure members arrive on-time for regularly scheduled appointments and are picked up upon completion of the entire scheduled treatment.

87. TECHNOLOGICAL ADVANCEMENT

DES/DDD shall implement the following technological measures according to the applicable time frame:

DES/DDD must have a website with links to the following information:

1. Formulary
2. Provider manual
3. Member handbook
4. Provider listing

5. Prior Authorization Criteria
6. Evidence Based Medicine Guidelines
7. A link to the AHCCCS website for Performance Measure results
8. When available, a link to the AHCCCS website for Member and Provider Survey results

DES/DDD must be able to perform the following functions electronically:

1. Provide Enrollment Verification in a HIPAA compliant 270/271 format
2. Accept the Benefit Enrollment and Maintenance transaction (834 format)
3. Accept the Payroll Deduction and Other Group Premium Payment for Insurance Products transaction (820 format)
4. Allow Claims inquiry and response in a HIPAA compliant 276/277 format
5. Accept HIPAA compliant electronic claims transactions in the 837 format (See Section D, Paragraph 44, Claims Payment/Health Information System)
6. Generate HIPAA compliant electronic remittance in the 835 format (See Section D, Paragraph 44, Claims Payment/Health Information System)
7. Make Claims payments via electronic funds transfer (See Section D, Paragraph 44, Claims Payment/Health Information System)
8. Acceptance of Prior Authorization requests, in a HIPAA compliant 278 format, no later than 10/01/09. AHCCCS will work with Contractors to develop functionality requirements.

Use of Website: The Contractor is required to post their clinical performance indicators compared to the AHCCCS standard and statewide averages on their website. In addition, AHCCCS will post Contractor performance indicators on its website.

88. SUPPORT OF ARIZONA BASED TRANSLATION AND CLINICAL RESEARCH

AHCCCS is collaborating with the University of Arizona Medical School, Arizona State University, TGen, and other Arizona based research programs to encourage greater participation of the community in Arizona based translation and clinical research. The Contractor is encouraged to support AHCCCS-approved volunteer opportunities for member participation in community based clinical studies and translation research. As part of this collaboration AHCCCS providers will have the opportunity to be community research associates. The Arizona Translational Research and Education Consortium will provide statewide governance and oversight of the community engagement in Arizona translational and clinical research. The Consortium is expecting to receive a grant from the National Institutes of Health to support the infrastructure for this community involvement in beneficial translation research trials and studies.

[END OF SECTION D]

SECTION E - CONTRACT TERMS AND CONDITIONS

1. APPLICABLE LAW

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

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

2. AUTHORITY

This contract is issued under the authority of the Contracting Officer who signed this contract. Changes to the contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by an unauthorized state employee or made unilaterally by DES/DDD are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and DES/DDD 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. RELATIONSHIP OF PARTIES

DES/DDD under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

7. ASSIGNMENT AND DELEGATION

DES/DDD shall not assign any right nor delegate any duty under this contract without prior written approval of the Contracting Officer, who will not unreasonably withhold such approval.

8. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

DES/DDD shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs

and activities), and the Americans with Disabilities Act; EEO provisions; Copeland Anti-Kickback Act; Davis-Bacon Act; Contract Work Hours and Safety Standards; Rights to Inventions Made Under a Contract or Agreement; Clean Air Act and Federal Water Pollution Control Act; Byrd Anti-Lobbying Amendment. DES/DDD shall maintain all applicable licenses and permits.

9. THIRD PARTY ANTITRUST VIOLATIONS

DES/DDD assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to DES/DDD toward fulfillment of this contract.

10. RIGHT TO ASSURANCE

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

11. TERMINATION FOR CONFLICT OF INTEREST

AHCCCS may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCS is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when DES/DDD receives written notice of the cancellation unless the notice specifies a later time.

12. GRATUITIES

AHCCCS may, by written notice to DES/DDD, immediately terminate this contract if it determines that employment or a gratuity was offered or made by DES/DDD or a representative of DES/DDD to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. AHCCCS, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the gratuity offered by DES/DDD.

13. SUSPENSION OR DEBARMENT

DES/DDD shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(A) AND (B)]. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity.

DES/DDD shall not retain as a director or officer of the DES/DDD entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

14. TERMINATION FOR CONVENIENCE

AHCCCS reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, return receipt requested, to DES/DDD of the termination at least 90 days before the effective date of the termination. In the event of termination under this paragraph, all documents, data and reports prepared by DES/DDD under the contract shall become the property of and be delivered to AHCCCS. DES/DDD shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

15. TERMINATION FOR DEFAULT

Temporary Management/Operation by AHCCCS: Pursuant to the Balanced Budget Act of 1997, 42 CFR 438.700 et seq. and State Law ARS §36-2903, AHCCCS is authorized to impose temporary management for DES/DDD under certain conditions. Under federal law, temporary management may be imposed if AHCCCS determines that there is continued egregious behavior by DES/DDD, including but not limited to the following: substantial failure to provide medically necessary services DES/DDD is required to provide; imposition on enrollees premiums or charges that exceed those permitted by AHCCCS, discrimination among enrollees on the basis of health status or need for health care services; misrepresentation or falsification of information to AHCCCS or CMS; misrepresentation or falsification of information furnished to an enrollee or provider; distribution of marketing materials that have not been approved by AHCCCS or that are false or misleading; or behavior contrary to any requirements of Sections 1903(m) or 1932 of the Social Security Act. Temporary management may also be imposed if AHCCCS determines that there is substantial risk to enrollees' health or that temporary management is necessary to ensure the health of enrollees while DES/DDD is correcting the deficiencies noted above or until there is an orderly transition or reorganization of DES/DDD. Under federal law, temporary management is mandatory if AHCCCS determines that DES/DDD has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. In these situations, AHCCCS shall not delay imposition of temporary management to provide a hearing before imposing this sanction.

State law ARS §36-2903 authorizes AHCCCS to operate DES/DDD as specified in this contract. Prior to operation of DES/DDD by AHCCCS pursuant to state statute, DES/DDD shall have the opportunity for a hearing unless AHCCCS determines that emergency action is required. Operation by AHCCCS shall occur only as long as it is necessary to assure delivery of uninterrupted care to members, to accomplish orderly transition of those members to other contractors, or until DES/DDD reorganizes or otherwise corrects contract performance failure.

Termination: AHCCCS reserves the right to terminate this contract in whole or in part due to the failure of DES/DDD to comply with any term or condition of the contract and as authorized by the Balanced Budget Act of 1997 and 42 CFR 438.708. If DES/DDD is providing services under more than one contract with AHCCCS, AHCCCS may deem unsatisfactory performance under one contract to be cause to require DES/DDD to provide assurance of performance under any and all other contracts. In such situations, AHCCCS reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail written notice of the termination and the reason(s) for it to DES/DDD by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCS shall provide DES/DDD with a pre-termination hearing before termination of the contract.

16. TERMINATION - AVAILABILITY OF FUNDS

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

Notwithstanding any other provision in the Agreement, this Agreement may be terminated by DES/DDD, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, DES/DDD shall have no further obligation to AHCCCS.

17. RIGHT OF OFFSET

AHCCCS shall be entitled to offset against any amounts due the Contractor any expenses or costs incurred by AHCCCS concerning the Contractor's non-conforming performance or failure to perform the contract.

18. NON-EXCLUSIVE REMEDIES

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

19. NON-DISCRIMINATION

DES/DDD 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. DES/DDD 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.

20. EFFECTIVE DATE

The effective date of this contract shall be the date referenced on page 1 of this contract.

21. TERM OF CONTRACT AND OPTION TO RENEW

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 When AHCCCS issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days from the date of mailing by AHCCCS, even if the extension has not been signed by DES/DDD, unless within that time DES/DDD 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 22, Disputes, and administered accordingly.

22. DISPUTES

Contract claims and disputes shall be adjudicated in accordance with AHCCCS rules.

Except as provided by 9 A.A.C. Chapter 22, Article 6 the exclusive manner for DES/DDD to assert any dispute against AHCCCS shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and ARS §36-2932. All disputes except as provided under 9 A.A.C. Chapter 22, Article 6 shall be filed in writing and be received by AHCCCS no later than 60 days from the date of the disputed notice. All disputes shall state the factual and legal basis for the dispute. Pending the final resolution of any disputes involving this contract, DES/DDD 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.

23. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

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

24. INCORPORATION BY REFERENCE

This solicitation and all attachments and amendments, DES/DDD proposal, best and final offer accepted by AHCCCS, and any approved subcontracts are hereby incorporated by reference into the contract.

25. COVENANT AGAINST CONTINGENT FEES

DES/DDD 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.

26. CHANGES

AHCCCS may at any time, by written notice to DES/DDD, 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, DES/DDD may assert its right to an adjustment in compensation paid under this contract. DES/DDD must assert its right to such adjustment within 30 days from

the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 22, Disputes, and be administered accordingly.

When AHCCCS issues an amendment to modify the contract, the provisions of such amendment will be deemed to have been accepted 60 days after the date of mailing by AHCCCS, even if the amendment has not been signed by DES/DDD, unless within that time DES/DDD notifies AHCCCS in writing that it refuses to sign the amendment. If DES/DDD provides such notification, AHCCCS will initiate termination proceedings.

27. TYPE OF CONTRACT
Firm Fixed-Price

28. 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.

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

30. NO GUARANTEED QUANTITIES
AHCCCS does not guarantee DES/DDD any minimum or maximum quantity of services or goods to be provided under this contract.

31. CONFLICT OF INTEREST
DES/DDD 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. DES/DDD shall fully and completely disclose any situation that may present a conflict of interest. If DES/DDD is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or Contractor or an entity owning or controlling same, DES/DDD shall disclose this relationship prior to accepting any assignment involving such party.

32. DISCLOSURE OF CONFIDENTIAL INFORMATION
DES/DDD shall not, without prior written approval from AHCCCS, either during or after the performance of the services required by this contract, use, other than for such performance, or disclose to any person other than AHCCCS personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to DES/DDD by AHCCCS.

33. COOPERATION WITH OTHER CONTRACTORS
AHCCCS may award other contracts for additional work related to this contract and DES/DDD shall fully cooperate with such other contractors and AHCCCS employees or designated agents, and carefully fit its own work to such other contractors' work. DES/DDD shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCS employees.

34. OWNERSHIP OF INFORMATION AND DATA
Any data or information system, including all software, documentation and manuals, developed by DES/DDD pursuant to this contract, shall be deemed to be owned by AHCCCS. The Federal government reserves a

royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for Federal government purposes, such data or information system, software, documentation and manuals. Proprietary software which is provided at established catalog or market prices and sold or leased to the general public shall not be subject to the ownership or licensing provisions of this section.

Data, information and reports collected or prepared by DES/DDD in the course of performing its duties and obligations under this contract shall be deemed to be owned by AHCCCS. The ownership provision is in consideration of DES/DDD use of public funds in collecting or preparing such data, information and reports. These items shall not be used by DES/DDD for any independent project of DES/DDD or publicized by t DES/DDD without the prior written permission of AHCCCS. Subject to applicable state and Federal laws and regulations, AHCCCS shall have full and complete rights to reproduce, duplicate, disclose and otherwise use all such information. At the termination of the contract, DES/DDD shall make available all such data to AHCCCS within 30 days following termination of the contract or such longer period as approved by AHCCCS, Office of the Director. For purposes of this subsection, the term "data" shall not include member medical records.

Except as otherwise provided in this section, if any copyrightable or patentable material is developed by DES/DDD in the course of performance of this contract, the Federal government, AHCCCS and the State of Arizona shall have a royalty-free, nonexclusive, and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the work for state or Federal government purposes. DES/DDD shall additionally be subject to the applicable provisions of 45 CFR Part 74 and 45 CFR Parts 6 and 8.

35. AHCCCS RIGHT TO OPERATE CONTRACTOR

If, in the judgment of AHCCCS, DES/DDD performance is in material breach of the contract or DES/DDD is insolvent, AHCCCS may directly operate DES/DDD to assure delivery of care to members enrolled with DES/DDD until cure by DES/DDD of its breach, by demonstrated financial solvency or until the successful transition of those members to other contractors.

If AHCCCS undertakes direct operation of DES/DDD, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of DES/DDD as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until DES/DDD corrects the Contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of DES/DDD, to commence, defend and conduct in its name any action or proceeding in which DES/DDD may be a party.

All reasonable expenses of AHCCCS related to the direct operation of DES/DDD, including attorney fees, cost of preliminary or other audits of DES/DDD and expenses related to the management of any office or other assets of DES/DDD, shall be paid by DES/DDD or withheld from payment due from AHCCCS to DES/DDD.

36. AUDITS AND INSPECTIONS

DES/DDD shall comply with all provisions specified in applicable A.R.S. 35-214 and 35-215 and AHCCCS rules and policies and procedures relating to the audit of the Contractor's records and the inspection of DES/DDD's facilities. DES/DDD shall fully cooperate with AHCCCS staff and allow them reasonable access to DES/DDD's staff, subcontractors, members, and records [42 CFR 438.6(g)].

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, DES/DDD's or any subcontractor's books and records shall be subject to audit by AHCCCS and, where applicable, the Federal government, to the extent that the books and records relate to the performance of the contract or subcontracts [42 CFR 438.242(b)(3)].

AHCCCS, or its duly authorized agents, and the Federal government may evaluate through on-site inspection or other means, the quality, appropriateness and timeliness of services performed under this contract.

37. LOBBYING

No funds paid to DES/DDD by AHCCCS, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. DES/DDD shall disclose if any funds paid to DES/DDD 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.

38. CHOICE OF FORUM

The parties agree that jurisdiction over any action arising out of or relating to this contract shall be brought or filed in a court of competent jurisdiction located in the State of Arizona.

39. DATA CERTIFICATION

DES/DDD shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial and encounter data must be submitted concurrently with the data. Certification may be provided by the DES/DDD Director, Deputy Director of the Division, CFO or an individual who is delegated authority to sign for, and who reports directly to the Director, Deputy Director or CFO. 42 CFR 438.604 et.seq.

40. TERMINATION

In the event the contract, or any portion thereof, is terminated for any reason, or expires, DES/DDD 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. DES/DDD 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. DES/DDD 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 DES/DDD has paid all such obligations, DES/DDD 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 DES/DDD to indemnify AHCCCS for any claim by any third party against the State or AHCCCS arising from DES/DDD's performance of this contract and for which DES/DDD would otherwise be liable under this contract.
f. Any dispute by DES/DDD, with respect to termination or suspension of this contract by AHCCCS, shall be exclusively governed by the provisions of Section E, Paragraph 22, Disputes.
g. Any funds, advanced to DES/DDD for coverage of members for periods after the date of termination, shall be returned to AHCCCS within 30 days of termination of the contract.

41. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

DES/DDD 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, DES/DDD 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 DES/DDD and subcontractor records or to inspect papers of any employee thereof

to ensure compliance. Should the State determine that the DES/DDD 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 DES/DDD.

42. IRS W9 FORM

In order to receive payment under any resulting contract, DES/DDD shall have a current IRS W9 Form on file with the State of Arizona.

43. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

DES/DDD shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

SECTION F - LIST OF ATTACHMENTS

ATTACHMENT A: RESERVED

ATTACHMENT B(1): ENROLLEE GRIEVANCE SYSTEM

DES/DDD 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. DES/DDD shall provide the ACOM *Enrollee Grievance Policy* to all providers and subcontractors at the time of contract. DES/DDD shall also furnish this information to enrollees within a reasonable time after DES/DDD receives notice of the enrollment. Additionally, DES/DDD shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

The written information provided to enrollees describing the Grievance System including the grievance process, the appeal process, enrollee rights, grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the Contractor's service area and in an easily understood language and format. DES/DDD shall inform enrollees that oral interpretation services are available in any language, that additional information is available in prevalent non-English languages upon request and how enrollees may obtain this information.

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

At a minimum, DES/DDD's Grievance System Standards and Policy shall specify:

1. That DES/DDD shall maintain records of all grievances and appeals and requests for hearings.

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

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

4. That DES/DDD shall acknowledge receipt of each grievance and appeal. For Appeals, DES/DDD 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 DES/DDD shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.

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

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

8. That if DES/DDD 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 DES/DDD and that the enrollee is not permitted to file a grievance directly with the AHCCCS.

11. That DES/DDD 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 DES/DDD'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 DES/DDD network under 42 CFR 438.52(b)(2)(ii) when the DES/DDD is the only DES/DDD in the rural area.

17. The definition of a standard authorization request and that for standard authorization decisions, DES/DDD 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 DES/DDD establishes a need for additional information and delay is in the enrollee's best interest [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

18. The definition of an expedited authorization request. For expedited authorization decisions, DES/DDD 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 DES/DDD establishes a need for additional information and delay is in the enrollee's interest [42 CFR 438.210(d)(2)].

19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If DES/DDD extends the timeframe to make a standard or expedited authorization decision, DES/DDD 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. DES/DDD 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 DES/DDD shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.

21. The definition of a standard appeal and that DES/DDD 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 DES/DDD shall resolve all expedited appeals not later than three business days from the date DES/DDD receives the appeal (unless an extension is in effect) where DES/DDD 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. DES/DDD 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 DES/DDD denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. DES/DDD 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 DES/DDD's Notice of Action to file an appeal.

25. That DES/DDD shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 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 shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:

    a) DES/DDD receives notification of the death of an enrollee;
    b) The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);

c) The enrollee is admitted to an institution where he is ineligible for further services;
d) The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
e) The enrollee has been accepted for Medicaid in another local jurisdiction;

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

28. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of DES/DDD's action, 2) a. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or b. the appeal involves a denial and the physician asserts that the requested service/treatment represents a necessary continuation of a previous authorized service, 3) the services were ordered by an authorized provider, and 4) the enrollee requests a continuation of benefits.

    For purposes of this paragraph, benefits shall be continued based on the authorization which was in place prior to the denial, termination, reduction or suspension which has been appealed.

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

30. That for appeals, DES/DDD 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 DES/DDD 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 DES/DDD 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 no later than 30 days after the date the enrollee receives DES/DDD's notice of appeal resolution and how to do so, b) the right to receive continued benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds DES/DDD.

33. That DES/DDD 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 DES/DDD mailing of the appeal resolution notice, 3) the AHCCCS Administration issues a state fair hearing decision adverse to the enrollee

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

    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. DES/DDD's Notice of Appeal Resolution
    d. other information relevant to the resolution of the appeal

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

37. That if DES/DDD 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 DES/DDD 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 DES/DDD or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, DES/DDD may recover the cost of those services from the enrollee.

ATTACHMENT B(2): PROVIDER CLAIMS DISPUTE SYSTEM STANDARDS AND POLICY

DES/DDD shall have in place a written claims dispute system policy for providers. The policy shall be in accordance with applicable Federal and State laws, regulations and policies. The claims dispute policy shall include the following provisions:

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

2. The Provider Claims Dispute System Policy must specify that all claim disputes claim disputes challenging claim payments, denials or recoupments must be filed in writing with DES/DDD no later that 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment whichever is later.

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

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

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

6. Each 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 DES/DDD during the claims dispute process is dated upon receipt.

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

9. A copy of DES/DDD's Notice of Decision (hereafter referred to as Decision) shall be mailed to all parties no later than 30 days after the provider files a claim dispute with the Contractor, unless the provider and Contractor agree to a longer period. The Decision must include and describe in detail, the following:

    a. the nature of the grievance
    b. the issues involved
    c. the reasons supporting DES/DDD's Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
    d. the Provider's right to request a hearing by filing a written request for hearing to DES/DDD no later than 30 days after the date the Provider receives DES/DDD's decision.
    e. If the claim dispute is overturned, the requirement that the DES/DDD shall reprocess and pay the claim(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

10. If the Provider files a written request for hearing , DES/DDD must ensure that all supporting documentation is received by the DES, Division of Services and Support, Appellate Services Administration (DES/DSS/ASA), no later than five business days from the date DES/DDD receives the provider's written hearing request. The file sent by DES/DDD 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 claim dispute
f. a summary of DES/DDD's actions undertaken to resolve the claim dispute and basis of the determination

11. The following material shall be included in the file sent by DES/DDD:

    a. written request for hearing filed by the Provider
    b. copies of the entire file which includes pertinent records; and DES/DDD's Decision
    c. other information relevant to the Notice of Decision of the claim dispute

12. If DES/DDD's decision regarding a claim dispute is reversed through the appeal process, DES/DDD shall reprocess and pay the claims(s) in a manner consistent with the Decision within 15 business days of the date of the Decision.

13. DES/DDD shall ensure once a decision is reached by DES/DSS/ASA a copy is sent to the AHCCCS Office of Administrative Legal Services (OALS).

ATTACHMENT D: CHART OF DELIVERABLES

CONTRACTS

REPORT	DATE DUE	SEND TO:
Initial contracts with AHCCCS and any amendments and renewals (Section E, ¶31)	Within 60 days of receipt from AHCCCS	Contracts & Purchasing Administrator (DBF)
Request to assign any right or delegate any duty(Section E, ¶7)	Approval required prior to assignment	Contracts & Purchasing Administrator (DBF)
Subcontracts for: • Automated Data Processing • Third Party Administrators • Management Services • Capitated or other risk subcontracts requiring claims processing by the subcontractors(Section D, ¶33) • RFP for Medical Services	30 days prior to start date	DHCM ALTCS Manager
Advertisements or published information for commercial benefit (Section E, ¶11)	Prior approval required	Contracts & Purchasing Administrator (DBF)

BEHAVIORAL HEALTH

REPORT	DATE DUE	SEND TO:
Annual Case Review of Behavioral Health Services to Members (Section D, ¶12)	August 30	Clinical Quality Management Unit (DHCM)

DATA ANALAYSIS AND RESEARCH

REPORT	DATE DUE	SEND TO:
Corrected Pended Encounter Data (Section D, ¶74)	Monthly, according to established schedule	Encounter Administrator (DHCM)
New Day Encounter (Section D, ¶74 and (Encounter Reporting User Manual)) Medical Records for Data Validation (Section D, ¶ 74, Data Validation User Manual)	Monthly, according to established schedule 90 days after the request received from AHCCCS	Encounter Administrator (DHCM) Encounter Administrator (DHCM)

EXECUTIVE MANAGEMENT

REPORT	DATE DUE	SEND TO:
Cultural Competency Annual Evaluation (Section D, ¶69)	November 15	ALTCS Operations Unit (DHCM)
Network Development and Management Plan (Section D, ¶28)	November 15	ALTCS Operations Unit (DHCM)
Resignation and addition of any key staff (Section D, ¶25)	Within 7 days of learning of resignation	ALTCS Operations Unit (DHCM)
All physician incentive agreements (Section D, ¶39)	Upon signing of agreement	ALTCS Financial Manager (DHCM)
Physician Incentive Plan (PIP) reporting (Section D, ¶39)	Annually by October 1st of each contract year	ALTCS Financial Manager (DHCM)
Changes to Fraud and Abuse Plan (Section D, ¶70)	When changes are made, prior to distribution	Office of Program Integrity (OPI)
All incidents of suspected fraud and abuse (Section D, ¶70)	Upon learning of the incident	As directed in ACOM Fraud and Abuse Policy
Modifications of Operational & Financial Review Corrective Action Plan (Section D, ¶79)	Prior to implementation of modification	ALTCS Operations Unit (DHCM)
Proposed merger, reorganization or ownership change (Section D, ¶54)	Prior approval required	ALTCS Operations Unit (DHCM)
Related party subcontracts (Section D, ¶55)	Prior approval required	ALTCS Operations Unit (DHCM)
Staff functions located outside of Arizona (Section D, ¶25)	August 15,	ALTCS Operations Unit (DHCM)
Organizational Chart with "Key Staff" positions (Section D, ¶25)	August 15	ALTCS Operations Unit (DHCM)
Functional Organizational Chart with key program areas, responsibilities and reporting lines. (Section D, ¶25)	August 15	ALTCS Operations Unit (DHCM)
Administrative Services Annual Subcontractor Assignment and Evaluation Report(Section D, ¶ 33)	Annually 90 days after start of contract year	ALTCS Operations Unit (DHCM)
Business Continuity and Recovery Plan Summary (Section D, ¶83)	October 15	ALTCS Operations Unit (DHCM)
Administrative Directives (Section D, ¶26)	10 days after the end of each quarter (August, November, February, May)	ALTCS Operations Unit (DHCM)

FINANCE

REPORT	DATE DUE	SEND TO:
Monthly Financial statement (not including months that are also a quarter end) in DES/DDD standard format (Section D, ¶75)	30 days after month end	ALTCS Financial Coordinator (DHCM)
Quarterly Claims Dashboard Report (Section D, ¶44)	15 days after quarter end	ALTCS Financial Coordinator (DHCM

Quarterly Financial Statement (Section D, ¶75)	60 days after quarter end	ALTCS Financial Coordinator (DHCM)
FQHC Member Month Information (Section D, ¶75)	60 days after quarter end	ALTCS Financial Coordinator (DHCM)
Draft Audited Financial Statement (Section D, ¶75)	120 days after year end	ALTCS Financial Coordinator (DHCM)
Draft Management Letter (Section D, ¶75)	90 days after year end	ALTCS Financial Coordinator (DHCM)
Annual Submission of Budget (Section D, ¶75)	July 31	ALTCS Financial Coordinator (DHCM)
Final Audited Financial Statement (Section D, ¶75)	150 days after year end	ALTCS Financial Coordinator (DHCM)
Final Management Letter (Section D, ¶75)	120 days after year end	ALTCS Financial Coordinator (DHCM)
Annual Disclosure Statement (Section D, ¶75)	120 days after year end	ALTCS Financial Coordinator (DHCM)
Annual Reconciliation (Section D, ¶75)	120 days after year end	ALTCS Financial Coordinator (DHCM)
Advances, Distributions, Loans (Section D, ¶50)	Prior approval required	ALTCS Financial Coordinator (DHCM)
Claims recoupments exceeding $50,000 per provider within a contract year (Section D, ¶44)	Prior approval required	ALTCS Financial Coordinator (DHCM)
Reinsurance claims (Section D, ¶58)	Within 12 months from the date of service	As per AHCCCS Reinsurance Manual
Corporate cost allocation plans, adjustment in management fees, fund distributions affecting equity (Section D, ¶49 & 50)	November 15	ALTCS Financial Coordinator (DHCM)
Summary of contract rates for long term care and home and community based services (See Financial Reporting Guide for format)	December 1	ALTCS Financial Coordinator (DHCM)

GRIEVANCE SYSTEM

REPORT	DATE DUE	SEND TO:
Grievance Systems Reports (Section D, ¶23)	As per the Grievance System Reporting Guide	Division of Health Care Management (DHCM)
Request for Hearing Files (Section F, ¶Attachment B)	5 business days from the date appeal is received	Office of Legal Assistance

MEMBER SERVICES/CASE MANAGEMENT

REPORT	DATE DUE	SEND TO:
All Member Informational Materials (Newsletters, Brochures, etc.) (Section D, ¶17)	Prior to Distribution	ALTCS Unit (DHCM)
Annual Member Survey (Section D, ¶ 66)	Prior to Distribution	ALTCS Unit (DHCM)
Annual Member Survey results analysis and improvement strategies (Section D, ¶ 66)	Upon completion	ALTCS Unit (DHCM)

Member Handbook (Section D, ¶ 17)	Upon any changes. Prior to Distribution	ALTCS Unit (DHCM)
Placement outside the state (Section D, ¶14)	Prior approval required	ALTCS Unit (DHCM)
Changes or corrections to member's circumstances (income, living arrangements, TPL, services, etc.) (Section D, ¶18)	ALTCS electronic member change report requirements	AHCCCS Electronic Submission
Case Management Plan (Section D, ¶16)	November 15	ALTCS Case Management Manager (DHCM)
Targeted Case Management Plan (Attachment E)	November 15	ALTCS Case Management Manager (DHCM)
Case management internal monitoring process, results, and continuous improvement strategies (Section D, ¶16)	As requested	ALTCS Case Management Manager (DHCM)

NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:
Network Summary (Section D, ¶32)	10/15, 5/15	ALTCS Unit (DHCM)
All material changes in provider network (Section D, ¶29)	In advance of the change	ALTCS Unit (DHCM)
Ball v. Biedess (Rodgers) Semi-Annual Report (Section D, ¶28)	May 15 (Oct, Nov, Dec, Jan, Feb, Mar) Nov 15 – (Apr, May, Jun, Jul, Aug, Sep)	ALTCS Unit (DHCM)
Unexpected major network changes (Section D, ¶29)	Within 1 day of change	ALTCS Unit (DHCM)
Provider who refuses to sign a contract (if providing more than 25 services in the contract year) (Section D, ¶33)	Document refusal within 7 days of final attempt to gain contract	ALTCS Unit (DHCM)

THIRD PARTY LIABILITY

REPORT	DATE DUE	SEND TO:
Report the following cases of Third Party Liability (Section D, ¶63): • Uninsured/underinsured motorist insurance • First and third-party liability insurance • Tortfeasors, including casualty • Trust recovery • Adoption recovery • Estate recovery • Worker's Compensation	Upon Identification	AHCCCS TPL Subcontractor
Report all joint liability cases (Section D, ¶63)	Within 5 days of identification	AHCCCS TPL Subcontractor

CLINICAL QUALITY MANAGEMENT (QM)

REPORT	DATE DUE	SEND TO
Quality Assessment/Performance Improvement Plan and Evaluation (Checklist to be submitted with the Document) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)
Maternity Care Plan (Section D, ¶20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)
Sterilization Report (Section D, ¶ 20) (AMPM Chapter 400)	Immediately following procedure	Clinical Quality Management Unit (DHCM)
Stillbirth Report (Section D, ¶ 20) (AMPM Chapter 400)	Immediately following procedure	Clinical Quality Management Unit (DHCM)
EPSDT Monitoring Report (Section D, ¶ 20) (AMPM Chapter 400)	December 15	Clinical Quality Management Unit (DHCM)
Monthly Pregnancy Termination Report (Section D, ¶20) (AMPM Chapter 400)	End of the month following pregnancy termination.	Clinical Quality Management Unit (DHCM)
EPSDT Improvement and Adult Quarterly Monitoring Report (Template must be used) (Section D, ¶ 20) (AMPM Chapter 400)	30 days after the end of each quarter	Clinical Quality Management Unit (DHCM)
Credentialing Quarterly Report (Section D, ¶20)	30 days after the end of each quarter	Clinical Quality Management Unit (DHCM)
Semi-annual report of number of pregnant women who are HIV/AIDS positive (Section D, ¶10 - Maternity)	30 days after the end of the 2nd and 4th quarter of each contract year	Clinical Quality Management Unit (DHCM)
Performance Improvement Project Baseline Report(Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)
Performance Improvement Project Re-measurement Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	December 15	Clinical Quality Management Unit (DHCM)
Performance Improvement Project Final Report (Standardized format to be utilized) (Section D, ¶ 20) (AMPM Chapter 900)	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	Clinical Quality Management Unit (DHCM)
QM Quarterly Report (Section D, ¶20)	45 days after end of each quarter	Clinical Quality Management Unit (DHCM)
Pediatric Immunization Audit (Section D, Paragraph 20)	As Requested	Clinical Quality Management Unit (DHCM)

MEDICAL MANAGEMENT

REPORT	DATE DUE	SEND TO
Quarterly Inpatient Hospital Showing (State Medicaid Manual and the *AMPM*, Chapter 1000)	15 days after the end of each quarter	Medical Management Unit
Utilization Management Plan and Evaluation (*AMPM*, Chapter 900)	Annually on December 15th	Medical Management Unit
UM Quarterly Report (Section D, ¶21)	60 Days after the end of each quarter	Medical Management Unit
HIV Specialty Provider List (*AMPM*, Chapter 300)	Annually, on December 15th	Medical Management Unit
Transplant Report (*AMPM*, Chapter 1000)	15 days after the end of each month	Medical Management Unit
Non-Transplant and Transplant Catastrophic Reinsurance covered Diseases and Biological Medications (Section D, ¶58)	Annually, within 30 days of the beginning of the contract year, enrollment to the plan, and when newly diagnosed.	Medical Management Unit

ATTACHMENT E: TARGETED CASE MANAGEMENT

DES/DDD shall provide targeted case management services for DES/DDD clients who are financially eligible for the Title XIX and Title XXI acute care program but who do not meet the functional eligibility requirements of the ALTCS program. The non-ALTCS DES/DDD recipients who become eligible for case management services under this amendment are entitled to case management services but must receive their acute care services through the AHCCCS health plans. Recipients shall have a choice of case managers available from DES/DDD. Recipients may refuse case management services however, this will result in disenrollment from targeted case management.

1. TARGETED CASE MANAGEMENT SERVICES FOR NON-ALTCS RECIPIENTS

The case management responsibilities as described in Chapter 1600, Section 1640 of the *AHCCCS Medical Policy Manual* shall apply to DES/DDD recipients enrolled with an AHCCCS acute care contractor (non-ALTCS members). DES/DDD shall submit, annually, with their ALTCS Case Management Plan to AHCCCS a written plan describing the implementation and monitoring of Targeted Case Management.

"Case manager" means a person who is either a degreed social worker, licensed registered nurse, or one with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. DES/DDD shall ensure adequate staffing to meet case management requirements. If case management staffing is not adequate to meet the needs of the recipients, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCS, to address caseload sizes. Staffing must be sufficient to cover case manager absenteeism and turnover. AHCCCS will review caseload sizes during the annual Targeted Case Management Services Review.

DES/DDD shall implement a systematic method of monitoring its case management program. This internal monitoring shall be conducted at least quarterly by DES/DDD. DES/DDD shall compile a written report of the monitoring activity to include an analysis of the aggregated data and a description of the continuous improvement strategy DES/DDD has taken to resolve identified deficiencies. This information shall be made available upon request by AHCCCS.

2. PAYMENT

Payment to DES/DDD for targeted case management services must not duplicate payments made to public agencies or private entities under other program for this same purpose and will be made by AHCCCS on a capitated basis as a pass through of federal funds received by AHCCCS. See Section 56 – Compensation for a description of the pass-through process

To determine the number of recipients, DES/DDD will submit data to AHCCCS, by the 10th working day of each month, using CONNECT, which is a direct process to transmit the match file. The data will be processed through a series of edits designed to match Social Security Number, name, sex, and date of birth. If the DES/DDD client passes through the match criteria, then the client's enrollment and eligibility will be verified. Only currently eligible and enrolled clients will be reported as matched. AHCCCS will only pay for targeted case management services for those clients considered matched on the monthly transmission.

Recipient records reported by DES/DDD that do not result in a match will be identified on a "potential match" report. This report will be sent to DES/DDD for further research. DES/DDD will not be paid for clients considered a potential match. Resubmitted records which result in a match will be paid as of the first of the month in which the match was made.

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

3. ON-SITE REVIEWS

In accordance with AHCCCS Rule 9 A.A.C 28, Article 5, AHCCCS will conduct an operational review of targeted case management services every year for the purpose of, but not limited to, ensuring program compliance. The type and duration of the review will be solely at the discretion of AHCCCS and will include, but not be limited to, Case Management Services Review. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCS will give DES/DDD at least four weeks advance notice of the date of the on-site review. AHCCCS may conduct a review in the event DES/DDD undergoes a reorganization or makes changes in three or more key staff positions within a 12-month period.

In preparation for the reviews, DES/DDD shall cooperate fully with AHCCCS and the AHCCCS Review Team by forwarding in advance materials that AHCCCS may request. Any documents not requested in advance by AHCCCS shall be made available upon request of the Review Team during the course of the review. DES/DDD personnel as identified in advance shall be available to the Review Team at all times during AHCCCS on-site review activities. While on-site, DES/DDD shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

DES/DDD will be furnished a draft copy of the Review Report and given an opportunity to comment on any review findings prior to AHCCCS finalizing the report. Where there are outstanding deficiencies, DES/DDD may be required to submit a corrective action plan without the opportunity to comment on the draft report.

Recommendations made by the Review Team to bring DES/DDD into compliance with federal, state, AHCCCS, and/or RFP requirements, must be implemented by DES/DDD. AHCCCS may conduct a follow-up review or require a corrective action plan to determine DES/DDD's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial review.

DES/DDD shall submit a corrective action plan to improve areas of non-compliance identified in the review. Once the corrective action plan is approved by AHCCCS, it shall be implemented by DES/DDD. Modifications to the corrective action plan must be agreed to by both parties.

4. ANNUAL SUBMISSION OF BUDGET

DES/DDD shall submit to AHCCCS, by July 31st of each year, an estimate of the costs of providing targeted case management services pursuant to this contract. The cost estimates must be fully supported by documentation stating the nature of the costs and the methods and data used to develop the estimates.

If at any time during the term of this contract DES/DDD determines that its funding is insufficient, it shall notify AHCCCS in writing and shall include in the notification recommendations on resolving the shortage. AHCCCS, with DES/DDD, may request additional money from the Governor’s Office of Strategic Planning and Budgeting.

Requests for FFP: Requests for federal financial participation (FFP) from DES/DDD and the pass through of these funds to DES/DDD from AHCCCS shall both adhere to the mandatory Cash Management Improvement Act (CMIA) of 1990 as established by the General Accounting Office of the Arizona Department of Administration (GAO/ADDA).

5. SANCTIONS

If DES/DDD violates any provision stated in law, AHCCCS Rules, AHCCCS policies and procedures, or this contract, AHCCCS may impose sanctions in accordance with the provisions of this contract, applicable law and

regulations. Written notice will be provided to DES/DDD specifying the sanction to be imposed, the grounds for such sanction and the amount of payment to be withheld.