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

1. AMENDMENT NO.:	2. CONTRACT NO.:	3. EFFECTIVE DATE OF MODIFICATION:	4. PROGRAM:
6	**YH07-0001-01**	**July 1, 2008**	**DHCM-ALTCS**
5. CONTRACTOR/PROVIDER NAME AND ADDRESS:			
6. PURPOSE: To amend Section B, Capitation Rates, Section D, Program Requirements, Paragraph 10, Covered Services - Dental. This Contract Amendment incorporates Amendments 1, 2 and 3 into the applicable Sections.			

7. The contract referenced above is amended as follows:

A. **SECTION B, CAPITATION RATES – the footer has been changed to correspond to this Amendment number and date. There has been no change to the rates.**

B. **SECTION D, PROGRAM REQUIREMENTS, Paragraph 10, Covered Services - Dental:**

Delete the letter "A" at the beginning of the first subparagraph.

Delete the following language:

"B. Adult Dental Language: The Program Contractor shall provide dental services to adults 21 years of age and older according to the AMPM Chapter 1200. Dental services are limited to $1,000.00 a year (October through September) but are not inclusive of dentures and emergency dental services. Contractors shall develop systems to monitor utilization to assure appropriate Medicaid payments.

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

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

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT.

IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.

9. NAME OF CONTRACTOR:	10. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME:	TYPED NAME: MICHAEL VEIT
TITLE:	TITLE: CONTRACTS AND PURCHASING ADMINISTRATOR
DATE:	DATE:

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SECTION B. CAPITATION RATES

The Program Contractor shall provide services as described in this contract. In consideration for these services, the Program Contractor will be paid as shown below for the term of October 1, 2007 through September 30, 2008 (CYE 08) unless otherwise modified by contract amendment.

SAMPLE ONLY

CAPITATION RATES
(per member per month)

County				
Dual Full Long Term Care				
Non-Dual Full Long Term Care				
Acute Care Only				
Prior Period Coverage				
HIV/AIDS				

SECTION C. DEFINITIONS

A.A.C.	Arizona Administrative Code.
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.
ANNUAL ENROLLMENT CHOICE (AEC)	The opportunity for a person to change contractors every 12 months, effective their anniversary date.
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 defined by A.R.S. § 36-2902, et seq.
AHCCCSA	Arizona Health Care Cost Containment System Administration.
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCSA 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.
ANNIVERSARY DATE	The month the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Program Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Program Contractors or the last date the member was given an opportunity to change.
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.

BIDDER'S LIBRARY	A repository of manuals, statutes, rules and other reference material located on the AHCCCS website at www.azahcccs.gov .
CAPITATION	Payment to contractor by AHCCCSA 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 the Program Contractor.
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.
CLAIM DISPUTES	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.
CONTINUING OFFEROR	An existing ALTCS Program Contractor serving the GSA that proposals are being solicited for, who submits a response to this solicitation.
CYE	Contract Year Ending, corresponds to federal fiscal year (Oct. 1 through Sept. 30). For example, Contract Year Ending 2002 is 10/1/01 – 9/30/02.
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 the Program Contractor or before payment is made by the Program Contractor. (This assumes the Program Contractor can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party render the service so that the Program Contractor is only liable for coinsurance and/or deductibles.)
COUNTY OF FISCAL RESPONSIBILITY	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.
COVERED SERVICES	The health and medical services to be delivered by the Program Contractor as defined in 9 A.A.C. 28, Article 2 and 9 A.A.C. 31, Article 2, the AMPM and Section D of this contract. [42 CFR 438.210(a)(4)]
CRS	Children's Rehabilitative Services, 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.
CRS RECIPIENT	A CRS recipient is a CRS eligible individual who has completed the initial medical visit at an approved CRS Clinic, which allows the individual to participate in the CRS program.

DAYS	Calendar days unless otherwise specified as defined in the text, as defined in 9 A.A.C. 22, Article 1.
DELEGATED AGREEMENT	An 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.
DIRECTOR	The Director of AHCCCS.
DISCLOSING ENTITY	An AHCCCS provider or a fiscal agent.
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 health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. [42 CFR 438.114(a)]
ENCOUNTER	A record of a health care related service rendered by a provider or providers registered with AHCCCSA 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 in 9 A.A.C. 28, Article 4.
EPD	Elderly and Physically Disabled.
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.
EXHIBITS	All items attached as part of the solicitation.
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 program portion of AHCCCS as defined in 42 CFR 400.203.
FFY	Federal Fiscal Year, October 1 through September 30.
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.
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 (TICKET TO WORK)	A Federal program that expands Title XIX eligibility to individuals, 16 through 64 years old, who are disabled and whose earned income, after allowable deductions, is at or below 250% of the Federal Poverty Level.
GSA	Geographic Service Area, an area designated by the Administration within which a contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that contractor of record, as defined in 9 A.A.C. 28, Article 1.
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.
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 as defined in 9 A.A.C. 28, Article 11.
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	The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.
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 SERVICES AGREEMENT	An 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	An entity to which the Program Contractor delegates comprehensive management and administrative services necessary for the operation of the Contractor.
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 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 post January 1, 2006. 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 the system, as defined in A.R.S. § 36-2931.
NON-CONTRACTING PROVIDER	A person who provides services as prescribed in A.R.S. § 36-2939 and who does not have a subcontract with an AHCCCS contractor.
OFFEROR	A person or other entity that submits a proposal to the Administration in response to a Request For Proposal, as defined in 9 A.A.C. 22, Article 1.
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 the Program Contractor to collect from legally liable first or third parties after the Program Contractor 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 the Program Contractor 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.
PMMIS	AHCCCSA's Prepaid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location. [42 CFR 438-114(a)]

POTENTIAL ENROLLEE	A Medicaid eligible recipient who is not enrolled with a contractor.
PPC	Prior Period Coverage, the period prior to the member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor.
PROGRAM CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCSA 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.
PIP	Performance Improvement Project, formerly referred to as Quality Improvement Projects (PIPs).
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 Administration to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a certain 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 a Program Contractor, or a party that is, or may be, controlled or significantly influenced by a Program Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RFP	Request For Proposals, a document prepared by AHCCCSA 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.
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	An 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 AHCCCSA 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 required by members generally.

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.
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.
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 known as the State Child Health Plan or KidsCare Plan in AZ. Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "State Children's Health Insurance Program" (SCHIP and HIFA). The Arizona version of SCHIP is referred to as "KidsCare".
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, ICF MR 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 400)

[END OF SECTION C]

SECTION D. PROGRAM REQUIREMENTS

1. PURPOSE and APPLICABILITY

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

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

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

2. INTRODUCTION

AHCCCSA's 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

The ALTCS Program

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

The ALTCS population has grown from approximately 10,000 in its first full year to 43,495 as of July, 2007. Of this population, 56%, 24,443 are members who are elderly and/or members with physical disabilities (EPD population) and, 44%, 19,052 are members with developmental disabilities (DD population). Approximately 3% of the EPD population are members under the age of 21 years of age.

ALTCS Guiding Principles

- *Member-centered case management*
  The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Services are mutually selected to assist the member in attaining his/her goals(s) for achieving or

maintaining their highest level of self-sufficiency. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

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

ALTCS Eligibility

Financial eligibility
Anyone may apply for ALTCS at any of the 15 ALTCS eligibility offices located throughout the state. The applicant must be an Arizona resident as well as a U.S. citizen or qualified legal immigrant as defined in ARS § 36-2903.03. To qualify financially for the ALTCS program applicants must have countable income and resources below certain thresholds. The AHCCCS Eligibility Policy Manual provides a detailed discussion of all eligibility criteria. The Manual is on the AHCCCS Website at: www.azahcccs.gov/publications/eligibility.

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

Additional information may be obtained by visiting the AHCCCS website: www.azahcccs.gov

3. ENROLLMENT AND DISENROLLMENT

AHCCCSA has the exclusive authority to enroll and disenroll members. The Program Contractor shall not disenroll any member for any reason unless directed to do so by AHCCCSA. The Program Contractor may request AHCCCSA to change the member's enrollment in accordance with the ACOM *Enrollment Choice and Change of Contractor Policy.* The Program Contractor may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. An AHCCCS member may request disenrollment from the Program Contractor for cause at any time. Please refer those requests due to situations defined in Section A (1) of the ACOM *Change of Plan Policy* to the AHCCCS Verification Unit at (602) 417-4000 or (800) 962-6690. For medical continuity requests, the Program Contractor shall follow the procedures outlined in the ACOM *Enrollment Choice and Change of Contractor Policy* [42 CFR 438.56], before notifying the AHCCCSA.

AHCCCSA will disenroll the member when the member becomes ineligible for the AHCCCS program, in certain situations when they move out of the Program Contractor's service areas, changes Program Contractors during the member's open enrollment/annual enrollment choice period, Program Contractor does not, because of moral or religious objections, cover the service the member seeks or when approved for a Program Contractor change through the ACOM *Enrollment Choice and Change of Contractor Policy.*

Prior Period Coverage - The Program Contractor is liable for costs for covered services provided during the "prior period" leading up to actual enrollment with the Program Contractor. The "prior period" is defined as the period from the eligibility effective date, up to the effective date of enrollment. For detailed discussions on enrollment and prior period coverage, refer to The Eligibility Policy Manual located at www.azahcccs.gov.

Nursing Refund Payments **-** Effective 11/1/2000, nursing facilities must refund any payment received from a resident or family member (in excess of share of cost), for the period of time from the effective date of Medicaid eligibility.

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

4. OPEN/ANNUAL ENROLLMENT

Open Enrollment
At the time multiple Program Contractors are initially available in a member's geographic service area, all existing members in that geographic service area will be given the opportunity to choose the Program Contractor with whom they will be enrolled [42 CFR 438.56(c)(2)(ii)]. Information required by the BBA will be provided to all members (enrollees). Existing members who do not indicate their desire to change Program Contractors will remain with the Program Contractor they are currently enrolled with at the time multiple Program Contractors become available. If the Program Contractor they are currently enrolled with is not awarded a contract, the process described following the Annual Enrollment Choice information will be implemented.

Annual Enrollment Choice
AHCCCSA conducts an Annual Enrollment Choice (AEC) in Geographic Service Areas (GSAs) with multiple Program Contractors for members. During AEC, members may change Program Contractors subject to the availability of other Program Contractors within their Geographic Service Area. Members are mailed an enrollment letter, and other information required by the BBA, 60 days prior to their AEC date. Members may choose a new Program Contractor by contacting AHCCCSA to complete the enrollment process. If the member does not participate in the AEC, no change of Program Contractor will be made (except for approved changes under the ACOM *Enrollment and Change of Contractor Policy* during the new anniversary year. The Program Contractor shall comply with the ACOM *Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy*, the ACOM *Enrollment Choice in a Choice County and Change of Contractor* policies, and the AMPM. [42 CFR 438.56(c)(2)(ii)

For purposes of this contract award, the following enrollment methodologies will be used when current contractors are not awarded contracts or there is a decision to add contractors in a county:

- If an existing program contractor is not awarded a contract, and the Administration awards one contract in that county

  All members from the exiting program contractor will be assigned to the new program contractor.

- If a new contractor is added to any county with an existing Program Contractor

  AHCCCS will offer open enrollment to all members in that county. Members will have the option to stay with their current program contractor or enroll with the new program contractor.

- If an existing program contractor in any county other than Maricopa County is not awarded a contract, and the Administration awards two new contracts in that county

  Members from the exiting program contractor will be selectively assigned to the two new program contractors. The new program contractors will receive approximately the same amount of members. As above, assigned selective enrollment will be based upon program contractors' network and will be conducted to cause minimal disruption to the member. Members will also be given the option to change their program contractor assignment.

- If an existing program contractor in Maricopa County is not awarded a contract, and the Administration awards one or two new contracts in Maricopa County

  Members from the exiting program contractor will be selectively assigned to the existing program contractor and the new program contractors. The new program contractor(s) will receive a larger percentage of the assigned selective enrollment than the existing program contractor. Selective assignment will be based upon the program contractors' networks. The purpose of selective assignment is to cause minimal disruption in a member's residential setting and service providers. Members will also be given the option to change their program contractor assignment.

- If all existing program contractors in Maricopa County are not awarded a contract, and the Administration awards two or three new contracts in Maricopa County

  Members from the exiting program contractors will be selectively assigned to the new program contractors. The new program contractors will receive approximately the same amount of members. As above, assignment will be based upon program contractors' network and will be conducted to cause minimal disruption to the member. Members will also be given the option to change their program contractor assignment if they wish.

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

5. ENROLLMENT HIERARCHY

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

Initial Choice – New Members

ALTCS members residing in a GSA with multiple Program Contractors are permitted to select a Program Contractor of their choice at the time of their initial enrollment into the program. When an ALTCS application is received in an ALTCS eligibility office, BBA required materials for enrollment choice will be sent to the applicant's home with an appointment notice for an interview. During the application process, the ALTCS eligibility specialist will assist the applicant or their representative in selecting a Program Contractor by

providing them with current provider network information. If the applicant is currently residing in a nursing facility or an alternative residential facility, the eligibility interviewer will identify which Program Contractors include that facility in their network. The eligibility interviewer will also search for the applicant's PCP in the provider network information.

Decision Tree
If the applicant is unable or unwilling to make an enrollment choice and there is no representative without a conflict of interest, AHCCCS will make the enrollment choice for the applicant based on the philosophy that most applicants will want to remain living where they currently do, and will want to keep their current PCP. When neither or all Program Contractors contract with the facility, enrollment will then be determined if the applicant's PCP is contracted with any of the Program Contractors. If the PCP is contracted with only one of the Program Contractors, the applicant will be enrolled with that Program Contractor. When neither or all the Program Contractors contract with the PCP, the applicant's enrollment will be made utilizing an enrollment algorithm (auto-assignment). For more detailed information, refer to The AHCCCS Eligibility Policy Manual, Chapter 1100, Section 1104.00.

Auto-Assignment Algorithm
If the applicant does not exercise their enrollment choice and AHCCCS is not able to make an enrollment based on the policy referenced above in the *Initial Choice–New Member* section, auto-assignment will be utilized to systematically select a Program Contractor for the applicant. When the algorithm applies, 60% of these applicants will be enrolled with SCAN Long Term Care and 40% with Bridgeway. An algorithm that favors these two Program Contractors will be utilized until a target membership of 1,500 Maricopa County Members is reached by each Program Contractor.

After the targeted membership sizes have been reached, targeted percentages will be developed based on factors previously noted in this paragraph. AHCCCSA may change the algorithm at anytime during the term of this contract. AHCCCS is not obligated to adjust the algorithm for any financial impact this may have on a Program Contractor.

6. PLAN CHANGES

In Geographic Service Areas where the member has a choice of Program Contractors, the member may change Program Contractors in accordance with the *ACOM Enrollment Choice in a Choice County and Change of Program Contractor* Policy.

7. COUNTY OF FISCAL RESPONSIBILITY

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

If a member is placed out of the current Program Contractor's service area, the current Program Contractor may request a program contractor change by submitting a Program Contractor Change Request Form (DE-621) to the Program Contractor responsible for the member's new county of residence and request that the new Program Contractor agree to accept the member. If the new Program Contractor agrees to accept the member, the DE-621 will be sent to AHCCCSA for processing. If the new Program Contractor does not agree to accept the ALTCS member, the current Program Contractor may request AHCCCSA to review the request. AHCCCSA will make the final decision. The Program Contractor shall cooperate in all transition activities as required in the ACOM *Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Change: Acute Care*

and Arizona Long Term Care System and the Enrollment Choice in a Change County and *Change of Program Contractors* Policy: ALTCS and Elderly/Physically Disabled (EPD) Contractors.

A Program Contractor Change Request (PCCR) Form is not required when a member moves from the Program Contractor's service area to receive home and community based services in their home outside the current Program Contractor's service area, however, the Program Contractor shall report the change in address to the ALTCS local office within 5 days of becoming aware of the change in address. For more detailed information, refer to 9 A.A.C. 28, Article 7 and the ACOM *Change of Program Contractor* Policy.

8. TRANSITION ACTIVITIES

The Program Contractor shall comply with the *AMPM* and the ACOM *Member Transition for Annual Enrollment Choice and Other Plan Changes* and the ACOM *Enrollment Choice in a Choice County and Change of Program Contractor* policies standards for member transitions between Program Contractors, to or from an AHCCCSA Contractor, upon eligibility termination and upon termination or expiration of a contract. Also, see Paragraph 3, Enrollment and Disenrollment. The Program Contractor 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. 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.

The Program Contractor shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the AHCCCS Transition staff and staff from other Program Contractors and Acute Health Plans to ensure a safe and orderly transition.

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

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

When relinquishing members, the Program Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special needs of transitioning members. The Program Contractor, 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 Program Contractor and service information, emergency numbers and instructions on how to obtain services.

In the event the contract or any portion thereof, is terminated for any reason, or expires, the Program Contractor shall assist AHCCCSA in the transition of its members to other Program Contractors, and shall abide by standards and protocols set forth above. In addition, AHCCCSA reserves the right to extend the term of the contract on a month-to-month basis to assist in any transition of members. The Program Contractor shall make provisions for continuing all management and administrative services until the transition of all

members is completed and all other requirements of this contract are satisfied. The Program Contractor shall submit, upon request, to AHCCCSA for approval a detailed plan for the transition of its members in the event of contract expiration or termination. The name and title of the Program Contractor's transition coordinator shall be included in the transition plan. The Program Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process and shall be responsible for the following:

a. Notification of subcontractors and members.
b. Payment of all outstanding obligations for medical care rendered to members.
c. Until AHCCCSA is satisfied that the Program Contractor has paid all such obligations, the Program Contractor shall provide the following reports to AHCCCSA:
   1) A monthly claims aging report by provider/creditor including IBNR amounts;
   2) A monthly summary of cash disbursements; and
   3) Copies of all bank statements received by the Program Contractor.

   Such reports shall be due on the fifth day of each succeeding month for the prior month.
d. In the event of termination or suspension of the contract by AHCCCSA, such termination or suspension shall not affect the obligation of the Contractor to indemnify AHCCCSA for any claim by any third party against the State or AHCCCSA arising from the Program Contractor's performance of this contract and for which the Program Contractor would otherwise be liable under this contract.
e. Any dispute by the Program Contractor with respect to termination or suspension of this contract by AHCCCSA shall be exclusively governed by the provisions of Section E, Paragraph 27. Disputes.
f. Any funds advanced to the Program Contractor for coverage of members for periods after the date of termination shall be returned to AHCCCSA within 30 days of termination of the contract.

Other Transition Activities: When an ALTCS member resides in an AHCCCS registered setting with no contract at the time of enrollment, the Program Contractor must give at least 7 days advance written notice advising the member that he or she must move to a facility contracting with the ALTCS Program Contractor. The reasons for the transfer must be included in the notice to the member and/or the member's representative. Medical Assistance to members who do not move to a contracting facility is limited to acute care services only. If a member's condition does not permit transfer to another facility, the Program Contractor 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 Home Page on the Internet at www.azahcccs.gov or upon request. The Program Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS rules, Statutes and other resources are also available to all interested parties through the AHCCCS Home Page. Upon adoption by AHCCCS, updates will be made available to Program Contractors. Once notification to the Contractors has taken place, the Program Contractor shall be responsible for implementing and maintaining current copies of updates.

10. COVERED SERVICES

The Program Contractor 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 438.210(a)(4)] and 438.224. The Program Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the service is furnished [42 CFR 438.210(a)(3)(i)(iii)]. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness or condition of the enrollee [42 CFR 438.210(a)(3)(ii)]. The Program Contractor may place appropriate limits on a service on the

basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be reasonably expected to achieve their purpose.

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

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

The Program Contractor 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)].

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.

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

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

Notice of Action: The Program Contractor must notify the requesting provider, and give the member written notice of any decision by the Program Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 CFR. 438.404., The notice to the provider must be in writing. See Attachments B (1).

ACUTE CARE SERVICES

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

Anti-hemophilic Agents and Related Services: The Program Contractor shall provide services for the treatment of hemophilia, Von Willebrand's disease, and Gaucher's disease. (See also ¶58, Reinsurance, *Catastrophic Reinsurance*). AHCCCSA holds a single-source specialty contract for anti-hemophilic agents and related services for hemophilia. Non-hemophilia related services are not covered under this contract. Non-hemophilia related care is defined as any care that is provided not related to the hemophilia services.

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

***Audiology*:** The Program Contractor 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.

***Behavioral Health*:** The Program Contractor 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/BehavioralHealth/index.asp.

For ALTCS 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 medication 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. The Program Contractor 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. § 36, Chapter 2, Article 3. See Section D, Paragraph 13, Children's Rehabilitative Services.

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

Dental: 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*.

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

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

***Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*:** The Program Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings for members under age 21. The Program Contractor 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 submit to AHCCCSA, Division of Health Care Management, all EPSDT reports as required by AHCCCS medical policy. The Program Contractor is required to meet specific participation/utilization rates for EPSDT members; these are described in the *AMPM*.

Emergency services: The Program Contractor shall have and/or provide the following as 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. The Program Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Program Contractor is encouraged to contract with or employ the services of non-emergency facilities (e.g. urgent care centers) to address member non-emergency care issues occurring after regular office hours or on weekends. The Program Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies. The Program Contractor shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
b. All medical services necessary to rule out an emergency condition
c. Emergency transportation and
d. Member access by telephone to a physician, registered nurse, physician assistant or nurse practitioner for advice in emergent or urgent situations, 24 hours per day, 7 days per week.

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

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

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

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

Additionally, the Program Contractor may not:

1. Limit what constitutes an emergency medical condition as defined in CFR 438.114, on the basis of lists of diagnoses or symptoms.
2. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the Program Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claims submission by the hospital within 10

calendar days of presentation for emergency services constitutes notice to the Program Contractor. This notification stipulation is only related to the provision of emergency services.

3. Require notification of Emergency Department treat and release visits as a condition of payment unless the Program Contractor 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. The Program Contractor 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.

***Eye Examinations/ 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 Program 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*.

Family Planning: The Program Contractor shall provide Family Planning services in accordance with the *AMPM*, Section 420, to members who choose to delay or prevent pregnancy. The Program Contractor is responsible for annually notifying members of reproductive age (12-55 years) of the availability of Family Planning services. If the Program Contractor does not provide family planning services, it must contract for these services through another health care delivery system which allows members adequate freedom of choice in selecting a provider.

Health Risk Assessment and Screening: The Program Contractor shall provide these services for non-hospitalized 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; nutritional assessment in cases when the member has a chronic, debilitating condition affected by nutritional needs; mammogram and prostate screenings; physical examinations and diagnostic work-ups; and immunizations. Required assessment and screening services for members under age 21 are included in the AHCCCS EPSDT periodicity schedule.

Hospital: Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health. 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 provided on an outpatient or ambulatory basis (i.e. laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis for up to 24 hours 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: The Program Contractor shall provide immunizations for adults (21 years of age and older) to include diphtheria-tetanus, influenza, pneumococcus, rubella, measles, hepatitis-B or others as medically indicated. EPSDT immunization requirements include diphtheria, tetanus, pertussis vaccine (DPT), oral/inactivated polio vaccine (OPV/IPV), measles, mumps, rubella vaccine (MMR), H. influenza, type B

(HIB), hepatitis B (Hep B), pneumoccacal conjugate and varicella vaccine. (Please refer to the AMPM for current immunization requirements.)

Indian Health Service (IHS): The Program Contractor 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. AHCCCSA will reimburse claims for acute care services provided to Title XIX members who receive medically necessary 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, a Program Contractor may obtain laboratory test data on members from a laboratory or hospital based laboratory subject to the requirements specified in ARS § 36-2903 R. The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by the Administration.

Maternity: The Program Contractor 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 nurse 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 the Program Contractor, and the Program Contractor has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by licensed midwives if they are in the Program Contractor's provider network. All licensed midwife labor and delivery services must be provided in the member's home since licensed midwives do not have admitting privileges in hospitals or AHCCCS registered free-standing birthing centers. Members receiving maternity services from a licensed midwife must also be assigned to a PCP for other health care and medical services.

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

The Program Contractor shall inform all assigned AHCCCS pregnant women of voluntary HIV testing and the availability of medical counseling if the test is positive. The Program Contractor shall provide information in the member handbook to encourage pregnant women to be tested and instructions on where to be tested. Semi-annually, the Program Contractor 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 of the contract year.

***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, 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 are conducted as a part of the EPSDT screenings for members under age 21, and to assist ALTCS members 21 years of age and older whose health status may improve with nutrition intervention. Assessment of nutritional status on a periodic basis may be provided as determined necessary, and as a part of the health risk assessment and screening services provided by the member's PCP. Assessments may also be provided by a registered dietitian when ordered by the member's PCP. 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.

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

Podiatry: The Program Contractor 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 42 CFR 438.114, 422.113(c) and 422.133, the following conditions apply with respect to coverage and payment of emergency and post-stabilization care services, except where otherwise noted in contract:

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

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

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

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

Pregnancy Termination: AHCCCS covers pregnancy termination if the pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated; 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 appropriate assigned Program Contractor 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, Program Contractor formularies and prior authorization requirements. An appropriate over the counter (OTC) medication may be prescribed as defined in the AMPM when it is determined to be a lower-cost alternative to a prescription medication.

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

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

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

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 the Program Contractor's use or the Program Contractor may select its own transplantation provider.

Transportation: These services include emergency and non-emergency medically necessary transportation. Emergency transportation, including transportation initiated by an emergency response system such as 911, may be provided by ground, air or water ambulance to manage an AHCCCS member's emergency medical condition at an emergency scene and transport the member to the nearest appropriate medical facility. Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services.

Triage/ Screening and Evaluation: These are covered services when provided by acute care hospitals, IHS facilities and urgent care centers 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.

LONG TERM CARE SERVICES

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

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

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

Self-Directed Attendant Care: A service option within Attendant Care. Implementation for this option will begin on or about October 1, 2007. See AMPM Chapters 1200, 1300 and 1600 for requirements pertaining to Self-Directed Attendant Care.

Spouses as Paid Caregivers: A service option within Attendant Care. Implementation for this option will begin on or about 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.

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

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

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

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

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

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

Hospice: A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with the Program Contractor. Program Contractors are 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: Partial care services provide 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. Program Contractors who employ independent nurses to provide private duty nursing must develop oversight activities to monitor service delivery and quality of care.

Respite Care: A service that provides a non-routine interval of rest and/or relief to a family member or other unpaid person(s) caring for the ALTCS member. It is available for up to 24-hours per day and is limited to 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 age 21, may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

Nursing facility, including Religious Nonmedical Health Care Institutions: The Program Contractor 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 homes. (See Section C for a definition of "home") In addition, there are other alternative HCBS settings as defined in 9 A.A.C. 28 Article 1 available for members. 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. Alternative residential settings include the following:

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

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."

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Alzheimer's Treatment Assistive Living Facilities: An ALTCS approved alternative setting as provided for by Laws 1999, Ch. 313, §§ 35 (Assistive Living Facilities Demonstration Pilot Project), Alzheimer's Treatment Assistive Living Facilities were approved as a demonstration pilot effective October 1, 1999 through September 30, 2002. The pilot was extended by laws 2001, Ch. 235, §§ 35 to December 31, 2007.

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 9A.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 Center*: An ALTCS approved alternative residential setting as defined in, A.R.S. §36-401, that provides supervision and coordination of necessary services to more than 10 residents. Under A.R.S. §36-2939 members residing in Assisted Living Centers must be offered the choice of single occupancy.

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

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 AHCCCSA, 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 *AMPM*, Chapter 100.

12. BEHAVIORAL HEALTH

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

a. Behavior Management (behavioral health personal care, family support/home care training, self-help/peer support)
b. Behavioral Health Case Management Services (limited)
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 - (ADHS/BHS 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.)

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

Referrals: The Program Contractor shall develop, monitor and continually evaluate its processes for timely referral, evaluation and treatment planning for behavioral health services. Requests for behavioral health services made by the family, guardian, or the member shall be assessed by the Contractor for appropriateness within three business days of the request. If it is determined that services are needed, a referral for evaluation shall be made within one business day. 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. The Program Contractor shall ensure that all behavioral health services provided are medically necessary as determined by a qualified behavioral health professional.

EPSDT: The Program Contractor shall ensure that PCPs screen for behavioral health needs at each EPSDT visit, and when appropriate, initiate a behavioral health referral. The Program Contractor 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 that the member receives appropriate medically necessary behavioral health services.

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

Quality management processes for behavioral health services must be included in the Program Contractor's Quality Management Plan and shall meet the quality management requirements of AHCCCSA as specified in the *AMPM*, Chapter 900.

Coordination of Care: The Program Contractor shall ensure that coordination of care occurs between behavioral health provider(s), primary care physicians, and other involved agencies and parties. The Program Contractor must monitor to ensure that primary care physicians receive clinical information as established in AMPM Chapter 500, Policy 510, and AMPM Chapter 900, Policy 940.

Crisis Services: The Program Contractor shall develop policies for individuals who are unable or unwilling to consent to treatment. The policy must address:

a) Involuntary evaluation/petitioning
b) Court ordered process
c) Execution of court order
d) Judicial review

For more information, refer to the AHCCCS *Behavioral Health Services Guide* that is available on the AHCCCS website at:
www.azahcccs.gov/Publications/GuidesManuals/BehavioralHealth/BehavioralHealthServicesGuide

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. The Program Contractor 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. The Program Contractor is responsible for care of members until those members are determined eligible by Children's Rehabilitative Services Administration (CRSA). In addition, the Program Contractor 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. The Program Contractor 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 and the AHCCCS Contractor Operations Manual, including Section 409 "Notices of Action".

The Program Contractor shall respond to requests for services potentially covered by CRSA in accordance with Section 409 "Notices of Action" of the ACOM. The Program Contractor is responsible to address prior authorization requests if CRSA fails to comply with the timeframes specified in Section 409. The Program

Contractor remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition, 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 a CRS condition.

Referral to CRSA does not relieve the Program Contractor of the responsibility for timely providing 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, the Program Contractor must promptly respond to the service authorization request and authorize provision of medically necessary services. CRSA cannot contest the Program Contractor's prior authorization determination if CRSA fails to timely respond to a service authorization request. Program Contractors, through their Medical Directors, may request review from the CRS Regional Medical Director when it denies a service that is not covered by the CRS Program. The Program Contractor 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 the Program Contractor 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, the Program Contractor is responsible for all applicable deductibles and copayments. If the member is on Medicare, the AHCCCS Policy 201 – Medicare Cost Sharing for members in Traditional Fee for Service and Policy 202 – Medicare Cost Sharing for Members in Medicaid Managed Care Plans 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, the Program 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 Program 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 Program Contractor 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. Program Contractors are not expected to set up special contractual arrangements to provide long term care services out of the service area but, should consider authorization when member-specific providers, such as family Attendant Care, are available during the temporary absence. ALTCS members temporarily absent from Arizona without authorization from the Program Contractor are eligible for acute emergency services only. Temporary absence without appropriate approvals can impact a member's eligibility for ALTCS. The Program Contractor shall report absences of more than 30 days from the state to the ALTCS eligibility office for a determination of continued eligibility as specified in The AHCCCS Eligibility Policy Manual.

The Program Contractor shall submit a written request to AHCCCSA Division of Health Care Management, ALTCS Unit before placing a member outside the state to facilitate a coordinated review with the Division of Member Services for any potential eligibility impact.

15. ALTCS TRANSITIONAL PROGRAM

The ALTCS Transitional Program is available for members (both institutional and HCBS) who, at the time of medical reassessment, have improved either medically, functionally or both to the extent that they no longer

need institutional care, but who still need significant long term care services. For those members who are living in a medical institution when determined eligible for the ALTCS Transitional program, the Program Contractor shall arrange for home and community based placement as soon as possible, but not later than 90 consecutive days after the effective date of eligibility for the ALTCS Transitional Program.

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

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

16. CASE MANAGEMENT

Case management is the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. The process involves a review of the ALTCS member's strengths and needs by the member, his/her family or representative and the case manager. The review should result in a mutually agreed upon appropriate and cost effective service plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting.
A case manager is a person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case managers shall not provide direct care services to members enrolled with the Program Contractor, but shall authorize appropriate services and/or refer members to appropriate services.

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

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

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

a) Respect the member's rights;
b) Provide adequate information and training to assist the member/family in making informed decisions and choices;
c) Provide a continuum of service options that support the expectations and agreements established through the care plan process;
d) Facilitate access to non-ALTCS services available throughout the community;
e) Educate the member/family on how to report unplanned gaps or other problems with service delivery to the Program Contractor 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.

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

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

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

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

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

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.

Client Assessment and Tracking System (CATS): The Program Contractor shall ensure complete, correct and timely entry of data related to placement history and cost effectiveness studies into the CATS. "Timely" shall mean within 14 days of the event which gave rise to the transaction (e.g., service approval by the case manager, placement change). Unless the Program Contractor is currently transmitting data to CATS electronically, all data entry shall be entered on-line. If the Program Contractor is not currently on-line, it must have a systems interface in place so it can update the case management information no less than twice per month with an error rate of 5%

or less. Program Contractors are not required to enter service authorizations into the CATS. The Program Contractor is, however, expected to maintain a uniform tracking system in each member chart documenting the begin and end date of services inclusive of renewal of services and the number of units authorized for services as required by the *AMPM*, Chapter 1600.

The Program Contractor shall provide AHCCCSA, within the timeline specified in Section F, Attachment D with an annual Case Management Plan. This plan shall outline how all case management policy standards in AMPM Chapter 1600 will be implemented and monitored by the Program Contractor. The Administrative Standards in AMPM Chapter 1600, including but not limited to the Contractor's methods for monitoring and maintaining caseloads, conducting quarterly case file audits and reviewing the consistency of member assessments/service authorizations on a quarterly basis must also be described in the plan. . The plan shall also include an evaluation of the Program Contractor's Case Management Plan from the prior year, to include lessons learned and strategies for improvement.

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

The Program Contractor shall ensure adequate staffing to meet case management requirements. The Program Contractor's case management plan shall 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.

Each case manager's caseload may not exceed a weighted value of 96. Program Contractors may assign a weighted value lower than those outlined below. The following formula represents the maximum allowable per case manager.

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

(# of HCBS members x 2.0)
(# of ALF members x 1.6)
(# of ACO members x 1.0)
+ (# of NF members x 0.8)
= 96 or less

17. MEMBER HANDBOOK and MEMBER COMMUNICATIONS

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

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

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

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

Oral interpretation services must be available and free of charge to all members regardless of the prevalence of the language. The Program Contractor 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)].

The Program Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the AHCCCS Member Information Policy. Regardless of the format chosen by the Program Contractor, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment [42 CFR 438.10(b)(1) and (b)(3)]. The Program Contractor must notify its members that alternative formats are available and how to access them [42 CFR 438.10(d)].

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

The Program Contractor 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.*
   The Program Contractor shall review and update the Member Handbook at least once a year. The handbook must be submitted to AHCCCS, Division of Health Care Management for approval by August 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 the Program Contractor's provider network, which at a minimum, includes those items listed in the ACOM *Member Information Policy.*

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

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

- 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
- Program Contractor specific issues

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

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

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

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

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

18. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS Member Change Report Form (DE-701) provides the Program Contractor with a method for complying with notification to the ALTCS eligibility offices and AHCCCSA of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, living arrangements, share of cost, income or resources; a change in medical condition which could affect eligibility; admission to Arizona State Hospital; no long term care services provided; demographic changes or the member's death.

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

The Program Contractor shall ensure members have the Preadmission Screening and Resident Review (PASRR) Level I and, if needed, Level II screenings prior to admission to a nursing facility. Level I is the identification of members who are suspected of having mental illness or 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 AHCCCSA. Should withholding of FFP occur, AHCCCSA will recoup the withheld amount from a Program Contractor's subsequent capitation payment. The Program Contractor may, at its option, recoup the withholding from the nursing facility which admitted the member without the proper PASRR.

20. QUALITY MANAGEMENT

Quality Management (QM)

The Program Contractor shall provide quality medical care to members, regardless of payer source or eligibility category. The Program Contractor shall use and disclose medical records and any other health and enrollment information that identifies a particular member in accordance with Federal and State privacy requirements. The Program Contractor shall execute processes to assess, plan, implement, evaluate, and as

mandated report, quality management and performance improvement activities, as specified in the AMPM, that include at least the following [42 CFR 438.240(a)(1) and (e)(2)]:

1. Conducting Performance Improvement Projects (PIPs);
2. QM monitoring and evaluation activities;
3. Investigation, analysis, tracking and trending of quality of care issues, abuse and/or complaints that includes:
   a) Acknowledgement letter to the originator of the concern
   b) Documentation of all steps utilized during the investigation and resolution process
   c) Follow-up with the member to assist in ensuring immediate health care needs are met
   d) Closure/resolution letter that provides sufficient detail to ensure that the 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 contact name/telephone number to call for assistance or to express any unresolved concerns
   e) Documentation of implemented corrective action plan(s) or action(s) taken to resolve the concern;
   f) Evidence of the resolution implemented.
4. AHCCCS mandated Performance Measures; and
5. Credentialing, recredentialing and provisional credentialing processes for providers and organizations [42 CFR 438.206(b)(6)] [42 CFR 438.214].

Contractors 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, including the utilization of the case manager 90 day onsite visits with members. The Contractor must develop a process that, at a minimum, meets the requirements specified in the AMPM, Chapter 900.

AHCCCS has established a uniform credentialing, recredentialing and provisional credentialing policy. The Program Contractor shall demonstrate that its providers are credentialed and [42 CFR 438.214]:

a. Shall follow a documented process for credentialing and recredentialing of providers who have signed contracts or participation agreements with the Program Contractor;
b. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment; and
c. Shall not employ or contract with providers excluded from participation in Federal health care programs.

The Program Contractor shall submit, within timelines specified in Attachment D, a written QM plan, QM evaluation of the previous year's QM program and Quarterly QM Report that addresses its strategies for performance improvement and conducting the quality management activities described in this section. The Program Contractor may combine its Quality Management Plan with the Plan that addresses Medical Management as described in Section D, Paragraph 21, Medical Management.

Performance Standards: **All Performance Measures described below may apply to all member populations [42 CFR 438.240(a)(2);(b)(2) and (c)].**

Program Contractors must meet AHCCCS stated Minimum Performance Standards. However, it is equally important that Program Contractors continually improve their performance measures outcomes from year to year. Program Contractors shall strive to meet the benchmark established by AHCCCS.

AHCCCS has established three levels of performance:

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

Goal – A Goal is a reachable standard for a given performance measure for the Contract Year. If the Program Contractor has already met or exceeded the AHCCCS Minimum Performance Standard for any measure the Program Contractor must strive to meet the established Goal for the measure(s).

Benchmark – A Benchmark is the ultimate standard to be achieved. Program Contractors that have already achieved or exceed the Goal for any performance measure must strive to meet the Benchmark for the measure (s). Program Contractors that have achieved the Benchmark are expected to maintain this level of performance for future years.
A Program Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions on Program Contractors that do not meet the Minimum Performance Standard and do not show statistically significant improvement in a measure rate and/or require those Contractors to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure or service area. AHCCCS may require a corrective action plan of any Program Contractor that shows a statistically significant decrease in its rate, even if it meets or exceeds the Minimum Performance Standard.

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

Performance Measure
The Program Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance measures. Complete descriptions of these measures can be found in the most recently published results and analysis of performance measures, or upon request from AHCCCSA. These activities will be monitored by AHCCCSA during the Operational and Financial Review.

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.

The current ALTCS quality performance measures identified by AHCCCSA include:

Diabetes Performance Measures
AHCCCS uses Health Plan Employer Data and Information Set (HEDIS¿ specifications from the National Committee for Quality Assurance (NCQA) as a guideline for measurement of diabetes care services. AHCCCS has identified three of the HEDIS indicators for performance measurement: Hb A_{1c} testing, lipid screening, and eye exams.

The population included in this measurement consists of elderly or physically disabled (E/PD) members enrolled in ALTCS. The sample frame consists of E/PD members who:

- were ages 18 through 75 years as of September 30 of the contract year,
- were continuously enrolled with one ALTCS Contractor, with no more than one gap in enrollment, not exceeding 31 days, as of September 30 of the contract year, and
- had a diagnosis of type 1 or type 2 diabetes in the measurement period or the year prior to the measurement period.

Members are identified as having type 1 or type 2 diabetes by encounter data. For example, a member is identified as having diabetes if he or she had one face-to-face encounter with a diagnosis of diabetes in an acute inpatient or emergency room setting during the measurement period or the previous year.

Specific indicators that comprise these measures are:

Hb A_{1c} testing — This indicator measures the percent of members who had one or more Hb A_{1c} tests during the measurement period.

Lipid (LDL-C) screening — This indicator measures the percent of members who had one or more lipid screenings during the measurement period or the preceding year.

Eye examinations — This indicator measures the percent of members who had a retinal exam by an optometrist or ophthalmologist during the measurement period or the preceding year.

Initiation of Services Performance Measures
The methodology for this measurement is based on two study questions:

- What is the number and percentage (overall, by urban and rural counties, and by individual Contractor) of sample members to whom a home and community-based service was provided within 30 days of enrollment?
- For those members who did not receive services within 30 days of enrollment, what were the reasons?

The sample frame consists of E/PD members who:

- were enrolled for 30 days or more with an ALTCS Contractor during the measurement period (contract year ending September 30), and
- were newly placed in the HCBS program during the measurement period.

The sample frame does not include ventilator-dependent members, as Contractors are required to initiate services for those members within 14 days of enrollment.

A representative random sample is selected for each Contractor. Data are first collected from AHCCCS encounter. If services within 30 days of enrollment were not found in AHCCCS encounter data, Contractors are asked to provide service delivery information from medical or case management records or their claims data.

In analyzing initiation of services, AHCCCS does not include members who:

- were residing in and receiving services from an assisted living facility,
- were admitted to a hospital or nursing home,
- were receiving hospice services, or
- refused services

when these situations were documented as occurring within 30 days of enrollment.

Services included in the numerator for this Performance Measure do not include all covered home and community-based services. For example, emergency-alert and home-modification services are not included because they are typically provided in conjunction with nursing, personal care or supportive services. The intent is to measure the health care services that primarily allow members at risk of institutionalization to remain in their homes or the community.

Incorporation of New Performance Measures
AHCCCS intends to incorporate two new Performance Measures in the CYE 2009 contract to support quality management/quality improvement efforts for E/PD members. The measures were selected through a collaborative process between AHCCCS Administration and Program Contractors. Methodologies for measuring these areas are still under development, and may be subject to change; however, the measures would generally consist of the following:

- Influenza Vaccination - The percent of ALTCS members who received an influenza vaccination during the preceding flu season, by placement (HCBS vs. nursing facility), Contractor, geographic area (county, GSA and/or rural vs. urban area) and overall. Documentation of refusal of vaccination also would be measured. Data would be collected through a hybrid methodology, from the AHCCCS encounter system and augmented with data collected by Contractors from medical records and/or case management systems.
- Incidence of Pressure Ulcers - AHCCCS may use or adapt existing measures; e.g., measures utilized by the Centers for Medicare and Medicaid Services (CMS), for incidence of nursing facility residents who have

pressure sores and are classified as either high risk or low risk, and/or a measure of hospitalization rates for pressure ulcers. Study indicators would be reported by placement (HCBS vs. nursing facility), Contractor, geographic area (county, rural vs. urban area) and overall. Data for the CMS-developed measure may be collected from Minimum Data Set (MDS) data maintained by the Arizona Department of Health Services, medical records and/or case management systems. Data for a measure of hospitalization may be collected through a hybrid methodology, from the AHCCCS encounter system and augmented with data collected by Contractors from medical records and/or case management systems.

Methodologies for the measures will be available to Contractors for comment prior to implementation.

EPSDT Participation

The Contractor shall take affirmative steps to increase member participation in the EPSDT Program. The 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.

ALTCS E/PD Performance Standards for CYE 2008:

Performance Measures	CYE 08 Minimum Performance Standard	CYE 08 Goal	Benchmark
Diabetes Care (1)			
Annual Hb A1c Testing	**77%**	**78%**	**89%**
Biennial Lipid Profiles	**81%**	**82%**	**91%**
Biennial Retinal Exams	**67%**	**68%**	**68%**
Initiation of HCB Services	**84%**	**85%**	**98%**
EPSDT Participation (1)	**50%**	**53%**	**80%**

(1) The percent of all children under 21 years who had at least one EPSDT visit during the contract year. The MPS and Goal are based on CYE 2003 rates, which were measured but not reported for ALTCS Contractors.

Quality Improvement

Program Contractors shall implement an ongoing quality assessment and performance improvement programs for the services it furnishes to members [42 CFR 438.240(a)(1). Basic elements of the Program Contractor quality assessment and performance improvement programs, at a minimum, shall comply with the following requirements:

A. Quality Assessment Program

The Program Contractor shall have an ongoing assessment program for services [42 CFR 438.240(a)(1)].

1. The Performance Improvement Projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction.
2. The Program Contractor must[42 CFR 438.240(b)(2) and (c)
   a. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS.
   b. Submit to the State, data specified by the State, that enables the State to measure the Program Contractor's performance; or
   c. Perform a combination of the activities.
3. The Program Contractor must have in place a process for internal monitoring of Performance Measure rates, using 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 AHCCCSA in conjunction with its Quarterly EPSDT Progress Report, according to a format developed by AHCCCS.

B. Performance Improvement Program

Program Contractors must have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following [42 CFR 438.240(b)(1) and (d)(1)]:

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

The Program Contractor must report the status and results of each project to the State 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 annually on quality of care [42 CFR 438.240(d)(2)].

C. Data Collection Procedures

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

21. MEDICAL MANAGEMENT

The Program Contractor 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 the Program Contractor 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 438.210(b)(2)]
        3) Monitor and ensure that all enrollees with special health care needs have direct access to care
3. Development and/or Adoption of Practice Guidelines [42 CFR 438.235(b), that
    a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
    b. Consider the needs of the Contractor's members;
    c. Are adopted in consultation with contracting health care professionals;
    d. Are reviewed and updated periodically as appropriate;
    e. Are disseminated by Contractors to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    f. Provide a basis for consistent decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply [42 CFR 438.236(d)];

4. Concurrent review;
   a. Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services and other areas to which the guidelines apply;
   b. 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 MM Committee; and
9. Quarterly Utilization Management Report (details in the *AMPM*)

The Program Contractor will assess, monitor and report quarterly through the MM Committee medical decisions to assure compliance with timeliness, language and Notice of Action intent, and that the decisions complies with all Program Contractor coverage criteria.

The Contractor shall have a process to report MM data and management activities through a MM Committee. The Contractor's MM committee will analyze the data, make recommendations for action, monitor the effectiveness of actions and report these findings to the committee. The Contractor 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)].

The Contractor shall maintain a written MM plan that addresses its plan for monitoring MM activities (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

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

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

and any other matters arising under this contract which rise to the level of administrative hearing or a judicial proceeding. Unless there is an agreement with the State in advance, the Program Contractor shall be responsible for all attorney fees and costs awarded to the claimant in a judicial process.

23. GRIEVANCE SYSTEM REPORTS

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

24. MEMBER/PROVIDER COUNCILS

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

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

25. STAFF REQUIREMENTS and SUPPORT SERVICES

The Program Contractor shall have in place, either directly or indirectly, the organizational, management 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 that has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR 438.610(a) and (b)]. The Program Contractor is responsible for maintaining a significant local (within the State of Arizona) presence. This presence would include staff as described in a., b., d., e., f., h., i., j., k., l., o., p., q. and r. below. After contract award, the Program Contractor must obtain approval from AHCCCS prior to moving functions outside the State of Arizona. Such a request for approval 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.

At a minimum, the following staff functions are required:

a. An **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. A **Medical Director** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all major clinical and QM/MM program 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. A **Financial Officer/CFO** to oversee the budget, accounting systems and financial reporting implemented by the Program Contractor.
d. A **Quality Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant or is a Certified Professional in Health Care Quality.
e. **Utilization/Medical Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant.
f. A **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 AHCCCSA requirements.
g. **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.
h. **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.
i. **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.
j. **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.
k. **Case Managers** to coordinate the provision of services to members in HCBS and institutional settings.
l. **Provider Services/Contracts 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.
m. **Claims Administrator** and **Claims Processors** to ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.
n. **Encounter Processors** to ensure the timely and accurate processing and submission to AHCCCSA of encounter data and reports.
o. A **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.
p. **Compliance Officer** who shall 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 AHCCCSA, Office of Program Integrity. See paragraph 70 for more information.
q. **Clerical and support staff** as necessary to ensure proper functioning of the Program Contractor's operation.
r. **Program Contractor Staff** sufficient to implement and oversee compliance with both the Program Contractor's Cultural Competency Plan and the ACOM *Cultural Competency Policy*, and to oversee compliance with all AHCCCS requirements pertaining to Limited English Proficiency (LEP).
s. **A Business Continuity Planning and Recovery Coordinator** as noted in the ACOM Business Continuity and Recovery Planning Policy.
t. **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.
u. **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 or is a Certified Professional in Health Care Quality.

v. **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.

The Program Contractor shall inform AHCCCSA, Division of Health Care Management, in writing within seven days of learning of an intended resignation in any of the following key positions listed below. The name of the interim contact person should be included with the notification. In addition, AHCCCSA may require the Program Contractor to provide a written plan for filling the vacant position, including expected timelines. The name of the permanent employee shall be submitted as soon as the new hire has taken place.

- Administrator/CEO/COO
- Medical Director
- Financial Officer/CFO
- Quality Management/Medical Management Coordinator
- Case Management Administrator/Manager
- Claims Administrator
- Behavioral Health Coordinator
- Grievance Manager
- Provider Services/Contracts Manager
- Compliance Officer

The Program Contractor shall ensure that all staff have appropriate training, education and experience to fulfill the requirements of the position.

26. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

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

27. MEDICAL DIRECTOR

The Program Contractor shall have on staff a Medical Director who is currently actively licensed as a physician in Arizona through the Arizona Medical Board or the Arizona Osteopathic Board. The Medical Director must have at least 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 the Program Contractor must clearly identify a physician who will be available and accountable for these areas in which the Medical Director's training/experience may be lacking. The Medical Director shall be responsible for:

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

prior authorization, concurrent review, claims review, discharge planning, credentialing and referral management, as well as for medical review in the grievance, appeal and fair hearing processes.

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

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

28. NETWORK DEVELOPMENT

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

- Promoting member-centered care through the development of services and settings that support the mutually agreed upon care plan through all service settings (nursing facilities, assisted living facilities and at home) including the ALTCS Guiding Principles of (as defined in Section D, paragraph 2):
    - *Member-Centered Case Management*
    - *Consistency of Services*
    - *Available and Accessible Services*
    - *Most Integrated Setting*
    - *Collaboration with Stakeholders*
- Support of the member's informal support system (e.g., family caregivers) through respite services, adult day health programs, etc.
- Development of HCB services and settings to meet the needs of members who have cognitive impairments, 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 needs as well as the membership in general. To that end the Program Contractor shall develop, maintain and monitor a provider network, including

home and community based service providers and alternative residential settings, that is supported by written agreements which is sufficient to provide all covered services to ALTCS members. The Program Contractor shall ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation. 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 dictated by member needs [42 CFR 438.206(b)(1)]; [42 CFR 438.206(c)(1)(i), (ii) and (iii)].

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 to non-ALTCS persons within the same service area [42 CFR 438.210.(a)(2)]. 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 Program Contractor shall develop and maintain a provider Network Development and Management Plan which ensures that the provision of covered services will occur as stated above [42 CFR 438.207(b)]. The 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 AHCCCSA is an assurance of the adequacy and sufficiency of the Program Contractor's provider network. The Program Contractor shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in services, covered benefits, geographic service areas, payments or eligibility of a new population.

The plan shall identify the current status of the network at all levels (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) and project future needs based upon, at a minimum, membership growth; the number and types (in terms of training, experience and specialization) of providers that exist in the Program Contractor's service area, as well as the number of physicians who have privileges with and practice in hospitals; the expected utilization of services, given the characteristics of its population and its health care needs; the numbers of providers not accepting new Medicaid patients; and access of its membership to specialty services as compared to the general population of the community. [42 CFR 438.206(b)(1)] The Offeror's Network Development and Management Plan should include input from members, providers and staff regarding current and future network needs.

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. The Program Contractors must have as part of their network development plan a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home (attendant care, personal care and homemaker). Work Force Development is defined as all activities that increase the number of individuals participating in the long-term health care workforce. It includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for the continued training of current caregivers (i.e. Program Contractor supported/sponsored training). Work Force Development also includes efforts to review compensation and benefit incentives, while providing a plan for the expansion of the paraprofessional network at all levels of client care. See the Citizens Workgroup on the Long-Term Care Workforce Report, April 2005, in the Bidder's Library.

The plan should, at a minimum, include the following:

1. Evaluation of prior year's plan
2. Current status of network including:
   a. how members access the system
   b. relationships between the various levels
3. Current network gaps and the methodology used to identify them
4. Immediate short-term interventions when a gap occurs including expedited or temporary credentialing
5. Interventions to fill network gaps, and barriers to those interventions
6. Outcome measures/evaluation of interventions
7. Ongoing activities for network development
   a. Current unmet needs
   b. Future needs relating to membership growth
8. Coordination between contractor departments and outside organizations, including member/provider council
9. A description of the network for special populations including but not limited to behavioral health and young adults and children including
   a. Current unmet needs
   b. Future needs relating to membership growth

   The description should include a list of these providers along with a description of services provided by the program and projected utilization.
10. A description of the adequacy of the geographic access to tertiary hospital services
11. The methodology(ies) the Program Contractor uses to collect and analyze provider feedback about the network designs and implementation. When specific provider issues are identified, the protocols for handling them.
12. The strategies the Program Contractor has for Work Force Development.
13. Strategies the Contractor will take to provide members with "in-home" HCBS versus placing members in Assisted Living Facilities and Nursing Facilities.
14. Listing of non-Medicare Certified Home Health Agencies the Contractor is using. The listing is to be provided on the form distributed by AHCCCS and attached to the Plan.
15. A listing of Assisted Living Facilities for which the Contractor has already obtained a waiver from the Single Choice Occupancy requirement. Listing must include the name of the facility and the date of the waiver approval.
16. A listing of nursing facilities who have withdrawn from the Medicaid Program but are still being utilized by the Contractor. The listing must include the name of the facility and the number of residents the Contractor has in each facility.

The Plan must include answers to the following questions:

a) Does the Program Contractor utilize any of the following strategies to reduce unnecessary emergency department utilization by its membership? If so, how are members educated about these options?
   1. Physician coverage/call availability after-hours and on weekends
   2. Same day PCP appointments
   3. Nurse call-in centers/information lines
   4. Urgent care facilities

b) What are the most significant barriers to efficient network deployment within the Program Contractor's service area? How can AHCCCS best support the Program Contractor's efforts to improve its network and the quality of care delivered to its membership?

c) What types of ALTCS members are assigned to specialists for their primary care needs?

In accordance with the Network Standards specified in Attachment E and the members' needs, the proposed network shall be sufficient to provide covered services within designated time and distance limits. For Maricopa and Pima Counties only, this includes a network such that 95% of its members residing within the boundary area of metropolitan Phoenix or Tucson do not have to travel more than 5 miles to see a PCP or pharmacy. A member residing outside the metropolitan boundary area, but within Maricopa or Pima County, must not have to travel

more than 10 miles to see such providers if a provider resides within 10 miles and is willing to contract with the ALTCS Program Contractor. Any exceptions to the Network Standards must be prior approved by AHCCCSA, Division of Health Care Management.

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

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

Other: AHCCCS is committed to workforce development and support of the medical residency and dental student training programs in the state of Arizona. Working proactively with these programs is beneficial to protect their viability, and also provides an excellent opportunity for the Program Contractors to educate future providers on the principles of managed care. In addition, AHCCCS believes that these programs can influence the provider capacity issues in Arizona. In the future, AHCCCS would like to provide incentives to those programs that are working to retain physicians in Arizona after completion of the program.

Ball v Biedess (Rodgers): In order to fulfill the settlement in the Ball v. Biedess (Rodgers) case the Program Contractor is responsible for establishing a network of contracted providers adequate to ensure that critical services are provided without gaps. The Program Contractor 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".
The Program Contractor shall implement policies and procedures to identify, correct, and track gaps in service. 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 the Program Contractor 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.
- The Program Contractor's process for providing services in the event of a gap in service. This shall include guidelines on how timely the Program Contractor 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), the Program Contractor shall submit a report to AHCCCS outlining trends and corrective actions regarding gaps in services, grievances related to service gaps, and other reports as deemed necessary to fulfill the settlement agreement in the Ball v. 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

The Contractor must make resources available to assist homeless clinics with administrative issues such as obtaining Prior Authorization, and resolving claims issues.
AHCCCA 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.

Dual Eligibles: For the purposes of improving the care coordination for dual eligible members in the future, AHCCCS will expect all Program Contractors to either:

a) become a Medicare Advantage Special Needs Plan (MA SNP) or
b) develop formal relationships with a Medicare Advantage Plan(s) or MA SNP(s).

29. NETWORK MANAGEMENT

The Program Contractor shall have policies and procedures in place that pertain to all service specifications described in the *AMPM* [42 CFR 438.214(a)]. In addition, the Program Contractor shall have policies on how the Program Contractor will:

a. Communicate with the network regarding contractual and/or program changes and requirements;
b. Monitor network compliance with policies and rules of AHCCCSA and the Program Contractor, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes
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

Program Contractor policies shall be subject to approval by AHCCCSA, Division of Health Care Management, and shall be monitored through operational audits. A material change in Program Contractor policy or process requires 30 days advance notice to affected providers and members. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the members, providers, or AHCCCS program, or may significantly impact the delivery of services provided by an AHCCCS Program Contractor.

Program Contractors are required to submit the member notices to AHCCCS for approval 30 days prior to the notice being sent. Upon receipt of the member notice for review, AHCCCSA may comment on the material change or may intervene if the policy/process change will have an adverse affect to the overall system.

Provider notices do not require prior approval, however, the Contractor must notify AHCCCSA of the material policy change 15 days prior to the provider notice being sent out. During the 15 day time period, AHCCCS shall have the right to comment or may intervene if the change to policy/process will lead to an adverse affect to the overall system. This provision is not intended to include contract negotiations between Program Contractors and providers.

Program Contractors 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.

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

All material changes in the Program Contractor's provider network must be approved in advance by AHCCCSA, Division of Health Care Management. A material change is defined as one which affects, or can reasonably be foreseen to affect, the Program Contractor's ability to meet the performance and network standards as described in this contract. AHCCCSA will assess proposed changes in the Program Contractor's provider network for potential impact on members' health care and provide a written response to the Program Contractor. For emergency situations, AHCCCSA will expedite the approval process.

The Program Contractor shall notify AHCCCSA, 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) the Program Contractor'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

The Program Contractor shall develop, distribute and maintain a provider manual. The Program Contractor shall document the approval of the provider manual by its Administrator and Medical Director and shall maintain documentation which verifies that the provider manual is reviewed at least annually. The Program Contractor shall ensure that each contracted provider (individual or group that submits claim and encounter data) is made aware of a website provider manual or, if requested is issued a hard copy of the provider manual.

The Program Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements such as covered services, billing, etc. At a minimum, the provider manual must contain information on the following:

a. A table of contents
b. Introduction to the Program Contractor which explains its organization and administrative structure
c. Provider responsibilities and the Program Contractor's expectation of the provider
d. Overview of the Program Contractor's Provider Services department and function
e. Listing and description of covered and non-covered services, requirements and limitations, including behavioral health services and how to access them
f. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
g. Description of cost sharing responsibilities
h. The Program Contractor's policy regarding PCP assignments
i. Referrals to specialists and other providers
j. ACOM Change of Program Contractor policy
k. Grievance system process and procedures for providers and enrollees

l. Billing and encounter submission information
m. Policies and procedures relevant to the network including, but not limited to, utilization management and claims submission
n. Reimbursement information, including reimbursement for members eligible for both Medicare and Medicaid (dual eligibles), or members with other insurance
o. Explanation of remittance advice
p. Prior authorization and notification procedures
q. Claims medical review
r. Concurrent review
s. Fraud and abuse
t. AHCCCS appointment and office waiting time standards
u. Formulary information, including updates when changes occur must be provided in advance to providers, including pharmacies. (The formulary may be separate from the Provider Manual.) The Program Contractor is not required to send a hard copy, unless requested, of the formulary each time it is updated. A memo may be used to notify providers of updates and changes, and refer providers to view the updated formulary on the Program Contractor's website
v. EPSDT services, standards and forms. EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children Program.
w. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable
x. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English or who use sign language
y. Eligibility verification
z. Information about a member's right to be treated with dignity and respect as specified in 42 CFR 438.100.
aa. Notification that the Program Contractor has no policies which prevent the provider from advocating on behalf of the member
bb. How to access or obtain Practice Guidelines and coverage criteria adopted by the Program Contractor
cc. Maternity/Family Planning services
dd. Peer review and appeal process

31. PROVIDER REGISTRATION

The Program Contractor shall ensure that all its subcontractors register with AHCCCSA 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 AHCCCSA. This provider registration process must be completed in order for the Program Contractor to report services a subcontractor renders to enrolled members and for the Program Contractor 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) effective for dates of service on or after May 23, 2007. Program Contractors shall work with providers to obtain their NPI.

32. NETWORK SUMMARY

The Program Contractor shall submit electronically, information regarding its provider network. This information shall be submitted as specified in Section J, Exhibits, Exhibit C of the ALTCS RFP issued February 8th, 2006 . Network Updates will be submitted on October 15 and April 15 of each contract year. The AHCCCS Division of Health Care Management will notify the Program Contractor if there is a change in the frequency of submissions or file specifications.

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

33. SUBCONTRACTS

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

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

a. Delegated agreements that delegate:
    1. Any function related to the management of the contract with AHCCCS. Examples include 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

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

Before entering into a subcontract which delegates duties or responsibilities to a subcontractor the Program Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Program Contractor delegates duties or responsibilities to a subcontractor, then the Program Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance in inadequate. In order to determine adequate performance, the Program Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule approved by AHCCCSA. 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)].

The Program Contractor must submit annually (within 90 days from the start of the contract year) a statement whether any Contractor duties and responsibilities have been established under a., b., and c. of the second subparagraph above have been delegated to a subcontractor. If duties and responsibilities have been delegated to a subcontractor the Program Contractor must submit annually (within 90 days from the start of the contract year) a report listing 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
- Program Contractor's corrective action plan

The Program Contractor 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.

Provider Agreements

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

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

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

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

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

All subcontracts must contain verbatim all the provisions of Attachment A, Minimum Subcontract Provisions. 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 the Program Contractor/ Contractor.
h. A description of the subcontractor's patient medical, dental and cost record keeping system.
i. Specification that the subcontractor shall cooperate with quality assurance programs and comply with the utilization control and review procedures specified in 42 CFR Part 456, as specified in the AMPM.
j. A provision stating that a merger, reorganization or change in ownership of a subcontractor that is related to or affiliated with the Program Contractor shall require a contract amendment and prior approval of AHCCCSA.
k. Procedures for enrollment or re-enrollment of the covered population (may also refer to the Provider Manual).
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 AHCCCSA shall have no responsibility or liability for any such taxes or insurance coverage.
m. A provision that the subcontractor must obtain any necessary authorization from the Program Contractor or AHCCCSA for services provided to eligible and/or enrolled members.
n. A provision that the subcontractor must comply with encounter reporting and claims submission requirements as described in the subcontract.
o. Provision(s) that allow the Program Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.
p. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Program Contractor.
q. For Nursing Facility subcontracts, a provision that the subcontractor must have procedures in place to ensure that temporary nursing care registry personnel, including Nurse Aides, are properly certified and licensed before caring for members, in accordance with 42 CFR 483.75(e) 3 and (g) 2. The provision must also require the subcontractor to ensure these registry personnel are fingerprinted as required by ARS §36-411.
r. A provision that compensation to individuals or entities that conduct utilization management and concurrent review activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary services to any enrollee (42 CFR 438.210(e)).

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

34. ADVANCE DIRECTIVES

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

a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care must comply with federal and state law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:
   (1) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)
   (2) Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].

(3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
(4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
(5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.

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

c. The Program Contractor 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 AHCCCSA
(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

AHCCCSA may at any time negotiate or contract on behalf of the Program Contractor and AHCCCSA for specialized hospital and medical services. AHCCCSA will consider existing Program Contractor resources in the development and execution of specialty contracts. AHCCCSA may require the Program Contractor to modify its delivery network to accommodate the provisions of specialty contracts. The Program Contractor may elect to not use the specialty contract, however, in no case shall AHCCCS reimbursement exceed that payable under the relevant specialty contract.

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

Currently, AHCCCSA only has specialty contracts for transplant services and anti-hemophiliac agents and pharmaceutical related services. AHCCCSA shall provide at least 60 days advance written notice to the Program Contractor prior to the implementation of any specialty contract.

36. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

Maricopa and Pima counties only*:* Effective October 1, 2003, legislation authorizes the Inpatient Hospital Reimbursement Program. The program is defined in the Arizona Revised Statutes (A.R.S.) 36-2905.01, and requires hospital subcontracts to be negotiated between Program Contractors in Maricopa and Pima counties and hospitals to establish reimbursement levels, terms and conditions. Subcontracts shall be negotiated by the Program Contractor and hospitals to cover operational concerns, such as timeliness of claims submission and payment, payment of discounts or penalties, and legal resolution, which may, as an option, include establishing arbitration procedures. These negotiated subcontracts shall remain under close scrutiny by AHCCCSA to insure availability of quality services within specific service districts, equity of related party interests, and reasonableness of rates. The general provisions of this program encompass acute care hospital services and outpatient hospital services that result in an admission. The Program Contractor, upon request, shall make available to AHCCCSA, all hospital subcontracts and any amendments. For non-emergency patient-days, the Program Contractor shall ensure that at least 65% of its members use contracted hospitals. AHCCCSA

reserves the right to subsequently adjust the 65% standard. Further, if in AHCCCSA's judgment the number of inpatient days at a particular non-contracted hospital becomes significant, AHCCCSA may require a subcontract at that hospital. In accordance with R9-22-718, unless otherwise negotiated by both parties, the reimbursement for inpatient services provided at a non-contracted hospital shall be based on the rates as defined in A.R.S. § 36-2903.01, multiplied by 95%.

All counties EXCEPT Maricopa and Pima: The Contractor shall reimburse hospitals for member care in accordance with AHCCCS Rule 9 A.A.C. 22, Article 7. The Contractor is encouraged to obtain subcontracts with hospitals in all GSA's and must submit copies of these subcontracts, including amendments, to AHCCCSA, Division of Health Care Management.

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

Hospital Recoupments: The Program Contractor may conduct prepayment and postpayment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Program Contractor 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 the Program Contractor. See also Section D, Paragraph 44, Claims Payment System. For a more complete description of the guidelines for hospital reimbursement, please consult the applicable statutes and rules.

***Outpatient Hospital Services*:** With passage of SB 1410 (Laws of 2004, Chapter 279), effective for dates of service on and after July 1, 2005, in absence of a contract, the default payment rate for outpatient hospital services billed on a UB-92 will be based on the AHCCCS outpatient hospital fee schedule, rather than a hospital-specific cost-to-charge ratio (pursuant to ARS 36-2904).

37. PRIMARY CARE PROVIDER STANDARDS

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

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

The Program Contractor shall have a system in place to monitor and ensure that each member is assigned to an individual PCP and that the Program Contractor's data regarding PCP assignments is current. The Program Contractor is encouraged to assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians. PCP's with assigned members diagnosed with AIDS or as HIV positive shall meet criteria and standards set forth in the *AMPM*. PCPs assigned ventilator dependent members shall ensure each member is evaluated annually by a pulmonologist to assess the prospects of weaning the member from dependency on the ventilator.

To the extent required by this contract, the Program Contractor shall offer members freedom of choice within its network in selecting a PCP [42 CFR 438.6(m) and 438.52(d)]. The Program Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent

changes, or when there is a medically necessary reason. When a new member has been assigned to the Program Contractor, the Program Contractor shall inform the member in writing of his enrollment and of his PCP assignment within 12 business days of the Program Contractor's receipt of notification of assignment by AHCCCSA. The Program Contractor shall include with the enrollment notification a list of all the Program Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the ACOM *Member Information Policy*. The Program Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

a. Supervision, coordination and provision of care to each assigned member (except for 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.

Program Contractors will work with AHCCCSA to develop a methodology to reimburse clinics for the homeless and school based clinics. AHCCCSA and Program Contractors will identify coordination of care processes and reimbursement mechanisms. The Program Contractors will be responsible for payment of these services directly to the clinics.

The Program Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty and referral services provided to assigned members by specialty physicians, and other health care professionals. Program Contractor policies and procedures shall be subject to approval by AHCCCSA, 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. The Program Contractor shall have procedures in place that ensure the following standards are met:

The Program Contractor shall have monitoring procedures in place that ensure:

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

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

For **behavioral health services,** the Program Contractor shall be able to provide:
a. Emergency appointments within 24 hours of referral.
b. Routine appointments within 30 days of referral.

For **dental appointments**, the Program Contractor 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**, the Program Contractor shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:
a. First trimester- within 14 days of request
b. Second trimester within 7 days of request
c. Third trimester within 3 days of request
d. High risk pregnancies within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

For **medically necessary non-emergent transportation,** the Program Contractor 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 and does not have to wait more than one hour after making the call to be picked up after the appointment for transportation home.

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)]. The Program 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.

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

39. PHYSICIAN INCENTIVES/PAY FOR PERFORMANCE

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

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

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

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

Pay for Performance

Any pay for performance that meets the requirements of 42 CFR 417.479 must be approved by AHCCCS Division of Health Care Management prior to implementation.

40. REFERRAL MANAGEMENT PROCEDURES AND STANDARDS

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

a. Use of referral forms clearly identifying the Contractor
b. A system for resolving disputes regarding the referrals
c. 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
d. 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
e. Referral to Medicare Managed Care Plan including payment of copayments
f. 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, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
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)].
h. Specialty physicians shall not begin a course of treatment for a medical condition other than that for which the member was referred, unless approved by the member's PCP.

The Program Contractor shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act. The Program Contractor shall comply with all applicable physician referral requirements and conditions defined in 42 CFR Part 411, Part 424, Part 435 and Part 455. Sections 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services are:

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

41. MAINSTREAMING OF ALTCS MEMBERS

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

genetic information or physical or mental disability. Program Contractors 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. The Program Contractor must also make interpreters, including assistance for the visual or 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 13166, 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 disability of the participants to be served.

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

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

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

The Contractor is encouraged to use FQHCs/RHCs in Arizona to provide covered services and must comply with the federal mandates. AHCCCS expects the Program Contractors 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.

Contractors are required to submit member month information for Title XIX members for each FQHC/RHC on a quarterly basis to AHCCCSA Division of Health Care Management. AHCCCSA will perform periodic audits of the member information submitted. Contractors should refer to the AHCCCS Division of Health Care Management's policy on FQHC/RHC reimbursement for further guidance. The FQHCs/RHCs registered with AHCCCS are listed on the AHCCCS website: www.azahcccs.gov.

43. RESERVED

44. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM

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

The Program Contractor will ensure that changing or making major upgrades to the information systems affecting claims processing, or any other major business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation. At least 6 months before the

anticipated implementation date, the contractor shall provide the system change plan to AHCCCSA for review and comment.

The Contractor shall develop and maintain a 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. This system must produce a remittance advice related to the Program Contractor's payments to providers and must contain, 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.

The Contractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by AHCCCSA, 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. A Contractor shall not recoup monies from a provider later than 12 months after the date of original payment on a clean claim without prior approval of AHCCCSA unless the recoupment is a result of fraud, reinsurance audit findings, data validation or any other audits conducted by the AHCCCSA.

The Program Contractor 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.

The Program Contractor must void encounters that are recouped in full. For recoupments that result in a reduced 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 revised encounters must reach adjudicated status within 120 days of the approval of the recoupment. The Contractor should refer to the ACOM 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 Encounter Manual.

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. Claim payment requirements pertain to both contracted and non-contracted providers. The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Program Contractor's specified claims mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the date of service or the effective date of eligibility posting, whichever is later. Remittance advices accompanying the Program Contractor's payments to providers must contain adequate descriptions of all denials and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and provider rights for claim disputes.

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

- Program Contractors must be able to offer Electronic Claims Submission and Electronic Claims transfer to all providers. Additionally, the Program Contractor 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, 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."

The Program Contractor shall submit a monthly Claims Dashboard as specified in the AHCCCS Claims Reporting Guide. Beginning October 1, 2006, the Program Contractor shall submit:

1) Claims Dashboard reporting claims received on a UB92 or 837I
2) Claims Dashboard reporting claims received on a CMS1500, dental claim form, 837P or 837D
3) Claims Dashboard combining all claims

Unless a subcontract specifies otherwise, Contractors shall ensure that for each form type (Dental/Professional/Institutional), 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.

The monthly report must be received by the AHCCCSA, Division of Health Care Management, no later than 15 days from the end of each month.

45. MINIMUM CAPITALIZATION REQUIREMENTS

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

Minimum capitalization requirements by GSA are as follows:

Geographic Service Area (GSA)	# Members as of (January 1, 2006)	Potential Awards	Proposed Capitalization Requirement Per Contractor (rounded)
Maricopa (52)	13,705	3	$4,500,000
Mohave/Coconino/Apache/ Navajo (44)	1,296	1	$1,300,000
La Paz/Yuma (42)	465	1	$ 500,000
Pima/Santa Cruz (50)	3,936	2	$2,000,000
Cochise/Graham/Greenlee (46)	908	1	$1,000,000
Pinal/Gila (40)	1,227	1	$1,300,000
Yavapai (48)	994	1	$1,000,000

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

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

46. PERFORMANCE BOND OR BOND SUBSTITUTE

In addition to the minimum capitalization requirements, the Program Contractor shall be required to establish and maintain a performance bond of standard commercial scope issued by a surety company doing business in this state, an irrevocable letter of credit, or a cash deposit to AHCCCSA for as long as the Program Contractor has AHCCCS-related liabilities of $50,000 or more outstanding, or 15 months following the termination date of this contract, whichever is later, to guarantee: (1) payment of the Program Contractor's obligations to providers, and (2) performance by the Program Contractor of its obligations under this contract [42 CFR 438.116]. The performance bond shall be in a form acceptable to AHCCCSA as described in the ACOM *Performance Bond Policy*.

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

a. Paying any damages sustained by providers, contracted or otherwise, because of a breach of the Program Contractor's obligations under this contract;
b. Reimbursing AHCCCSA for any payments made by AHCCCSA on behalf of the Program Contractor; and
c. Reimbursing AHCCCSA for any extraordinary administrative expenses incurred by reason of a breach of the Program Contractor's obligations under this contract, including, but not limited to, expenses incurred after termination of this contract for reasons other than the convenience of the state by AHCCCSA.

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

The Program Contractor must request an annual acceptance from AHCCCSA when a substitute security in lieu of the performance bond, irrevocable letter of credit or cash deposit is established.

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

47. AMOUNT OF PERFORMANCE BOND

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

48. ACCUMULATED FUND DEFICIT

The Program Contractor and its owners shall fund any accumulated fund deficit through capital contributions in a form acceptable to AHCCCSA within 60 days after receipt by AHCCCSA of the final audited financial statement or as otherwise requested by AHCCCSA.

49. MANAGEMENT SERVICES AGREEMENTS AND COST ALLOCATION PLANS

If the Program Contractor has subcontracted for management services, the management service agreement and the corporate cost allocation plans must be approved in advance by AHCCCSA, Division of Health Care

Management as described in Paragraph 33, Subcontracts. Cost allocation plans must be submitted with the proposed management fee agreement. AHCCCSA reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If the fees or allocations are determined to be unjustified or excessive, amounts may be subject to repayment to the Program Contractor. In addition, sanctions may be imposed.

50. ADVANCES, DISTRIBUTIONS AND LOANS

The Program Contractor shall not, without the prior approval of AHCCCSA, make any advances, distributions, loans or loan guarantees to related parties or affiliates including another fund or line business within its organization. The Program Contractor shall not, without prior notification to AHCCCSA, make advances to its subcontractors in excess of $50,000. All requests for prior approval and notifications are to be submitted to the AHCCCSA Division of Health Care Management.

51. RESERVED

52. FINANCIAL VIABILITY STANDARDS AND PERFORMANCE GUIDELINES

AHCCCSA has established financial viability standards/performance guidelines. On a quarterly basis, AHCCCSA will review the following ratios with the purpose of monitoring the financial health of the Contractor. The two financial viability standards, the Current Ratio and Equity per Member, are the standards that best represent the financial solvency of the Contractor. Therefore, the Contractor must comply with these two financial viability standards.

AHCCCSA will also monitor the Medical Expense Ratio, the Administrative Cost Percentage, and the RBUC's Days Outstanding. These guidelines are analyzed as part of AHCCCSA's due diligence in financial statement monitoring. Sanctions will not be automatically imposed if the Contractor does not meet these performance guidelines. AHCCCSA takes into account Contractors' unique programs for managing care and improving the heath status of members when analyzing medical expense and administrative ratio results. However, if a critical combination of the Financial Viability Standards and Performance Guidelines are not met, or if a Contractor's experience differs significantly from other Contractors', additional monitoring, such as monthly reporting, may be required.

Financial Viability Standards

Current Ratio (Current assets divided by current liabilities. Current assets may include any long-term investments that can be converted to cash within 24 hours without significant penalty, i.e., greater than 20%. A request to include long-term investments that can be converted to cash within 24 hours in the current ratio calculation must be sent to AHCCCS, DHCM, within 30 days of the contract start date and within 30 days of contract renewal).	Standard: At least 1.00
Equity per Member (Unrestricted equity, less on-balance sheet performance bond divided by the number of members at the end of the period) For purposes of this measurement, the equity will be measured according to the "Performance Bond and Equity Per Member Requirements" effective October 1, 2007.	Standard: At least $2,000

Performance Guidelines

Medical Expense Ratio Total medical expense, including case management divided by total payments received from 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 more than 8%
Received But Unpaid Claims Days Outstanding (Received but unpaid claims divided by the average daily medical expenses for the period, net of sub-capitation expense)	Standard: No more than 30 days

53. SEPARATE INCORPORATION

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

54. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP

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

55. RELATED PARTY TRANSACTIONS

Any proposed subcontract involving a related party or entity requires prior approval from AHCCCSA, 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 the Program Contractor shall disclose all required information, justify all related party transactions reported, and certify the accuracy and completeness of the disclosures made. The Program Contractor shall demonstrate that transactions occurring between the provider and a related party-in-interest are reasonable, will not adversely affect the fiscal soundness of the Program Contractor, and do not present a conflict of interest.

56. COMPENSATION

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

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

Where payments are made by electronic funds transfer, AHCCCSA shall not be liable for any error or delay in transfer nor indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Program Contractor. Except for adjustments made to correct errors in payment, and as otherwise specified in this Section, any savings remaining to the Program Contractor as a result of favorable claims experience and efficiencies in service delivery at the end of the contract term may be kept by the Program Contractor.

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

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

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

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

The Program Contractor 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 and calculated share of cost, the Program Contractor 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 the Program Contractor or its subcontractors.

Capitation rates will be effective for the period October 1, 2007 through September 30, 2008. Actuaries establish the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries for the purpose of rebasing the capitation rates:

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

AHCCCS adjusts its rates to best match payment to risk. This further ensures the actuarial basis for the capitation rates. The following risk factors will be included for CYE ’08:

a. Reinsurance (as described in Paragraph 58)
b. HIV/AIDS supplemental payment
c. Medicare enrollment
d. HCBS member mixes
e. Member share of cost amounts

The above information is reviewed by AHCCCS’ actuaries in renewal years to determine if adjustments are necessary to maintain actuarially sound rates. A Program Contractor 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 [42 CFR 438.6(e)]. In addition to the above data used to review the appropriateness of capitation rates, during renewal years, AHCCCS may look at other factors that potentially impact appropriate reimbursement including the medical cost experience of members who exercise their right to choose a Program Contractor upon initial enrollment versus those who are auto assigned to a Program Contractor.

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

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

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

Prior Period Coverage (PPC) Capitation: The Program Contractor will be paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during prior period coverage. The PPC capitation rates will be set by AHCCCSA and will be paid to the Program Contractor along with the prospective capitation described above. Beginning October 1, 2006 HCBS will be covered during the PPC months.

Reconciliation of PPC Costs to Reimbursement: AHCCCSA will offer a reconciliation process for Program Contractors whose total PPC medical experience (excluding administrative and non-operating expenses) is more than 10% higher than the reimbursement associated with PPC (PPC capitation excluding administrative add-on). AHCCCSA will reimburse 100% of the amount in excess of 10% of a Program Contractor's reasonable costs. AHCCCSA may also require Program Contractors to provide documentation to support an audit of the PPC medical expenses and a reconciliation to audited medical expenses. AHCCCS may recoup from any program contractor, profit amounts in excess of a 10% limit.

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

Percent *in excess of* assumed percentage:	Amount to be recouped:
0 - 0.5 percentage points	0% of capitation overpayment
0.51 - 1.99 percentage points	20% of capitation overpayment
2 or more percentage points	30% of capitation overpayment

If the Program Contractor's actual HCBS percentage is *less* than the assumed percentage, AHCCCSA will reimburse a portion of the difference between the institutional rate and the HCBS capitation rate for the number

of member months lower than the assumed percentage. This reimbursement will be made in accordance with the following schedule:

Percent *lower than* assumed percentage:	Amount to be reimbursed:
0 -0.5 percentage points	0% of capitation
0.51 - 1.99 percentage points	20% of capitation underpayment
2 or more percentage points	30% of capitation underpayment

HIV-AIDS Supplement: On a quarterly basis, the Contractor shall submit to AHCCCSA, Division of Health Care Management, an unduplicated monthly count of members, by rate code, who are using approved HIV/AIDS drugs along with supporting pharmacy logs. The approved HIV/AIDS drug list is located on the AHCCCS website at www.azahcccs.gov. The report shall be submitted, along with the quarterly financial reporting package, within 60 days after the end of each quarter. The rate of reimbursement for this separate per member per month payment is specified in Section B and is subject to review during the term of the contract. AHCCCSA reserves the right to recoup any amounts paid for ineligible members as well as an associated penalty for incorrect encounter reporting.

Refer to the ACOM HIV/AIDS supplemental payment and review policies for further details and requirements.

Other: AHCCCSA requires Offerors who are awarded contracts to establish rates with their providers that are reflective of the awarded and renewal capitation rates.

AHCCCSA expects its Program Contractors to begin the rate negotiating process 6 to 7 months before the contract year end. The Contractors should provide AHCCCSA with documentation to support rate increases that need to be considered when building the capitation rates. AHCCCSA expects provider contracts to be finalized by the start of the contract year. All negotiations on rates are to be done in good faith.

The Administration requires that Program Contractors pass-through rate increases to nursing facility providers, as follows:

- For nursing facilities located in rural counties (all counties except Maricopa and Pima), Program Contractors shall pass-through a 7% rate increase per nursing facility provider.
- For nursing facilities located in urban counties (Maricopa and Pima counties), Program Contractors shall pass-through a 7% rate increase in the aggregate, with a minimum pass-through of 6% per nursing facility provider.

AHCCCS shall verify that these pass-through requirements have been met.

For HCBS rate increases, the Administration expects Program Contractors to establish rates with their HCBS providers that are reflective of the AHCCCS HCBS Fee-For-Service rate increases.

AHCCCS is evaluating pay for performance and incentive methodologies related to care provided in nursing facilities, in home and community based settings, and services provided by providers and facilities. It is anticipated that the pay for performance or incentive methodologies developed may be based on performance measures, medical management/utilization management data, designation of Centers of Excellence, use of recommended clinical guidelines and/or quality of care data. Contractors should anticipate participating in the development of pay for performance and incentive methodologies and incorporating into business operations as decisions are made."

57. VENTILATOR DEPENDENT REIMBURSEMENT RATES

There will be no Ventilator dependent rate effective October 1, 2006. The Division of Member Services will continue to track member ventilator dependent status for at least one contract year.

58. REINSURANCE

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

The following table represents current deductible and coinsurance levels:

Prospective Reinsurance

Statewide Plan Enrollment	*Deductible With Medicare Part A*	*Deductible Without Medicare Part A*	*Coinsurance*
0-1,999	**$10,000**	**$20,000**	**75%**
2,000 +	**$20,000**	**$30,000**	**75%**

a. Prospective Reinsurance: Prospective reinsurance covers all medically necessary acute care services, including outpatient and inpatient hospitalizations. Prospective reinsurance coverage applies to prospective enrollment periods. The deductible level is based on the Program Contractor's statewide ALTCS enrollment as of October 1st of each contract year.

b. Prior Period Coverage Reinsurance: Effective October 1, 2006, PPC will no longer be covered for reinsurance reimbursement.

Catastrophic Reinsurance**:** The reinsurance program includes a special Catastrophic Reinsurance program. This program encompasses members receiving certain biotech drugs (listed below), and those members diagnosed with hemophilia, von Willebrand's Disease, Gaucher's Disease and those considered by AHCCCSA to be high-cost behavioral health or traumatic brain injured (TBI). For additional detail and restrictions refer to the *AHCCCSA Reinsurance Claims Processing Manual* and the *AMPM*. There are no deductibles for catastrophic reinsurance cases. For those members diagnosed with hemophilia, vonWillebrand's Disease and Gaucher's Disease, all medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Program Contractor's paid amount, depending on the subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCCS contracted amount or the Program Contractor's paid amount, whichever is lower. For members receiving certain biotech drugs listed below, only the drug costs will be covered under the Catastrophic Reinsurance Program. All catastrophic claims are subject to medical review by AHCCCSA. The Program Contractor shall notify AHCCCSA, Division of Health Care Management, Reinsurance Unit, of cases identified for catastrophic reinsurance coverage within 30 days of (a) initial diagnosis, (b) enrollment with the Program Contractor, and (c) the beginning of each contract year. Catastrophic reinsurance will be paid for a maximum 30-day retroactive period from the date of notification to AHCCCSA. The determination of whether a case or type of case is catastrophic shall be made by the Director or designee based on the following criteria; 1) severity of medical condition, including prognosis; and 2) the average cost or average length of hospitalization and medical care, or both, in Arizona, for the type of case under consideration.

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

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

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

High Cost Behavioral Health: Effective October 1, 2007 high cost behavioral health will no longer be available under catastrophic reinsurance unless the case was approved prior to October 1, 2007 and was active on September 30, 2007. The change has been factored into the prospective capitation rate.

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

Biotech Drugs*:* Effective October 1, 2007, 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 even if used in the treatment of a CRS covered condition. Catastrophic reinsurance will cover the drug cost only. The drugs covered are Cerazyme, Aldurazyme, Fabryzyme, Myozyme, and Elaprase. 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 *AMPM*, for covered services for organ and tissue transplants. Reinsurance coverage for transplants is limited to 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of the Contractor's paid amount, whichever is lower. When a member is referred to a transplant facility for an AHCCCS covered organ transplant, the Program Contractor shall notify the AHCCCSA Division of Health Care Management.

Other: For all reinsurance case types other than transplants, Program Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after the reinsurance case reaches $650,000.

Encounter Submission and Payments for Reinsurance

a. ***Encounter Submission****:* A Program Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCSA. Upon submission, the Program Contractor certifies that the services listed were actually rendered. The encounters must be submitted in the format prescribed by AHCCCSA. The Program Contractor must initiate and evaluate an encounter for probable 1st and 3rd party liability before submitting the encounter for reinsurance consideration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st and 3rd party liability or a tort feasor.

The Program Contractor must maintain evidence that costs incurred have been paid by the Program Contractor before submitting reinsurance encounters. This information is subject to AHCCCSA review. Collections from 1st and 3rd parties should be reflected by the Program Contractor as reductions in the encounters submitted on a dollar-for-dollar basis. For purposes of AHCCCSA reinsurance, payments made by Program Contractor-purchased reinsurance are not considered 1st and 3rd party collections.

All reinsurance claims must reach a clean claim 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 whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss in any related reinsurance dollars.

b. ***Encounter Processing:*** AHCCCSA will accept for processing only those encounters that are submitted directly by an AHCCCS Program Contractor and that comply with the AHCCCS Encounter Reporting User Manual.

c. ***Payment of Regular Reinsurance Cases:*** AHCCCSA will reimburse a Program Contractor for costs incurred in excess of the applicable deductible level and subject to coinsurance percentages and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the Program Contractor, 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. Reimbursement for these reinsurance benefits will be made to the Program Contractor each month.

When a member with an annual enrollment choice changes Program Contractors within a contract year, for reinsurance purposes, all acute care, outpatient and inpatient hospitalization costs incurred for that member will follow the member to the receiving health plan. Therefore, all submitted encounters from the health plan the member is leaving (for dates of service within the current contract year) will be applied toward, but not exceed, the receiving health plan's deductible level. For further details regarding this policy and other reinsurance policies refer to the *AHCCCS Reinsurance Claims Processing Manual*.

d. ***Payment of Catastrophic Reinsurance Cases*:** Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the Program Contractor's paid amount, subject to coinsurance percentages. Program Contractors are required to submit all supporting service encounters for transplant services. Reinsurance payments may be linked to transplant encounter submissions. Please refer to the *AHCCCS Reinsurance Claims Processing Manual* for the appropriate billing of transplant services. Reimbursement for these reinsurance benefits will be made to the Program Contractor each month.

Reinsurance Audits

a. ***Pre-Audit:*** Medical audits on reinsurance cases will be conducted on a statistically significant random sample selected based on utilization trends. The Division of Health Care Management will select reinsurance cases based on encounter data received during the contract year to assure timeliness of the audit process. The Contractor will be notified of the documentation required for the medical audit. For closed contracts, a 100% audit may be conducted.

b. ***Audit:*** AHCCCSA will give the Program Contractor at least 45 days advance notice of any audit. The Program Contractor shall have all requested medical records and financial documentation available to the nurse auditors. Any documents not requested in advance by AHCCCSA shall be made available upon request of the Audit Team during the course of the audit. The Program Contractor representative shall be available to the Audit Team at all times during AHCCCSA audit activities. If an audit should be conducted on-site, the Program Contractor 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, the Program Contractor will be asked to send the required documentation to AHCCCSA. The documentation will then be reviewed by AHCCCS.

c. ***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.

d. ***Audit Determinations:*** The Program Contractor 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. AHCCCSA 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 the Program Contractor. A recoupment of reinsurance reimbursements made to the Program Contractor may occur based on the results of the medical audit. A Program Contractor whose reinsurance case is reduced or denied shall be notified in writing by AHCCCSA and will be informed of the cause for the reduction or denial determination and the applicable grievance and appeal process available.

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. AHCCCSA 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 the Program Contractor prior to modifying capitation rates. The Program Contractor may request a review of a program change if it believes the program change was not equitable; AHCCCSA will not unreasonably withhold such a review.

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

a. death of a member
b. inmate of a public institution (not eligible for AHCCCS/ALTCS benefits from date of incarceration as determined by AHCCCS)
c. duplicate capitation to the same Program Contractor
d. adjustment based on change in member's contract type
e. voluntary withdrawal

If a member is in county detention and it is determined by AHCCCS that the member does meet the inmate of a public institution definition, then the disenrollment is effective no earlier than the date following the date of notification to AHCCCSA of the member's inmate status. 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 the same Program Contractor, recoupment will be made as soon as the double capitation is identified. AHCCCSA 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. Certain HCBS ALTCS members may be liable for a share of cost, particularly those who become eligible through a special treatment income trust [42 CFR 438.108]. See the ALTCS Eligibility Policy Manual for a complete list of SOC adjustments on the AHCCCS website.
The Program Contractor receives monthly capitation payments which incorporate an assumed deduction for the share of cost which members contribute to the cost of care. The Program Contractor is responsible for collecting their members' share of cost. The Program Contractor has the option of collecting the share of cost or delegating this responsibility to the provider. The Program Contractor 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 the Program Contractor delegates this responsibility to the provider, the provider contract must spell out complete details of both parties' obligations in share of cost collection. The Program Contractor 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. The Program Contractor or its subcontractors shall not assess late fees for the collection of the share of cost from members.

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

61. COPAYMENTS

There are no copayments for ALTCS members for ALTCS covered services. [42 CFR 438.108].

62. PEDIATRIC IMMUNIZATIONS AND THE VACCINE FOR CHILDREN PROGRAM

Through the Vaccine For Children Program (VFC) federal and state governments' purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. Therefore, the Program Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through the VFC Program, the Program Contractor shall contact AHCCCS, Division of Health Care Management, Clinical Quality Management Unit. Any provider licensed by the State to administer immunizations may register with ADHS as a "VFC provider" and receive free vaccines. The Program Contractor shall not reimburse providers for the administration of vaccines in excess of the maximum allowable as set by CMS. The Program Contractor 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.

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

63. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Pursuant to federal and state law, AHCCCS is the payer of last resort except under limited situations. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have

been exhausted. The Program Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2903, and A.A.C. R9-22-1001 et seq. so that costs for services otherwise payable by the Contractor are cost avoided or recovered from a liable party. The term "State" shall be interpreted to mean "Contractor" for purposes of complying with the federal regulations referenced above. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

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

***Cost Avoidance**:* the Contractor shall take reasonable measures to determine the legally liable parties. This refers to any individual, entity or program that is or may be liable to pay all or part of the expenditures for covered services. The Contractor shall cost-avoid a claim if it establishes the probable existence of a liable party at the time the claim is filed. Establishing liability takes place when the Contractor receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member. If the probable existence of a party's liability cannot be established the Contractor must adjudicate the claim. The Contractor must then utilize post payment recovery which is described in further detail below. If 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, the Contractor is responsible for making these payments, even if the services are provided outside of the Contractor network. The Contractor is not responsible for paying coinsurance and deductibles that are in excess of what the Contractor 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 the Contractor refers the member for services to a third-party insurer, other than Medicare, and the insurer requires payment in advance of all co-payments, coinsurance and deductibles, the Contractor must make such payments in advance.

Members with CRS condition:

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 or Medicare for a CRS covered condition, the Contractor is responsible for all applicable deductibles and copayments. If the member is on Medicare, 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 the Program Contractor has not established the probable existence of a liable party at the time services were rendered or paid for, or was unable to cost-avoid. The following sections set forth requirements for Contractor recovery actions including recoupment activities, other recoveries and total plan case requirements.

Recoupments: The 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: The Program Contractor 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. The Program Contractor shall not pursue reimbursement in the following circumstances unless the case has been referred to the Program Contractor by AHCCCS or AHCCCS' authorized representative:

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

Upon identification of any of the above situations, the Program Contractor shall promptly report any cases 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 AHCCCSA's 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" 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 decribed in the *Technical Interface Guidelines.*

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

64. MEDICARE SERVICES AND COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligibles". Generally, program contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within the Program Contractor's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. Unless prior approval is obtained from AHCCCSA, the Program Contractor must limit their cost sharing responsibility according to the ACOM *Medicare Cost Sharing* policy. Program Contractors shall have no cost sharing obligation if the Medicare payment exceeds what the Program Contractor would have paid for the same service for a non-Medicare member.

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), effective January 1, 2006 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 File Integrity Section (MFIS), 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 IMN
c. Psychiatric Hospital – IMD

65. MARKETING

The Program Contractor shall submit all proposed marketing and outreach materials and events that will involve the general public to the AHCCCS Marketing Committee for prior approval in accordance with AHCCCS rules and the ACOM *Marketing Outreach and Incentives* Policy, a copy of which is available on the AHCCCS Website www.azahcccs.gov [42 CFR 438.104]. The Program Contractor must have signed contracts with hospitals, PCPs, specialists, pharmacies, nursing facilities and residential placement options (i.e., adult foster home, assisted living homes and centers, Alzheimer's Treatment Assisted Living Facilities) in order for them to be included in marketing materials.

Marketing material for a GSA with multiple Program Contractors may contain information such as the Program Contractor's philosophy, case management program or other aspects of their program, which may distinguish them from another Program Contractor. As applicable, Program Contractors will be allowed an 11 x 34 inch sheet folded three times to form an 8 ½ x 11 inch shape for their direct mail material.

66. SURVEYS

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

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

67. PATIENT TRUST ACCOUNT MONITORING

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

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

68. AMERICAN WITH DISABILITIES ACT (ADA) COMPLIANCE

The Program Contractor shall meet all applicable ADA requirements when providing services to members.

69. CULTURAL COMPETENCY

The Program Contractor shall have a Cultural Competency Plan which meets the requirements 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 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)]

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

70. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, all Program Contractors are required to notify the AHCCCS, Office of Program Integrity immediately of all suspected fraud or abuse [42 CFR 455.17]. The Program Contractor 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)]. 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.

The Program Contractor 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. The Program Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCS Administration.

The Program Contractor shall be in compliance with 42 CFR 438.608. The Program Contractor must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. The Program Contractor shall have written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected member fraud, provider fraud and member abuse cases to 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 articulates the organization's commitment to and processes for complying with all applicable federal and state standards.
2. The written designation of a compliance committee who are accountable to the Program Contractor's top management.
3. The Compliance Officer must be an onsite management official who reports directly to the Program Contractor's top management. Any exceptions must be approved by AHCCCSA.
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), Program Contractors, as a condition for receiving payments shall establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. The 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.

The Program Contractor's documented policies must be updated to include the requirements listed above on or before January 1, 2008. Contracts must be amended according to the Contractor contract update schedule, but no later than January 1, 2008.

The Program Contractor 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, the Program Contractor 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 the Program Contractor.

71. RECORDS RETENTION

The Program Contractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCSA and working papers used in the preparation of reports to AHCCCSA. The Program Contractor shall comply with all specifications for record keeping established by AHCCCSA. 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 AHCCCSA.

The Program Contractor shall make available at its office at all reasonable times during the term of this contract and the period set forth in paragraphs a. and b. below any of its records for inspection, audit or reproduction by any authorized representative of AHCCCSA, State or Federal government. The Program Contractor shall be responsible for any costs associated with the reproduction of requested information.

The Program Contractor shall preserve and make available all records for a period of five years from the date of final payment under this contract except as provided in paragraphs a. and b. below:

a. 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.
b. 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 AHCCCSA, shall be retained by the Program Contractor for a period of five years after the date of final disposition or resolution thereof.

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

72. DATA MANAGEMENT

The Program Contractor shall have the capability for all required technical interfaces with AHCCCSA. Refer to the *AHCCCS Technical Interface Guidelines* for further information. A copy of these guidelines are available online at www.azahcccs.gov.

73. DATA EXCHANGE REQUIREMENTS

The Program Contractor is authorized to exchange data with AHCCCSA relating to the information requirements of this contract and as required to support the data elements to be provided AHCCCSA in the formats prescribed by AHCCCSA and in 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*, and in the AHCCCS *Technical Interface Guidelines*, available online.

The information so recorded and submitted to AHCCCSA 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 to both parties by AHCCCSA.

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA)*:* The Program Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 107-191, 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of the Program Contractor by the dates required by the implementing Federal regulations.

74. ENCOUNTER DATA REPORTING

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

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

Encounter data must be provided to AHCCCSA by electronic media and should be received by AHCCCSA no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Program Contractor, whichever date is later. Requirements for encounter data are described in the *AHCCCSA Encounter Manual* and the *AHCCCSA Encounter Companion Document.* The *Encounter Submission Requirements* are included herein as Attachment C. Refer to Section D, Paragraph 73, Data Exchange Requirements, for further information.

An Encounter Submission Tracking Report must be maintained and made available to AHCCCSA upon request. The Tracking Report's purpose is to link each claim to an adjudicated or pended encounter returned to the Program Contractor. Further information regarding the Encounter Submission Tracking Report may be found in *The AHCCCSA 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 submitted encounters. This report shall be available to AHCCCSA upon request.

Twice each month AHCCCSA provides the Program Contractor with full replacement files containing provider and medical procedure coding information. These files should be used to assist the Program Contractor in accurate Encounter Reporting. Refer to Section D, Paragraph 73, Data Exchange Requirements, for further information.

75. REPORTING REQUIREMENTS

AHCCCSA, under the terms and conditions of its CMS grant award, requires periodic reports, encounter data and other information from the Program Contractor. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in this contract. Standards applied for determining adequacy of required reports are as follows:

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.

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

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

The Program Contractor shall comply with all financial reporting requirements contained in the *Financial Reporting Guide for ALTCS Program Contractors with the Arizona Health Care Cost Containment System. A* copy may be obtained from the Division of Health Care Management's ALTCS Unit (Finance) or online at www.azahcccs.gov/plans & providers. The required reports, which are subject to change during the contract term, are summarized in Section F, Attachment D.

76. REQUESTS FOR INFORMATION

AHCCCSA may, at any time during the term of this contract, request financial or other information from the Program Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the written consent of the Contractor except as required by law. Upon receipt of such written requests for information, the Program Contractor 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, the Program Contractor shall assist AHCCCSA in the dissemination of information prepared by AHCCCSA, or the federal government, to its members. The cost of such dissemination shall be borne by the Program Contractor. All advertisements, publications and printed materials which are produced by the Program Contractor and refer to covered services shall state that such services are funded under contract with AHCCCSA.

78. OPERATIONAL AND FINANCIAL READINESS REVIEWS

AHCCCSA may conduct Operational and Financial Readiness Reviews on all successful Program Contractors and will, subject to the availability of resources, provide technical assistance as appropriate. The Readiness Reviews will be conducted prior to the start of business. The purpose of Readiness Reviews is to assess new Program Contractors' readiness and ability to provide covered services to members at the start of the contract year and current Program Contractors' readiness to expand to new geographic service areas. A new Program Contractor will be permitted to commence operations only if the Readiness Review factors are met to AHCCCSA's satisfaction.

79. OPERATIONAL AND FINANCIAL REVIEWS

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

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

Certain documentation submission requirements may be waived at the discretion of AHCCCSA if the Program Contractor obtains accreditation by the National Commission on Quality Assurance (NCQA). The Program Contractor must submit the entire NCQA report to AHCCCSA for such waiver consideration.

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 the Program Contractor's performance and compliance with AHCCCS policies, rules and the terms of this contract. The review may look at any aspects of Program Contractor operations. The Program Contractor shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report nor final report to other AHCCCS Program Contractors.

The Program Contractor will be furnished a copy of the draft Operational and Financial Review report and given the opportunity to comment on any review findings prior to AHCCCSA issuing the final report. Recommendations made by the Review Team to bring the Program Contractor into compliance with federal, state, AHCCCS, and/or Contract requirements, must be implemented by the Program Contractor. AHCCCSA may conduct a follow-up review or require a corrective action plan to determine the Program Contractor's progress in implementing recommendations and achieving program compliance.

The Program Contractor shall submit a corrective action plan to improve areas of non-compliance identified in the review. Once the corrective action plan is approved by AHCCCSA, it shall be implemented by the Program Contractor. Modifications to the corrective action plan must be approved in advance by AHCCCSA. Unannounced follow-up reviews may be conducted to determine the Program Contractor's progress in implementing recommendations and achieving compliance. Review findings may be used in the scoring of subsequent bid proposals submitted by that Program Contractor.

80. SANCTIONS

AHCCCSA 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 45 CFR 92.36(i)(1); 45 CFR 74.48]. Written notice will be provided to the Program Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld. The Program Contractor may dispute the decision to impose a sanction in accordance with the process outlined in A.A.C. R9-34-401 et seq. Intermediate sanctions may be imposed, but are not limited to the following actions:

a. Substantial failure to provide medically necessary services that the Program Contractor is required to provide under the terms of this contract to its enrolled members.
b. Imposition of premiums or charges in excess of the amount allowed under the AHCCCS 1115 Waiver.
c. Discrimination 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 AHCCCSA.

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 42.
g. Distribution directly, or indirectly through any agent or independent contractor, of marketing materials that have not been approved by AHCCCSA or that contain false or materially misleading information.
h. Failure to meet AHCCCS Financial Viability Standards.
i. Material deficiencies in the Program Contractor's provider network.
j. Failure to meet quality of care and quality management requirements.
k. Failure to meet AHCCCS encounter standards.
l. Violation of other applicable State or Federal laws or regulations.
m. Failure to fund accumulated deficit in a timely manner.
n. Failure to increase the Performance Bond in a timely manner.
o. Failure to comply with any provisions contained in this contract.
p. Failure to report third party liability cases as described in paragraph 63.

AHCCCSA 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. Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll [42 CFR 438.702(a)(3)].
d. Suspension of all new enrollment, including auto assignments after the effective date of the sanction.
e. Suspension of payment for recipients enrolled after the effective date of the sanction until CMS or AHCCCSA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
f. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

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

Refer to the ACOM *Sanction Policy* for details.

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 pays participating school districts for specifically identified Medicaid services when provided to Medicaid-eligible children who are included under the Individuals with Disabilities Education Act (IDEA). The Medicaid services must be identified in the member's Individual Education Plan (IEP) as medically necessary for the child to obtain a public school education. These services include speech, physical and occupational therapies, audiology, nursing services, attendant care (health aid services provided in the classroom), transportation to and from school on days when the child receives an AHCCCS-covered MSBC service and behavioral health services.

Services provided through MSBC Care are specifically intended to allow children to attend school and do not replace medically necessary services provided outside the educational setting. Thus, the Contractor's determination of whether services are medically necessary and should be provided to a child shall be made independently of whether that child also 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.

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.

Arizona Early Intervention Program (AzEIP): The Arizona Early Intervention (AzEIP) Program is implemented through the coordinated activities of the Arizona Department of Economic Security (DES), the Arizona Department of Health Services (ADHS), Arizona State Schools for the Deaf and Blind (ASDB), the Arizona Health Care Cost Containment System (AHCCCS), and the Arizona Department of Education (ADE). The AzEIP Program is governed by the Individuals with Disabilities Act (IDEA), Part C (P.L.105-17). AzEIP, through federal regulation, is stipulated as the payor of last resort to Medicaid, and is prohibited from supplanting another entitlement programs, including Medicaid.

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

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 an appeal. It is not known if there will be any additional requirements of the AHCCCSA and Program Contractors.

E Health Connectivity: In February of 2007, AHCCCS was awarded a CMS Transformation Grant of $11.7M 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 health plans and Program Contractors to meet the goal of the executive order and to connect AHCCCS, AHCCCS Contractors, ancillary subcontractors and registered providers into a common web based electronic health information data exchange that will meet the standards established by State and Federal governments. AHCCCS 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.
CMS will provide grants to state Medicaid agencies to support development of IT infrastructure and applications to achieve the goal of health information data exchange. AHCCCS Contractors will be required to:

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. Contractors must amend all provider subcontracts to include the amended Minimum Subcontract provisions within six (6) months of issuance.
3. Program Contractors 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 and web based applications. AHCCCS health plan and program contractors are expected to deploy upgrades and enhancements as necessary to contracted providers.

83. BUSINESS CONTINUITY AND RECOVERY PLAN

The Program Contractor shall adhere to all elements of the ACOM *Business Continuity and Recovery Policy*. A copy of which may be found in the Bidders Library. The Program Contractor 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 the Program Contractor's main place of ALTCS business
- Complete loss of use of the main site and satellite offices out of state
- Loss of primary computer system/records
- Communication between the Program Contractor and AHCCCSA in the event of a business disruption
- Periodic testing

The Business Continuity and Recovery Plan shall be updated annually. The Program Contractor 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 Program Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

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

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

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

The Program Contractor shall have written plans for providing training and evaluating providers' compliance with the Program Contractor's medical records standards. Medical records shall be maintained in a detailed and comprehensive manner, which conforms to good professional medical practice, permits effective professional

medical review and medical audit processes, and which facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.

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

AHCCCSA 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 Program Contractor may obtain a copy of a member's medical records without written approval of the member, if the reason for such request is directly related to the administration of the AHCCCS program. AHCCCSA 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

AHCCCSA produces daily enrollment transaction updates identifying new members and changes to members' demographic, eligibility and enrollment data, which the Program Contractor shall use to update its member records. The daily enrollment transaction update, which is run 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.

AHCCCSA 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 Program Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records.

A weekly capitation transaction will be produced to provide contractors with member-level capitation payment information. This file will show changes to the prospective capitation payments, as sent in the monthly file, resulting from enrollment changes that occur after the monthly file is produced. This file will also identify mass adjustments to and/or manual capitation payments that occurred at AHCCCS after the monthly file is produced.
The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for the Program Contractor as of the first day of the next month. These updates contain the information used by AHCCCSA to produce the monthly capitation payment for the next month. The Program Contractor will reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, the Program Contractor resumes 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 Program Contractor detects an error through the monthly update process, the Program Contractor shall notify AHCCCSA, Division of Health Care Management.

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

86. SPECIAL HEALTH CARE NEEDS

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

(c)(3)]. Members enrolled in the ALTCS Program who are elderly, physically disabled, or developmentally disabled are automatically identified as having special health care needs.

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

87. TECHNOLOGICAL ADVANCEMENT

The Program Contractor must have a website with links to the following information and the ability to perform the following functions:

1. Formulary
2. Provider manual
3. Member handbook
4. Provider listing
5. Enrollment Verification
6. Claims inquiry
7. Accept HIPAA compliant electronic claims transactions (See paragraph 44)
8. Make claims payments via electronic funds transfer (See paragraph 44)

Program Contractors must have:

1. When available, a link to the AHCCCS website for Member and Provider Survey results
2. A link to the AHCCCS website for Performance Measure results

Program Contractors must provide searchable provider directories on their website. Web based directories must include the following functions and must be updated at least monthly, if necessary:

1. Name
2. Specialty/Service
3. Language spoken by Practioner
4. Office location (e.g., county, city, zip code)

The formulary, members' handbook and searchable provider directory must be located on the Contractor's website in a manner that consumers can easily find and navigate (e.g. "Consumer Page" from the Contractor's home page)

88. MEDICARE MODERNIZATION ACT (MMA)

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

Drugs Excluded from Medicare Part D: AHCCCS does cover 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, contractor formularies and prior authorization requirements if they are excluded from Medicare Part D coverage. Medications that are covered by Part D, but are not on a specific Part D Health Plan's formulary are not considered excluded drugs and will not be covered by AHCCCS.

As the Medicare Modernization Act is fully implemented, there may be required changes to business practices of AHCCCS and contractors or the contract. AHCCCS will identify potential impacts and work with contractors to implement necessary program changes.

SECTION E. CONTRACT TERMS AND CONDITIONS

1. APPLICABLE LAW

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

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

2. AUTHORITY

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

3. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract which consists of the RFP, the proposal of the successful Offeror, and Best and Final Offer including any attachments, executed amendments and modifications; and AHCCCSA 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

The Program Contractor under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

7. ASSIGNMENT AND DELEGATION

The Program Contractor 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. INDEMNIFICATION

Contractor/Vendor Indemnification (Not Public Agency)

The parties to this contract agree that the State of Arizona, its departments, agencies, boards and commissions shall be indemnified and held harmless by the Program Contractor for the vicarious liability of the State as a result of entering into this contract. However, the parties further agree that the State of Arizona, its departments, agencies, boards and commissions shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

Contractor/Vendor Indemnification (**Public Agency)**

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

9. INDEMNIFICATION -- PATENT AND COPYRIGHT

The Program Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement of any patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Program Contractor of any claim for which it may be liable under this paragraph.

For County Governments:

To the extent permitted by applicable law, the Contractor shall defend, indemnify and hold harmless the State against any liability including costs and expenses for infringement or patent, trademark or copyright arising out of contract performance or use by the State of materials furnished or work performed under this contract. The State shall reasonably notify the Contractor of any claims for which it may be liable under this paragraph.

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

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

11. ADVERTISING AND PROMOTION OF CONTRACT

The Program Contractor shall not advertise or publish information for commercial benefit concerning this contract without the prior written approval of the Contracting Officer.

12. PROPERTY OF THE STATE

Except as provided in this paragraph, any materials, including reports, computer programs and other deliverables, created under this contract are the sole property of AHCCCSA. The Program Contractor is not entitled to maintain any rights on those materials and may not transfer any rights to anyone else. The Program Contractor shall not use or release these materials without the prior written consent of AHCCCSA.

If a Program Contractor declares information to be confidential, AHCCCSA will maintain the information as confidential and will not disclose it unless it is required by law or court order.

13. THIRD PARTY ANTITRUST VIOLATIONS

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

14. RIGHT TO ASSURANCE

If AHCCCSA, in good faith, has reason to believe that the Program Contractor does not intend to perform or continue performing this contract, the procurement officer may demand in writing that the Program Contractor give a written assurance of intent to perform. The demand shall be sent to the Program Contractor by certified mail, return receipt required. Failure by the Program Contractor to provide written assurance within the number of days specified in the demand may, at the State's option, be the basis for terminating the contract.

15. TERMINATION FOR CONFLICT OF INTEREST

AHCCCSA 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 AHCCCSA is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be effective when the Program Contractor receives written notice of the cancellation unless the notice specifies a later time.

If the Program Contractor is a political subdivision of the State, it may also cancel this contract as provided by A.R. S. 38-511.

16. GRATUITIES

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

17. SUSPENSION OR DEBARMENT

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

The Program Contractor shall not retain as a director, officer, partner or owner of 5% or more of the Program Contractor entity, any person, or affiliate of such a person, who is debarred, suspended or otherwise excluded from Federal procurement activity.

AHCCCSA may, by written notice to the Program Contractor, immediately terminate this contract if it determines that the Program Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity.

18. TERMINATION FOR CONVENIENCE

AHCCCSA 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 the Program Contractor 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 the Program Contractor under the contract shall become the property of and be delivered to AHCCCSA. The Program Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

19. TEMPORARY MANAGEMENT/OPERATION OF A CONTRACTOR AND TERMINATION

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

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

Termination: AHCCCSA reserves the right to terminate this contract in whole or in part due to the failure of the Program Contractor 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 the Program Contractor is providing services under more than one contract with AHCCCSA, AHCCCSA may deem unsatisfactory performance under one contract to be cause to require the Contractor to provide assurance of performance under any and all other contracts. In such situations, AHCCCSA reserves the right to seek remedies under both actual and anticipatory breaches of contract if adequate assurance of performance is not received. The Contracting Officer shall mail

written notice of the termination and the reason(s) for it to the Program Contractor by certified mail, return receipt requested. Pursuant to the Balanced Budget Act of 1997 and 42 CFR 438.708, AHCCCSA shall provide the contractor with a pre-termination hearing before termination of the contract.

Upon termination, all documents, data, and reports prepared by the Program Contractor under the contract shall become the property of and be delivered to AHCCCSA on demand.

AHCCCSA may, upon termination of this contract, procure on terms and in the manner that it deems appropriate, materials or services to replace those under this contract. The Program Contractor shall be liable for any excess costs incurred by AHCCCSA in re-procuring the materials or services.

20. 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 AHCCCSA 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 Program Contractor, if, for any reason, there are not sufficient appropriated and available monies for the purpose of maintaining this Agreement. In the event of such termination, the Program Contractor shall have no further obligation to AHCCCSA.

21. RIGHT OF OFFSET

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

22. NON-EXCLUSIVE REMEDIES

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

23. NON-DISCRIMINATION

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

24. EFFECTIVE DATE

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

25. TERM OF CONTRACT AND OPTION TO RENEW

The initial term of this contract shall be for three (3) initial years, with two (2) one-year options to extend, not to exceed a total contracting period of five (5) years. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended. Any contract extension shall be through contract amendment, and shall be at the sole option of AHCCCSA.

If the Program Contractor has been awarded a contract in more than one GSA, each such contract will be considered separately renewable. AHCCCSA may renew the Program Contractor’s contract in one GSA, but not

in another. In the event AHCCCSA determines there are issues of noncompliance by the Program Contractor in one GSA, AHCCCSA may request an enrollment cap for the Program Contractor's contracts in all other GSAs. Further, AHCCCSA may require the Program Contractor to renew all currently awarded GSAs, or may terminate the contract if the Program Contractor does not agree to renew all currently awarded GSAs.
When the Contracting Officer issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days after the date of mailing by the Contracting Officer, even if the extension amendment has not been signed by the Program Contractor, unless within that time the Program Contractor notifies the Contracting Officer in writing that it refuses to sign the extension amendment. If the Program Contractor provides such notification, the Contracting Officer will initiate contract termination proceedings.

If the Program Contractor chooses not to renew this contract, the Program Contractor may be liable for certain costs associated with the transition of its members to a different Program Contractor. The Program Contractor is required to provide 180 days advance written notice to the Contracts and Purchasing Administrator of its intent not to renew the contract. If the Program Contractor provides the Contracts and Purchasing Administrator written notice of its intent not to renew this contract at least 180 days before its expiration, this liability for transition costs may be waived by the Contracting Officer.

26. INSURANCE

A certificate of insurance naming the State of Arizona and AHCCCSA as the "additional insured" must be submitted to AHCCCSA within 10 days of notification of contract award and prior to commencement of any services under this contract. This insurance shall be provided by carriers rated as "A+" or higher by the A.M. Best Rating Service. The following types and levels of insurance coverage are required for this contract:

Commercial General Liability: Provides coverage of at least $1,000,000 for each occurrence for bodily injury and property damage to others as a result of accidents on the premises of or as the result of operations of the Contractor.

Commercial Automobile Liability: Provides coverage of at least $1,000,000 for each occurrence for bodily injury and property damage to others resulting from accidents caused by vehicles operated by the Contractor.

Workers Compensation: Provides coverage to employees of the Contractor for injuries sustained in the course of their employment. Coverage must meet the obligations imposed by Federal and State statutes and must also include Employer's Liability minimum coverage of $100,000. Evidence of qualified self-insured status will also be considered.

Professional Liability (if applicable): Provides coverage for alleged professional misconduct or lack of ordinary skills in the performance of a professional act of service.

The above coverages may be evidenced by either one of the following:

The State of Arizona Certificate of Insurance: This is a form with the special conditions required by the contract already pre-printed on the form. The Program Contractor's agent or broker must fill in the pertinent policy information and ensure the required special conditions are included in the Program Contractor's policy.

The Accord form: This standard insurance industry certificate of insurance does not contain the pre-printed special conditions required by this contract. These conditions must be entered on the certificate by the agent or broker and read as follows:

> The State of Arizona and Arizona Health Care Cost Containment System are hereby added as additional insureds. Coverage afforded under this Certificate shall be primary and any insurance carried by the State or any of its agencies,

boards, departments or commissions shall be in excess of that provided by the insured Contractor. No policy shall expire, be canceled or materially changed without 30 days written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company.

For County Governments:

If the Contractor is insured pursuant to A.R.S. § 11-981 the Insurance provisions required by the Contract are satisfied.

27. DISPUTES

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

Except as provided by 9AAC Chapter 28, Article 6, the exclusive manner for the Program Contractor to assert any dispute against AHCCCSA shall be in accordance with the process outlined in 9 A.A.C. Chapter 34 and ARS §36-2932. Pending the final resolution of any disputes involving this contract, the Program Contractor shall proceed with performance of this contract in accordance with AHCCCSA's instructions, unless AHCCCSA specifically, in writing, requests termination or a temporary suspension of performance.

28. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

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

29. CONTRACT

The contract between AHCCCSA and the Program Contractor shall consist of (1) the Request for Proposal (RFP) and any amendments thereto, (2) the proposal submitted by the Program Contractor in response to the RFP, (3) any Best and Final Offers including any attachments, (4) executed amendments and modifications and (5) AHCCCSA policies and procedures. In the event of a conflict in language between the two documents referenced, the provisions and requirements set forth and/or referenced in the RFP shall govern. However, AHCCCSA reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the Program Contractor's proposal. In all other matters not affected by the written clarification, if any, the RFP shall govern.

The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for the expenditures under the contract until funds have been encumbered.

30. COVENANT AGAINST CONTINGENT FEES

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

31. CHANGES

AHCCCSA may at any time, by written notice to the Program Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Program Contractor may assert its right to an adjustment in compensation paid under this contract. The Program Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused

by such notice shall constitute a dispute within the meaning of Section E, Paragraph 27, Disputes, and be administered accordingly.

When AHCCCSA 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 AHCCCSA, even if the amendment has not been signed by the Program Contractor, unless within that time the Program Contractor notifies AHCCCSA in writing that it refuses to sign the amendment. If the Program Contractor provides such notification, AHCCCSA will initiate termination proceedings.

32. TYPE OF CONTRACT

Firm Fixed-Price stated as capitated per member per month except as otherwise provided.

33. AMERICANS WITH DISABILITIES ACT

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

34. WARRANTY OF SERVICES

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

35. NO GUARANTEED QUANTITIES

AHCCCSA does not guarantee the Program Contractor any minimum or maximum quantity of services or goods to be provided under this contract.

36. CONFLICT OF INTEREST

The Program Contractor shall not undertake any work that represents a potential conflict of interest, or which is not in the best interest of AHCCCSA or the State without prior written approval by AHCCCSA. The Program Contractor shall fully and completely disclose any situation that may present a conflict of interest. If the Program Contractor is now performing or elects to perform during the term of this contract any services for any AHCCCS health plan, provider or Program Contractor or an entity owning or controlling same, the Program Contractor shall disclose this relationship prior to accepting any assignment involving such party.

37. DISCLOSURE OF CONFIDENTIAL INFORMATION

The Program Contractor shall not, without prior written approval from AHCCCSA, 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 AHCCCSA personnel with a need to know, any information, data, material, or exhibits created, developed, produced, or otherwise obtained during the course of the work required by this contract. This nondisclosure requirement shall also pertain to any information contained in reports, documents, or other records furnished to the Program Contractor by AHCCCSA.

38. COOPERATION WITH OTHER CONTRACTORS

AHCCCSA may award other contracts for additional work related to this contract and Program Contractor shall fully cooperate with such other contractors and AHCCCSA employees or designated agents, and carefully fit its own work to such other contractors' work. The Program Contractor shall not commit or permit any act which will interfere with the performance of work by any other contractor or by AHCCCSA employees.

39. ASSIGNMENT OF CONTRACT AND BANKRUPTCY

This contract is voidable and subject to immediate cancellation by AHCCCSA upon the Program Contractor becoming insolvent or filing proceedings in bankruptcy or reorganization under the United States Code, or assigning rights or obligations under this contract without the prior written consent of AHCCCSA.

40. OWNERSHIP OF INFORMATION AND DATA

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

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

41. AHCCCSA RIGHT TO OPERATE PROGRAM CONTRACTOR

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

If AHCCCS undertakes direct operation of the Program Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Program Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Program Contractor, or until the Program Contractor corrects the Contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary

assistants, to execute any instrument in the name of the Program Contractor, to commence, defend and conduct in its name any action or proceeding in which the Program Contractor may be a party.

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

42. AUDITS AND INSPECTIONS

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

At any time during the term of this contract, and five (5) years thereafter unless a longer time is otherwise required by law, the Program Contractor's or any subcontractor's books and records shall be subject to audit by AHCCCSA 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)].

AHCCCSA, 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.

43. LOBBYING

No funds paid to the Program Contractor by AHCCCSA, or interest earned thereon, shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress or State Legislature, an officer or employee of a member of the United States Congress or State Legislature in connection with awarding of any Federal or State contract, the making of any Federal or State grant, the making of any Federal or State loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal or State contract, grant, loan, or cooperative agreement. The Program Contractor shall disclose if any funds paid to the Program Contractor by AHCCCSA have been used or will be used to influence the persons and entities indicated above and will assist AHCCCSA in making such disclosures to CMS.

44. 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.

45. DATA CERTIFICATION

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

46. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

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

States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers

47. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Program Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Program Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Program Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Program Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Program Contractor.

48. IRS W9 FORM

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

49. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

The Program Contractor shall continue to perform, in accordance with the requirements of the contract, up to the date of termination and as directed in the termination notice.

SECTION F. ATTACHMENTS

ATTACHMENT A. MINIMUM SUBCONTRACT PROVISIONS

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

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

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

Subcontractors who provide services under both the AHCCCS ALTCS and the Acute Care Program please see the following:

- Rules for the ALTCS are found in Arizona Administrative Code (AAC) Title 9, Chapter 28. AHCCCS statutes for long term care are generally found in Arizona Revised Statue (ARS) 36, Chapter 29, Article 2.

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

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

[The following provisions must be included verbatim in every contract.]

1. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

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

2. AWARDS OF OTHER SUBCONTRACTS

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

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

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

4. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

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

5. CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988

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

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

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

6. COMPLIANCE WITH AHCCCSA RULES RELATING TO AUDIT AND INSPECTION

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

7. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

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

8. CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to 42 CFR Part 431, Subpart F, ARS §36-107, 36-2932, 41-1959 and 46-135, AHCCCS Rules and the Health Insurance Portability and Accountability Act (CFR 164).

9. CONFLICT IN INTERPRETATION OF PROVISIONS

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

10. CONTRACT CLAIMS AND DISPUTES

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

11. ENCOUNTER DATA REQUIREMENT

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

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

AHCCCSA or the U.S. Department of Health and Human Services may evaluate, through inspection or other means, the quality, appropriateness or timeliness of services performed under this subcontract.

13. FRAUD AND ABUSE

If the Subcontractor discovers, or is made aware, that an incident of suspected fraud or abuse has occurred, the Subcontractor shall report the incident to the prime Contractor as well as to AHCCCSA, Office of Program Integrity. All incidents of potential fraud should be reported to AHCCCSA, Office of the Director, Office of Program Integrity.

14. GENERAL INDEMNIFICATION

The parties to this contract agree that AHCCCS shall be indemnified and held harmless by the Contractor and Subcontractor for the vicarious liability of AHCCCS as a result of entering into this contract. However, the parties further agree that AHCCCS shall be responsible for its own negligence. Each party to this contract is responsible for its own negligence.

15. INSURANCE

[This provision applies only if the Subcontractor provides services directly to AHCCCS members]

The Subcontractor shall maintain for the duration of this subcontract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance in amounts that meet Program Contractor's requirements. The Subcontractor agrees that any insurance protection required by this subcontract, or otherwise obtained by the Subcontractor, shall not limit the responsibility of Subcontractor to indemnify, keep and save harmless and defend the State and AHCCCSA, their agents, officers and employees as provided herein. Furthermore, the Subcontractor shall be fully responsible for all tax obligations, Worker's Compensation Insurance, and all other applicable insurance coverage, for itself and its employees, and AHCCCSA shall have no responsibility or liability for any such taxes or insurance coverage. (45 CFR Part 74) The requirement for Worker's Compensation Insurance doesn't apply when a Subcontractor is exempt under ARS 23-901, and when such Subcontractor executes the appropriate waiver (Sole Proprietor/Independent Contractor) form.

16. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state law and regulations, the Subcontractor shall not bill, or attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered services that were paid or could have been paid by the System.

17. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

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

18. NON-DISCRIMINATION REQUIREMENTS

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

19. PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT

The Contractor and Subcontractor shall develop, maintain and use a system for Prior Authorization and Utilization Review that is consistent with AHCCCS Rules and the Contractor's policies.

20. RECORDS RETENTION

The Subcontractor shall maintain books and records relating to covered services and expenditures including reports to AHCCCSA and working papers used in the preparation of reports to AHCCCSA. The Subcontractor shall comply with all specifications for record keeping established by AHCCCSA. 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 AHCCCSA.

The Subcontractor agrees to make available at its office at all reasonable times during the term of this contract and the period set forth in the following paragraphs, any of its records for inspection, audit or reproduction by any authorized representative of AHCCCSA, State or Federal government.

The Subcontractor shall preserve and make available all records for a period of five years from the date of final payment under this contract unless a longer period of time is required by law.

If this contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of this contract, or costs and expenses of this contract to which exception has been taken by AHCCCSA, shall be retained by the Subcontractor for a period of five years after the date of final disposition or resolution thereof unless a longer period of time is required by law. (45 CFR 74.53; 42 CFR 431.17; ARS 41-2548)

21. SEVERABILITY

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

22. SUBJECTION OF SUBCONTRACT

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

23. TERMINATION OF SUBCONTRACT

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

24. VOIDABILITY OF SUBCONTRACT

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

25. WARRANTY OF SERVICES

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

26. OFF-SHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, direct services under this contract shall be performed within the borders of the United States. Any services that are described in the specifications or scope of work that directly serve the State of Arizona or its clients and may involve access to secure or sensitive data or personal client data or development or modification of software for the State shall be performed within the borders of the United States. Unless specifically stated otherwise in specifications, this definition does not apply to indirect or "overhead" services, redundant back-up services or services that are incidental to the performance of the contract. This provision applies to work performed by subcontractors at all tiers.

27. FEDERAL IMMIGRATION AND NATIONALITY ACT

The Subcontractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Subcontractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of Program Contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the Program Contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the Program Contractor.

ATTACHMENT B (1). ENROLLEE GRIEVANCE SYSTEM

The Program Contractor shall have a written policy delineating its Grievance System which shall be in accordance with applicable Federal and State laws, regulations and policies, including, but not limited to 42 CFR Part 438 Subpart F. The Program Contractor shall provide the ACOM *Enrollee Grievance Policy* to all providers and subcontractors at the time of contract. The Program Contractor shall also furnish this information to enrollees within a reasonable time after the Program Contractor receives notice of the enrollment. Additionally, the Program Contractor shall provide written notification of any significant change in this policy at least 30 days before the intended effective date of the change.

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

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

At a minimum, the Program Contractor's Grievance System Standards and Policy shall specify:

1. That the Program Contractor shall maintain records of all grievances, appeals and requests for hearings.

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

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

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

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

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

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

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

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

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

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

12. The definition of action as the {42 CFR 438.400(b)]:
    a. Denial or limited authorization of a requested service, including the type or level of service;
    b. Reduction, suspension, or termination of a previously authorized service;
    c. Denial, in whole or in part, of payment for a service;
    d. Failure to provide services in a timely manner;
    e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
    f. Denial of a rural enrollee's request to obtain services outside the Program Contractor's network under 42 CFR 438.52(b)(2)(ii), when the contractor is the only Program 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 Program Contractor's network under 42 CFR 438.52(b)(2)(ii) when the Program Contractor is the only Program Contractor in the rural area.

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

18. The definition of an expedited authorization request. For expedited authorization decisions, the Program Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 3 business days following the receipt of the authorization with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Program Contractor establishes a need for additional information and delay is in the enrollee's interest [42 CFR 438.210(d)(2)].

19. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Program Contractor extends the timeframe to make a standard or expedited authorization decision, the contractor must give the enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Program Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

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

21. The definition of a standard appeal and that the Program Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect.

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

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

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

25. That the Program Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(e) below; 2) at least 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) The Contractor receives notification of the death of an enrollee;
    b) The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);

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

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

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

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

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

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

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

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

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

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

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

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

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

    a. the Enrollee's written request for hearing
    b. copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
    c. the Program Contractor's Notice of Appeal Resolution
    d. other information relevant to the resolution of the appeal

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

37. That if the Program Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Program Contractor shall pay for those services, as specified in policy and/or regulation.

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

ATTACHMENT B (2). PROVIDER CLAIM DISPUTE SYSTEM STANDARDS AND POLICY

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

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

2. The Provider Claim Dispute Policy must specify that all claim disputes challenging claim payments, denials or recoupments must be filed in writing with the Program Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later.

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

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

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

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

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

8. All claim disputes are filed in a secure designated area and are retained for five years following the Program Contractor'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 the Program Contractor's Notice of Decision (hereafter referred to as Decision) will be communicated in writing to all parties. The Decision must include and describe in detail, the following:

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

10. If the Provider files a written request for hearing, the Program Contractor must ensure that all supporting documentation is received by the AHCCCSA, Office of Legal Assistance, no later than five business days from the date the Program Contractor receives the provider's written hearing request. The file sent by the Program Contractor must contain a cover letter that includes:

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

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

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

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

ATTACHMENT C. ENCOUNTER SUBMISSION STANDARDS AND SANCTIONS

The Program Contractor shall exchange data with AHCCCSA in accordance with the *AHCCCS Technical Interface Guidelines.* The Program Contractor is responsible for any incorrect data, delayed encounter data submission and any penalty applied due to error, omission, deletion, or erroneous insert caused by data it submitted [42 CFR 242(b)(2)]. Any data that does not meet the standards required by AHCCCSA shall not be accepted by AHCCCSA. The Program Contractor is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCSA. If any unreported inconsistencies are subsequently discovered, the Program Contractor shall correct its records at its own expense.

The Program Contractor will be assessed sanctions for noncompliance with encounter submission requirements. AHCCCSA may also perform special reviews of encounter data, such as comparing encounter reports to the Program 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.

Pended Encounter Corrections

The Program 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 AHCCCSA error:

0-120 days	121-180 days	181-240 days	241-360 days	361 + days
No sanction	$ 5.00 per month	$10.00 per month	$15.00 per month	$20.00 per month

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

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

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

Before imposing sanctions, AHCCCSA will notify the Program Contractor in writing of the total number of sanctionable encounters pended more than 120 days. Pended encounters shall not be deleted by the Program Contractor as a means of avoiding sanctions for failure to correct encounters within 120 days. The Program Contractor shall document deleted encounters and shall maintain a record of the deleted CRNs with appropriate reasons indicated. The Program Contractor shall, upon request, make this documentation available to AHCCCSA for review.

Encounter Validation Studies

AHCCCSA will conduct encounter validation studies of the Program Contractor's encounter submissions, and sanction the Program 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 Program 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.

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

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

AHCCCSA will notify the Program Contractor in writing of the sanction amounts and of the selected data needed for encounter validation studies. The Program Contractor will have 90 days to submit the requested data to AHCCCSA. In the case of medical records requests, the Program Contractor's failure to provide AHCCCSA with the records requested within 90 days may result in a sanction of $1,000 per missing medical record. If AHCCCSA does not receive a sufficient number of medical records from the Program Contractor to select a statistically valid sample for a study, the Program 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. These criteria are defined as follows:

> *Timeliness*: The time elapsed between the date of service and the date that the encounter is received at AHCCCS. For all encounters for which timeliness is evaluated, a sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter record is received by AHCCCSA more than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment. It is anticipated that the sanction amount will be $1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. The Program Contractor will be notified of the sanction amount in effect for the studies at the time the studies begin.
>
> *Correctness*: A correct encounter contains a complete and accurate description of AHCCCS covered services provided to a member. A sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter is incomplete or incorrectly coded. It is anticipated that the sanction amount will be $1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. The Program Contractor will be notified of the sanction amount in effect for the studies at the time the studies begin.
>
> *Omission of data*: An encounter not submitted to AHCCCSA or an encounter inappropriately deleted from AHCCCSA's pending encounter file or historical files in lieu of correction of such record. For Study "A" and for Study "B", a sanction per encounter error extrapolated to the population of encounters may be assessed for an omission. It is anticipated that the sanction amount will be $5.00 per error extrapolated to the population of encounters for Study "A" and $10.00 per error extrapolated to the population of encounters for Study "B"; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if CMS changes sanction requirements. The Program Contractor will be notified of the sanction amount in effect for the studies at the time the studies begin.

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

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

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

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

The Program Contractor may file a written challenge to sanctions assessed by AHCCCSA not more than 35 days after the Program Contractor receives final study results from AHCCCSA. Challenges will be reviewed by AHCCCSA and a written decision will be rendered no later than 60 days from the date of receipt of a timely challenge. Sanctions shall not apply to encounter errors successfully challenged. A challenge must be filed on a timely basis and a decision must be rendered by AHCCCSA prior to filing a claims dispute pursuant to 9 A.A.C. 34, Article 401 et seq. Sanction amounts will be deducted from the Program Contractor's capitation payment.

Encounter Corrections

Program Contractors are required to submit replacement or voided encounters in the event that claims are subsequently corrected following the initial encounter submission. This includes corrections as result of inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCSA or the Program Contractor. Program Contractors shall refer to the Encounter Reporting User's Manual for instructions regarding submission of corrected encounters.

ATTACHMENT D. PROGRAM CONTRACTORS CHART OF DELIVERABLES

CONTRACTS

REPORT	DATE DUE	SEND TO:
Certificate of insurance naming AHCCCS as "additional insured" (Section E, ¶ 26)	Within 10 days of contract award	Contracts & Purchasing Administrator (DBF)
Proof of minimum capitalization (Section D, ¶ 45)	15 days after notification from AHCCCS of contract award	Contracts and Purchasing Administrator (DBF)
Performance Bond or Bond Substitute (Section D, ¶ 46)	30 days after notification from AHCCCS of the amount required	Contracts & Purchasing Administrator (DBF)
Subcontracts for: • Delegated Agreements • Management Services Agreements • Service Level Agreements • (Section D, ¶ 33) •	30 days prior to start date	Division of Health Care Management (DHCM) ALTCS Manager
Initial contracts with AHCCCS and any amendments and renewals (Section E, ¶ 31)	Within 60 days of receipt from AHCCCS	Contracts & Purchasing Administrator (DBF)
Management Services subcontractor audit (Section D, ¶ 43)	Within 120 days after subcontractors fiscal year end	Contracts & Purchasing Administrator (DBF)
Advertisements or published information for commercial benefit (Section E, ¶ 11)	Prior approval required	Contracts & Purchasing Administrator (DBF)
Insurance policy cancellation, expiration, or material change (Section E, ¶ 26)	30 days prior notice to 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)

ENCOUNTERS

REPORT	DATE DUE	SEND TO:
Encounter Data (Section D, ¶ 74 and Section F, Attachment C)	As required in AHCCCS Encounter Manual	Encounter Unit (DHCM)
Encounter Data Validation Studies (Section D, ¶ 74 and Section F, Attachment C)	Annually as requested	Encounter Unit (DHCM)

EXECUTIVE MANAGEMENT

REPORT	DATE DUE	SEND TO:
Cultural Competency Annual Evaluation (Section D, ¶ 69)	November 15	ALTCS Unit (DHCM)
Network Development and Management Plan (Section D, ¶ 28)	November 15	ALTCS Unit (DHCM)
Member/Provider Council Annual Plan (Section D, ¶ 24)	December 15	ALTCS Unit (DHCM)
Member/Provider Council correspondence including agendas and minutes. (Section D, ¶ 24)	[See Sec. D, ¶24]	ALTCS Unit (DHCM)
Modifications of Operational & Financial Review Corrective Action Plan (Section D, ¶ 79)	Prior to implementation of modification	ALTCS Unit (DHCM)
Proposed merger, reorganization or ownership change (Section D, ¶ 54)	Prior approval required	ALTCS Unit (DHCM)
Related party subcontracts (Section D, ¶ 55)	Prior approval required	ALTCS Unit (DHCM)

All Hospital sub-contracts and any amendments	After execution	ALTCS Unit DHCM
Resignation and addition of any key staff (Section D, ¶ 25)	Within 7 days of learning of resignation	ALTCS Unit (DHCM)
All physician incentive agreements (Section D, ¶ 39)	Upon signing of agreement	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
Marketing Materials (Section D, ¶ 65 and Section E, ¶ 11)	30 days prior to planned dissemination	ALTCS Unit (DHCM)
Marketing Attestation Statement (Section D, ¶ 65, Section E, ¶ 11 and ACOM Marketing Policy))	45 days after start of contract	ALTCS Unit (DHCM)
Physician Incentive Plan (PIP) Reporting (Section D, ¶ 39) **Reporting of Physician Incentive Plans has been suspended by CMS until further notice. No reporting is required until suspension is lifted.**	Annually by 10/1 of each contract year	ALTCS Financial Coordinator (DHCM)
Report of all subcontracts which delegate duties and responsibilities (Section D, ¶ 33)	Annually 90 days after start of contract	ALTCS Unit (DHCM)
Business Continuity and Recovery Plan Summary	October 15	ALTCS Unit (DHCM)

FINANCE

REPORT	DATE DUE	SEND TO:
Summary of Program Contractor's contract rates for long term care, behavioral health and home and community based services (See Financial Reporting Guide for format)	October 15	ALTCS Financial Coordinator (DHCM)
Monthly Claims Dashboard Report (Section D, ¶44)	15 days after month end	ALTCS Financial Coordinator (DHCM)
Monthly Financial statement (not including months that are also a quarter end) in Program Contractor's standard format (Section D, ¶75)	30 days after month end	ALTCS Financial Coordinator (DHCM)
Reinsurance claims (Section D, ¶ 58)	As per Section D, ¶ 58 and Reinsurance Manual	As per AHCCCS Reinsurance Manual
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)
Corporate cost allocation plans, adjustment in management fees, fund distributions affecting equity (Section D, ¶ 49 & 50)	October 1	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)
HIV-AIDS Drugs Report (Section D, ¶75)	60 days after quarter end	ALTCS Financial Coordinator (DHCM)
Draft Audited Financial Statement (Section D, ¶ 75)	90 days after year end	ALTCS Financial Coordinator (DHCM)
Draft Management Letter (Section D, ¶ 75)	90 days after year end	ALTCS Financial Coordinator (DHCM)
Annual Reconciliation to Draft Audit (Section D, ¶ 75)	90 days after year end	ALTCS Financial Coordinator (DHCM)

Final Audited Financial Statement (Section D, ¶ 75)	120 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)

GRIEVANCE SYSTEM

REPORT	DATE DUE	SEND TO:
Grievance System Report (Section D, ¶ 23)	See Grievance System Reporting Guide for frequency	Division of Health Care Management (DHCM)
Enrollee Grievance Report (Section D, ¶23)	See Grievance System Reporting Guide for frequency	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:
Case Management Plan (Section D, ¶ 16)	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)
Annual Member Survey (Section D, ¶ 66)	Prior to Distribution	ALTCS Unit (DHCM)
Annual Member Survey results, analysis and improvement strategies (Section D, ¶ 66)	45 days after finalized	ALTCS Unit (DHCM)
Member Handbook (Section D, ¶ 17)	Upon any changes prior to distribution	ALTCS Unit (DHCM)
All Member Informational Materials (Newsletters, Brochures, etc.) (Section D, ¶ 17)	Prior to Distribution	ALTCS Unit (DHCM)
Placement outside the state (Section D, ¶ 14)	Prior approval required	ALTCS Case Management Manager (DHCM)
Changes or corrections to member's circumstances (income, living arrangements, TPL, services, etc.) (Section D, ¶ 18)	ALTCS member change report Form (DE-701) requirements	Division of Member Services or local ALTCS Office

NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:
Network Summary (Section D, ¶ 32)	10/15, 4/15	ALTCS Unit (DHCM)
All material changes in provider network (Section D, ¶ 29)	In advance of the change	ALTCS Unit (DHCM)
Unexpected major network changes (Section D, ¶ 29)	Within 1 day of 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)
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: • Uninsured/underinsured motorist insurance • First and third-party liability insurance • Tortfeasors, including casualty • Trust recovery • Adoption recovery • Estate recovery • Worker's Compensation (Section D, ¶ 63)	Upon Identification	AHCCCS TPL Subcontractor
Report all joint liability cases (Section D, ¶ 63)	Within 5 days of identification	AHCCCS TPL Subcontractor

QM/MM

REPORT	DATE DUE	SEND TO
QM Plan and QM Evaluation (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)
MM Plan and MM Evaluation (Section D, ¶ 21)	December 15	Medical Management Unit (DHCM)
Quarterly Inpatient Hospital Showings (Section D, ¶ 20)	15 days after the end of each quarter. (15th of Jan., Apr., July & Oct.)	Medical Management Unit (DHCM)
Maternity Care Plan (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)
Comprehensive EPSDT Plan (including Dental) (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)
Quarterly EPSDT Progress Report Update (including Dental) (Section D, ¶ 20)	15 days after the end of each quarter	Clinical Quality Management Unit (DHCM)
Monthly Pregnancy Termination Report (Section D, ¶ 20)	End of the month following the pregnancy termination	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)
HIV Specialty Provider List (Chapter 300 AMPM)	December 15	Medical Management Unit (DHCM)
Performance Improvement Project Proposal (initial/baseline year of project) (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)
Performance Improvement Remeasurement Report (Section D, ¶ 20)	December 15	Clinical Quality Management Unit (DHCM)
Performance Improvement Project Final Report (Section D, ¶ 20)	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	Clinical Quality Management Unit (DHCM)
Non-Transplant and Transplant Catastrophic Reinsurance Covered Diseases (Section D, ¶58)	Annually within 30 days of the beginning of the contract year, enrollment to the plan, and when newly diagnosed.	EPARS Reinsurance Unit (DHCM)
QM Quarterly Report (Section D, ¶20)	45 days after end of each quarter	Clinical Quality Management Unit (DHCM)
MM Quarterly Report (Section D, ¶21)	45 days after the end of each quarter	Medical Management Unit (DHCM)
Transplant Log	15 days after month end	Medical Management Unit (DHCM)

ATTACHMENT E. NETWORK STANDARDS

Program Contractors shall develop and maintain a provider network that is supported by written agreements which is sufficient to provide all covered services to ALTCS members [42 CFR 438.206]. To that end, network standards have been established for all levels (institutional, HCBS, acute, alternative residential, non-emergency transportation, etc.) by county and GSA. If established network standards are not met, it must be explained in the Network Development and Management Plan.

Program Contractors shall have contracted providers or LOIs as defined in the following pages and that represent the minimum providers for a county/GSA. The standard (either an "X" or a number of facilities/providers required) will indicate the number of providers by a specific city, zone, facility location or countywide coverage. For example:

> For Apache County, due to the limited availability of providers in rural areas, nursing facilities and HCBS Community settings have been set at the location of available providers. HCBS Home, Behavioral Health and Acute Services must be provided countywide.
>
> For Cochise County, the Program Contractor must have signed contracts or LOIs with one nursing facility in Benson, one in Douglas, two in Sierra Vista and one in Willcox. HCBS Community settings have been established by the location of available providers. HCBS Home, Behavioral Health and most Acute Services must be provided county wide. Inpatient hospital standards have been set in Benson, Bisbee, Douglas, Sierra Vista and Willcox.

SPECIAL NOTES:

* Facility Location means the location of the provider within the county.

If a provider provides services in more than one (1) county, that provider should be listed in each county they provide services in. Include any restrictions or limitations they may have.

Network Standards enrollment data for all counties except Maricopa and Pima is based on fiscal county of responsibility and includes Ventilator Dependent members. Zone enrollment data for Maricopa and Pima Counties is based on county of residence and does not include Ventilator Dependent members. The number of enrollees may differ from Section J; Exhibit A GSA Map of the ALTCS RFP issued February 8th, 2006.

Apache County - GSA 44 Enrollment 1/01/06- 74

	Springerville	St. Johns	Countywide Coverage	Facility Location
Long Term Care				
Nursing Facility				X
HCBS Community	**Must have LOI* with 1 or more Assisted Living Facilities**			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)				X
Behavioral Health Facilities (Level II, Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)				X
DD Group Home				X
HCBS Home				
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	
Behavioral Health				
Behavioral Management			X	
Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial Rehabilitation			X	
Acute Services				
Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

- LOI – Letters of Intent or signed contract

Cochise County - GSA 46 Enrollment 1/01/06- 781

	Benson	Bisbee	Douglas	Sierra Vista	Willcox	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1		1	2	1		
HCBS Community	**Must have LOI* with 10 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Behavioral Management						X	
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X	X	X	X		
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		

Podiatrist						X	
Physician Specialist						X	
Therapies						X	
Transportation						X	

*LOI – Letters of Intent or signed contract

Coconino County - GSA 44 Enrollment 1/01/06 - 192

	Flagstaff	Fredonia	Page	Sedona	Williams	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	2			1			
HCBS Community	**Must have LOI* with 6 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Behavioral Management						X	
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X		X				
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X		X	X	X		
Podiatrist						X	

Physician Specialists						X	
Therapies						X	
Transportation						X	

*LOI – Letters of Intent or signed contract

Gila County - GSA 40 Enrollment 1/01/06 - 264

	Globe/Miami/ Claypool	Payson	Hayden/ Winkelman	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	2	2			
HCBS Community	**Must have LOI* with 2 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)					X
DD Group Home					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Behavioral Management				X	
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X			
Laboratory				X	
Medical Imaging				X	
PCP	X	X			
Pharmacy	X	X	X		
Podiatrist				X	

Physician Specialists				X	
Therapies				X	
Transportation				X	

*LOI – Letters of Intent or signed contract

Graham County - GSA 46 Enrollment 1/01/06 - 114

	Safford	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	1		
HCBS Community	**Must have LOI* with 3 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Behavioral Management		X	
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

*LOI – Letters of Intent or signed contract

Greenlee County - GSA 46 Enrollment 1/01/06 - 13

	Clifton/Morenci	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	Within 1 hour drive of Morenci		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Behavioral Management		X	
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	Within 1 hour drive of Morenci		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

*LOI – Letters of Intent or signed contract

La Paz County - GSA 42 Enrollment 1/01/06 - 70

	Parker	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	Within 1 hour drive of Parker		
HCBS Community			
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Behavioral Management		X	
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialists		X	
Therapies		X	
Transportation		X	

*LOI – Letters of Intent or signed contract

Maricopa County – GSA 52

Part I – Institutional and Alternative Residential Settings

For purposes of this contract and the evaluation of the responses to this RFP, AHCCCS has divided Maricopa County into 10 zones (defined by zip code boundaries). The following tables list the required number of contracts for 5 key provider settings. These standards will be used in the evaluation of proposals and may further be used for ongoing monitoring.

Zone 1 – Phoenix

Zone 1 is comprised of the following zip codes:

85022, 85023, 85024, 85027, 85029, 85032, 85046, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331,85377

Members 1/01/06 – 1,649

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	20	X
Assisted Living Center	3	X
Assisted Living Home	20	X

Zone 2 – Phoenix

Zone 2 is comprised of the following zip codes:

85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, , 85051, 85253, 85274

Members 1/01/06 – 2,033

Setting	Standard	Facility Location Within Zone
Nursing Facility	9	X
Adult Foster Care	15	X
Assisted Living Center	6	X
Assisted Living Home	10	X

Zone 3 – Buckeye, Goodyear, Phoenix & Tolleson

Zone 3 is comprised of the following zip codes:

85031, 85033, 85035, 85037, 85043, 85320, 85322, 85323, 85326, 85338, 85339, 85353

Members 1/01/06- 989

Setting	Standard	Facility Location Within Zone
Nursing Facility	2	X
Adult Foster Care	16	X
Assisted Living Center	0	X
Assisted Living Home	2	X

Zone 4 – Phoenix

Zone 4 is comprised of the following zip codes:

85001, 85002, 5003, 85004, 85006, 85007, 85008, 85009, 85010, 85025, 85034, 85036, 85040, 85041, 85042, 85044, 85045, 85048, 85055, 85056, 85271

Members 1/01/06–

1,431

Setting	Standard	Facility Location Within Zone
Nursing Facility	5	X
Adult Foster Care	5	X
Assisted Living Center	1	X
Assisted Living Home	5	X

Zone 5 – Gila Bend, Glendale & Wickenburg

Zone 5 is comprised of the following zip codes:

85301, 85302, 85303, 85304, 85305, 85306, 85308, 85310, 85311, 85313, 85337, 85342, 85358, 85361, 85390

Members 1/01/06 –

1,528

Setting	Standard	Facility Location Within Zone
Nursing Facility	4	X
Adult Foster Care	28	X
Assisted Living Center	2	X
Assisted Living Home	12	X

Zone 6 – El Mirage, Peoria, Sun City, Sun City West. & Surprise

Zone 6 is comprised of the following zip codes:

85275, 85307, 85309, 85335, 85340, 85345, 85351, 85355, 85361, 85363, 85372, 85373, 85374, 85375, 85376, 85379, 85380, 85381, 85382, 85383, 85387,85388,85396

Members 1/01/06 -

1,877

Setting	Standard	Facility Location Within Zone
Nursing Facility	10	X
Adult Foster Care	5	X
Assisted Living Center	8	X
Assisted Living Home	9	X

Zone 7 – Carefree, Cave Creek, Fountain Hills & Scottsdale

Zone 7 is comprised of the following zip codes:

85250, 85251, 85255, 85256, 85257, 85258, 85259, 85260, 85262, 85263, 85264, 85268

Members 1/01/06 - 754

Setting	Standard	Facility Location Within Zone
Nursing Facility	6	X
Adult Foster Care	4	X
Assisted Living Center	2	X
Assisted Living Home	2	X

Zone 8 – Tempe

Zone 8 is comprised of the following zip codes:

85281, 85282, 85283, 85284

Members 1/01/06 - 385

Setting	Standard	Facility Location Within Zone
Nursing Facility	1	X
Adult Foster Care	2	X
Assisted Living Center	2	X
Assisted Living Home	2	X

Zone 9 – Mesa

Zone 9 is comprised of the following zip codes:

85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256

Members 1/01/06 - 2,555

Setting	Standard	Facility Location Within Zone
Nursing Facility	10	X
Adult Foster Care	13	X
Assisted Living Center	8	X
Assisted Living Home	15	X

Zone 10 – Chandler, Gilbert, Queen Creek & Sunlakes

Zone 10 is comprised of the following zip codes:

85222, 85224, 85225, 85226, 85227, 85233, 85234, 85236, 85242, 85243, 85246, 85248, 85249, 85296, 85297

Members 1/01/06 - 983

Setting	Standard	Facility Location Within Zone
Nursing Facility	2	X
Adult Foster Care	5	X
Assisted Living Center	2	X
Assisted Living Home	8	X

Total for Zones 1 through 10

Setting	Standard
Nursing Facility	53
Adult Foster Care	113
Assisted Living Center	34
Assisted Living Home	85

Part II – Acute Care, Behavioral Health and Home and Community Based Services

In addition to the standards for the 4 settings covered in Part I, Part II delineates the standards for coverage of acute care, behavioral health and home and community based services. Inpatient Hospitals, PCP Services and Pharmacy Services have city-specific requirements. Countywide coverage is required for all other covered services. Also see Section D, Paragraph 28. Network Development for further requirements.

Acute Care Services Cities

Inpatient Hospitals
- Metropolitan Phoenix **
- Wickenburg

PCP
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Gila Bend
- Metropolitan Phoenix **
- Queen Creek
- Wickenburg

Pharmacy
- Avondale/Goodyear/Laveen
- Litchfield Park/Tolleson
- Buckeye
- Metropolitan Phoenix **
- Wickenburg

**For purposes of the RFP/Contract, Metropolitan Phoenix encompasses the following:
Phoenix, Paradise Valley, Cave Creek/Carefree, Fountain Hills, Scottsdale, Glendale, Sun City/Sun City West, Tempe, Mesa, Gilbert, Chandler, Apache Junction, Peoria, El Mirage, Surprise and Youngtown. Offerors/Program Contractors are expected to contract with at least one PCP and one pharmacy in each of these cities. Additionally, within this area, standards must be met as specified in Section D: Program Requirements, Paragraph 28. Network Development.

For inpatient hospital services, Offerors/Program Contractors are expected to contract with at least one hospital in the Central District (Zones 1, 2 &4), at least one in the Northwest District (Zones 3, 5, 6 & 7) and at least one in the Southwest District (Zones 8, 9 & 10).

County-wide Coverage*

Services include but are not limited to the following:

Acute Care Services
- Dentist
- Durable Medical Equipment & Supplies
- Laboratory
- Medical Imaging
- Podiatrist
- Physician Specialists
- Therapies
- Transportation

HCBS Services
- Adult Day Health Care
- Attendant Care
- Emergency Alert
- Home Modifications
- Habilitation
- Home Health Care
- Home-Delivered Meals
- Homemaker
- Hospice
- Personal Care
- Respite Care

County-wide Coverage*

Behavioral Health Facilities
- Level II, Behavioral Health
- Level III, Behavioral Health
- Therapeutic Home Care
- Rural Substance Abuse Transitional Agency

Behavioral Health
- Behavioral Management
- Emergency Care
- Evaluation
- Individual, Group, family Counseling
- Partial Care
- Medication Monitoring
- Behavioral Health Day program/Partial care
- Psychosocial Rehabilitation

County-wide Coverage

DDD Group Home

* See Section D. Program Requirements, Paragraph 10. Covered Services, for a complete listing of services to be provided.

Mohave County - GSA 44 Enrollment 1/01/06 - 805

	Bullhead City	Kingman	Lake Havasu City	Countywide Coverage	Facility Location
Long Term Care					
Nursing Facility	1	2	2		
HCBS Community	**Must have LOI* with 28 or more Assisted Living Facilities**				
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)					X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)					X
DD Group Home					X
HCBS Home					
Adult Day Health				X	
Attendant Care				X	
Emergency Alert				X	
Home Modifications				X	
Habilitation				X	
Home Health Care				X	
Home-Delivered Meals				X	
Homemaker				X	
Hospice				X	
Personal Care				X	
Respite Care				X	
Behavioral Health					
Behavioral Management				X	
Inpatient Services				X	
Emergency Care				X	
Evaluation				X	
Individual, Group, Family Counseling				X	
Medication Monitoring				X	
Behavioral Health Day Program/Partial Care				X	
Psychosocial Rehabilitation				X	
Acute Services					
Dentist				X	
Durable Medical Equipment & Supplies				X	
Inpatient Hospital	X	X	X		
Laboratory				X	
Medical Imaging				X	
PCP	X	X	X		
Pharmacy	X	X	X		
Podiatrist				X	

Physician Specialists				X	
Therapies				X	
Transportation				X	

*LOI – Letters of Intent or signed contract

Navajo County - GSA 44 Enrollment 1/01/06– 222

	Winslow	Show Low/ Pinetop/ Lakeside	Snowflake/ Taylor	Holbrook	Countywide Coverage	Facility Location
Long Term Care						
Nursing Facility	1	1				
HCBS Community	**Must have LOI* with 5 or more Assisted Living Facilities**					
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)						X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)						X
DD Group Home						X
HCBS Home						
Adult Day Health					X	
Attendant Care					X	
Emergency Alert					X	
Home Modifications					X	
Durable Medical Equipment					X	
Home Health Care					X	
Home-Delivered Meals					X	
Homemaker					X	
Hospice					X	
Personal Care					X	
Respite Care					X	
Behavioral Health						
Behavioral Management					X	
Inpatient Services					X	
Emergency Care					X	
Evaluation					X	
Individual, Group, Family Counseling					X	
Medication Monitoring					X	
Behavioral Health Day Program/Partial Care					X	
Psychosocial Rehabilitation					X	
Acute Services						
Dentist					X	
Durable Medical Equipment & Supplies					X	
Inpatient Hospital	X	X				
Laboratory					X	
Medical Imaging					X	
PCP	X	X	X	X		
Pharmacy	X	X	X	X		

Podiatrist					X	
Physician Specialists					X	
Therapies					X	
Transportation					X	

*LOI – Letters of Intent or signed contract

Pima County – GSA 50

For purposes of this contract and evaluation of the responses to this RFP, AHCCCS has divided Tucson in Pima County into 4 zones (defined by zip code boundaries). The following tables list the standard Number of Nursing Facilities and Assisted Living Facility LOI/contracts within each zone. These standards will be used in the evaluation of proposals and may further be used for ongoing network monitoring.

Tucson - Northwest Zone Enrollment 1/01/06 – 990

The Northwest Zone is comprised of the following zip codes:
85321, 85653, 85654, 85701, 85704, 85705, 85737, 85738, 85741, 85742, 85743, 85745

Long Term Care	Northwest Zone	Facility Location Within the Zone
Nursing Facility	3	X

HCBS Community	**Must have LOI* with 16 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)		X
DD Group Home		X

Tucson - Southwest Zone Enrollment: 1/01/06 - 691

The Southwest Zone is comprised of the following zip codes: (Includes Green Valley)
85601, 85614, 85713, 85714, 85723, 85724, 85735, 85736, 85746

Long Term Care	Southwest Zone	Facility Location Within the Zone
Nursing Facility	2	X

HCBS Community	**Must have LOI* with 10 or more Assisted Living Facilities**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)		X
DD Group Home		X

*LOI – Letters of Intent or signed contract

Pima County - GSA 50

For purposes of this contract and evaluation of the responses to this RFP, AHCCCS has divided Tucson in Pima County into 4 zones (defined by zip code boundaries). The following tables list the standard Number of Nursing Facilities and Assisted Living Facility LOI/contracts within each zone. These standards will be used in the evaluation of proposals and may further be used for ongoing network monitoring.

Tucson - Northeast Zone Enrollment: 1/01/06 – 1,275

The Northeast Zone is comprised of the following zip codes:
85619, 85702, 85712, 85715, 85716, 85717, 85718, 85719, 85731, 85739, 85749

Long Term Care	Northeast Zone	Facility Location Within the Zone
Nursing Facility	8	X

HCBS Community	**Must have LOI* with 14 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Home)		**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)		X
DD group Home		X

Tucson - Southeast Zone Enrollment: 1/01/06 - 925

The Southeast Zone is comprised of the following zip codes: (Includes Sahuarita)
85601, 85629, 85641, 85706, 85708, 85710, 85711, 85730, 85732, 85734, 85747, 85748
85757,

Long Term Care	Southeast Zone	Facility Location Within the Zone
Nursing Facility	1	X

HCBS Community	**Must have LOI* with 37 or more Assisted Living Facilities of which 2 must be Assisted Living Centers**	
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)		**X**
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)		X
DD Group Home		X

*LOI – Letters of Intent or signed contract

Pima County - GSA 50

HCBS Home	Tucson	Green Valley	Countywide Coverage	Facility Location
Adult Day Health			X	
Attendant Care			X	
Emergency Alert			X	
Home Modifications			X	
Habilitation			X	
Home Health Care			X	
Home-Delivered Meals			X	
Homemaker			X	
Hospice			X	
Personal Care			X	
Respite Care			X	

Behavioral Health				
Behavioral Management			X	
Inpatient Services			X	
Emergency Care			X	
Evaluation			X	
Individual, Group, Family Counseling			X	
Medication Monitoring			X	
Behavioral Health Day Program/Partial Care			X	
Psychosocial rehabilitation			X	

Acute Services				
Dentist			X	
Durable Medical Equipment & Supplies			X	
Inpatient Hospital	X			
Laboratory			X	
Medical Imaging			X	
PCP	X	X		
Pharmacy	X	X		
Podiatrist			X	
Physician Specialists			X	
Therapies			X	
Transportation			X	

*LOI – Letters of Intent or signed contract

Pinal County - GSA 40 Enrollment 1/01/06 - 963

	Apache Junction	Casa Grande	Coolidge	Eloy	Florence	Kearney	Mammoth/ San Man./ Oracle	County-wide Coverage	Facility Location
Long Term Care									
Nursing Facility	*1 – A.J. **5 – E. V.	1					3 - Tucson		
HCBS Community	**Must have LOI*** with 17 or more Assisted Living Facilities**								
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)									X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)									X
DD Group Home									X
HCBS Home									
Adult Day Health								X	
Attendant Care								X	
Emergency Alert								X	
Home Modifications								X	
Habilitation								X	
Home Health Care								X	
Home-Delivered Meals								X	
Homemaker								X	
Hospice								X	
Personal Care								X	
Respite Care								X	
Behavioral Health									
Behavioral Management								X	
Inpatient Services								X	
Emergency Care								X	
Evaluation								X	
Individual, Group, Family Counseling								X	
Medication Monitoring								X	
Behavioral Health Day Program/Partial Care								X	
Psychosocial Rehabilitation								X	
Acute Services									
Dentist								X	
DME & Supplies								X	
Inpatient Hospital		X							
Laboratory								X	
Medical Imaging								X	
PCP	X	X	X	X	X	X	X		

Pharmacy	X	X	X		X	X	X		
Podiatrist								X	
Physician Specialist								X	
Therapies								X	
Transportation								X	

*1 – Apache Junction; **5– East Valley, Maricopa County; *** LOI – Letters of Intent or signed contract

Santa Cruz County - 50 Enrollment 1/01/06 - 231

	Nogales	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	1		
HCBS Community	**Must have LOI* with 3 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Home Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Behavioral Management		X	
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

*LOI – Letters of Intent or signed contract

Yavapai County - GSA 48 Enrollment 1/01/06 – 994

	Cottonwood	Prescott	Camp Verde	Sedona	Prescott Valley	Countywide Coverage	Facility Location
Long Term Care							
Nursing Facility	1	3	1	1	1		
HCBS Community	**Must have LOI* with 20 or more Assisted Living Facilities**						
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)							X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)							X
DD Group Home							X
HCBS Home							
Adult Day Health						X	
Attendant Care						X	
Emergency Alert						X	
Home Modifications						X	
Habilitation						X	
Home Health Care						X	
Home-Delivered Meals						X	
Homemaker						X	
Hospice						X	
Personal Care						X	
Respite Care						X	
Behavioral Health							
Behavioral Management						X	
Inpatient Services						X	
Emergency Care						X	
Evaluation						X	
Individual, Group, Family Counseling						X	
Medication Monitoring						X	
Behavioral Health Day Program/Partial Care						X	
Psychosocial Rehabilitation						X	
Acute Services							
Dentist						X	
Durable Medical Equipment & Supplies						X	
Inpatient Hospital	X	X					
Laboratory						X	
Medical Imaging						X	
PCP	X	X	X	X	X		
Pharmacy	X	X	X	X	X		
Podiatrist						X	

Physician Specialists						X	
Therapies						X	
Transportation						X	

*LOI – Letters of Intent or signed contract

Yuma County - GSA 42 Enrollment 1/01/06 – 595

	Yuma	Countywide Coverage	Facility Location
Long Term Care			
Nursing Facility	4		
HCBS Community	**Must have LOI* with 11 or more Assisted Living Facilities**		
Assisted Living Facilities (Adult Foster Care, Assisted Living Center, Assisted Living Home)			X
Behavioral Health Facilities (Level II Behavioral Health, Level III Behavioral Health, Therapeutic Home Care, Rural Substance Abuse Transitional Agency)			X
DD Group Home			X
HCBS Home			
Adult Day Health		X	
Attendant Care		X	
Emergency Alert		X	
Environmental Modifications		X	
Habilitation		X	
Home Health Care		X	
Home-Delivered Meals		X	
Homemaker		X	
Hospice		X	
Personal Care		X	
Respite Care		X	
Behavioral Health			
Behavioral Management		X	
Inpatient Services		X	
Emergency Care		X	
Evaluation		X	
Individual, Group, Family Counseling		X	
Medication Monitoring		X	
Behavioral Health Day Program/Partial Care		X	
Psychosocial Rehabilitation		X	
Acute Services			
Dentist		X	
Durable Medical Equipment & Supplies		X	
Inpatient Hospital	X		
Laboratory		X	
Medical Imaging		X	
PCP	X		
Pharmacy	X		
Podiatrist		X	
Physician Specialist		X	
Therapies		X	
Transportation		X	

*LOI – Letters of Intent or signed contract