

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION  
DIVISION OF BUSINESS AND FINANCE  
INTERGOVERNMENTAL AGREEMENT AMENDMENT**

1. AMENDMENT NUMBER: <b>8</b>	2. CONTRACT NUMBER: <b>YH02-0018 E4403002</b>	3. EFFECTIVE DATE OF AMENDMENT: <b>January 1, 2006</b>	4. PROGRAM: <b>DHCM – CMDP</b>
5. CONTRACTOR/PROVIDER NAME AND ADDRESS: <p style="text-align: center;"><b>Arizona Department of Economic Security Comprehensive Medical and Dental Program (CMDP) PO Box 29202, Site Code 942C Phoenix, Arizona 85038-9202</b></p>			
6. PURPOSE: To clarify and add requirements contained in Amendment #8.			

7. The above referenced contract is hereby amended as follows:
- A. Add the Medicare Modernization and Improvement Act, Advance Directives, and the Federal Immigration and Nationality Act requirements.**
  - B. Add the Code of Federal Regulation citations**
  - C. Update Definitions and Term of the Contract.**
  - D. Add requirements for maternity services.**
  - E. Revise the goal dates for electronic submission of claims.**
  - F. Revise requirements for AHCCCS policy manual, referrals, network development, network management, accumulated fund deficit, subcontracts, disputes, reinsurance, coordination of benefits/third party liability,**

**G.**

*NOTE: Please sign, date and return all originals to: Gary Callahan, Contract Management Supervisor  
AHCCCS Contracts and Purchasing  
701 E. Jefferson, MD 5700  
Phoenix, AZ 85034*

8. EXCEPT AS PROVIDED FOR HEREIN, ALL TERMS AND CONDITIONS OF THE ORIGINAL CONTRACT NOT HERETOFORE CHANGED AND/OR AMENDED REMAIN UNCHANGED AND IN FULL EFFECT. IN WITNESS WHEREOF THE PARTIES HERETO SIGN THEIR NAMES IN AGREEMENT.	
9. ARIZONA DEPARTMENT OF ECONOMIC SECURITY	10. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
SIGNATURE OF AUTHORIZED INDIVIDUAL:	SIGNATURE:
TYPED NAME: <b>KATHERINE K. BABONIS</b>	TYPED NAME: <b>MICHAEL VEIT</b>
TITLE: <b>CHIEF PROCUREMENT OFFICER</b>	TITLE: <b>CONTRACTS AND PURCHASING ADMINISTRATOR</b>
DATE:	DATE:
11. IN ACCORDANCE WITH § A.R.S. 11-952, THIS AGREEMENT HAS BEEN REVIEWED BY THE UNDERSIGNED WHO HAS DETERMINED THAT IT IS IN THE PROPER FORM AND IS WITHIN THE POWERS AND AUTHORITY GRANTED TO THE CONTRACTOR.  BY _____ LEGAL COUNSEL FOR ADES  _____ Date	12. IN ACCORDANCE WITH § A.R.S. 11-952, THIS AMENDMENT IS IN PROPER FORM AND IS WITHIN THE POWER AND AUTHORITY GRANTED TO THE ADMINISTRATION UNDER § A.R.S 36-2903 ET SEQ. AND §36-2932 ET SEQ.  _____ LEGAL COUNSEL FOR THE ADMINISTRATION  _____ Date
13. SECRETARY OF STATE FILING INFORMATION:	

**SECTION B: CAPITATION RATES**

The Contractor shall provide services as described in this contract. In consideration for these services, the Contractor will be paid the following rates per member per month for the term January 1, 2006 through December 31, 2006:

**TABLE OF CONTENTS**

**SECTION B: CAPITATION RATES .....1**

**SECTION C: DEFINITIONS.....5**

**SECTION D: PROGRAM REQUIREMENTS .....13**

1. SCOPE OF SERVICES .....13

2. SPECIAL HEALTH CARE NEEDS .....20

3. BEHAVIORAL HEALTH SERVICES .....20

4. AHCCCS POLICY MANUALS.....23

5. PEDIATRIC IMMUNIZATION AND VACCINE FOR CHILDREN PROGRAM .....23

6. ENROLLMENT AND DISENROLLMENT.....23

7. MAINSTREAMING OF AHCCCS MEMBERS .....25

8. MEMBER INFORMATION.....25

9. SURVEYS .....26

10. TRANSITION OF MEMBERS.....26

11. STAFF REQUIREMENTS AND SUPPORT SERVICES.....27

12. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS .....28

13. PERFORMANCE STANDARDS .....29

14. QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT (QM/UM).....32

15. PHYSICIAN INCENTIVES .....33

16. APPOINTMENT STANDARDS.....34

17. REFERRAL PROCEDURES AND STANDARDS .....35

18. PROVIDER MANUAL .....36

19. PRIMARY CARE PROVIDER STANDARDS.....36

20. OTHER PROVIDER STANDARDS.....37

21. NETWORK DEVELOPMENT .....39

22. NETWORK MANAGEMENT .....40

23. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC) 41

24. PROVIDER REGISTRATION .....41

25. PROVIDER AFFILIATION TRANSMISSION.....42

26. PERIODIC REPORT REQUIREMENTS.....42

27. DISSEMINATION OF INFORMATION.....42

28. REQUESTS FOR INFORMATION .....42

29. OPERATIONAL AND FINANCIAL REVIEWS .....42

30. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM .....43

31. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT .....44

32. NURSING FACILITY REIMBURSEMENT .....45

33. COMPENSATION .....45

34. CAPITATION ADJUSTMENTS .....47

35. REINSURANCE.....48

36. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY .....52

37. MEDICARE SERVICES AND COST SHARING .....54

38. RECORDS RETENTION .....54

39. MEDICAL RECORDS .....55

40. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS .....55

41. RESERVED .....56

42. DATA EXCHANGE REQUIREMENT .....56

43. ENCOUNTER DATA REPORTING .....56

44. ENROLLMENT AND CAPITATION TRANSACTION UPDATE .....57

45. TERM OF CONTRACT AND OPTION TO RENEW .....58

46. SUBCONTRACTS .....58

47.	SPECIALTY CONTRACTS.....	60
48.	MANAGEMENT SERVICES SUBCONTRACTORS .....	61
49.	MANAGEMENT SERVICES SUBCONTRACTOR AUDITS .....	61
50.	FINANCIAL VIABILITY STANDARDS/PERFORMANCE GUIDELINES .....	61
51.	MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP .....	62
52.	SANCTIONS .....	62
53.	GRIEVANCE SYSTEM.....	63
54.	QUARTERLY GRIEVANCE SYSTEM REPORT .....	64
55.	MEDICARE MODERNIZATION ACT OF 2003 .....	64
56.	CULTURAL COMPETENCY.....	65
57.	MEDICAID SCHOOL BASED CLAIMING .....	65
58.	BUSINESS CONTINUITY AND RECOVERY PLAN.....	65
59.	CORPORATE COMPLIANCE .....	66
60.	TECHNOLOGICAL ADVANCEMENT .....	66
61.	PENDING LEGISLATIVE / OTHER ISSUES.....	67
62.	BALANCED BUDGET ACT OF 1997 (BBA) .....	67
63.	ADVANCE DIRECTIVES .....	68
<b>SECTION E: CONTRACT CLAUSES.....</b>		<b>69</b>
1)	APPLICABLE LAW .....	69
2)	AUTHORITY .....	69
3)	ORDER OF PRECEDENCE .....	69
4)	CONTRACT INTERPRETATION AND AMENDMENT .....	69
5)	SEVERABILITY .....	69
6)	RELATIONSHIP OF PARTIES .....	69
7)	ASSIGNMENT AND DELEGATION .....	69
8)	COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS.....	70
9)	RIGHT TO ASSURANCE .....	70
10)	TERMINATION FOR CONFLICT OF INTEREST.....	70
11)	GRATUITIES .....	70
12)	TERMINATION FOR CONVENIENCE .....	70
13)	TERMINATION FOR DEFAULT .....	70
14)	TERMINATION - AVAILABILITY OF FUNDS .....	71
15)	RIGHT OF OFFSET .....	71
16)	NON-EXCLUSIVE REMEDIES.....	71
17)	NON-DISCRIMINATION .....	71
18)	EFFECTIVE DATE .....	71
19)	DISPUTES .....	71
20)	RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS.....	71
21)	INCORPORATION BY REFERENCE .....	71
22)	COVENANT AGAINST CONTINGENT FEES.....	71
23)	CHANGES.....	72
24)	TYPE OF CONTRACT .....	72
25)	AMERICANS WITH DISABILITIES ACT.....	72
26)	WARRANTY OF SERVICES .....	72
27)	NO GUARANTEED QUANTITIES .....	72
28)	CONFLICT OF INTEREST.....	72
29)	DISCLOSURE OF CONFIDENTIAL INFORMATION .....	72
30)	COOPERATION WITH OTHER CONTRACTORS .....	72
31)	OWNERSHIP OF INFORMATION AND DATA .....	73
32)	AHCCCSA RIGHT TO OPERATE CONTRACTOR .....	73
33)	AUDITS AND INSPECTIONS .....	73
34)	LOBBYING.....	74
35)	SUSPENSION OR DEBARMENT.....	74

36)	DATA CERTIFICATION.....	74
37)	OFF SHORE PERFORMANCE OF WORK PROHIBITED .....	74
38)	FEDERAL IMMIGRATION AND NATIONALITY ACT .....	74
<b>ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS .....</b>		<b>76</b>
1)	ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES.....	76
2)	AWARDS OF OTHER SUBCONTRACTS.....	76
3)	CERTIFICATION OF COMPLIANCE – ANTI-KICKBACK AND LABORATORY TESTING .....	76
4)	CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION .....	76
5)	CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 .....	76
6)	COMPLIANCE WITH AHCCCSA RULES RELATING TO AUDIT AND INSPECTION.....	76
7)	COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS .....	76
8)	CONFIDENTIALITY REQUIREMENT .....	77
9)	CONFLICT IN INTERPRETATION OF PROVISIONS.....	77
10)	CONTRACT CLAIMS AND DISPUTES .....	77
11)	ENCOUNTER DATA REQUIREMENT .....	77
12)	EVALUATION OF QUALITY, APPROPRIATENESS, OR TIMELINESS OF SERVICES .....	77
13)	FRAUD AND ABUSE.....	77
14)	GENERAL INDEMNIFICATION .....	77
15)	INSURANCE.....	77
16)	LIMITATIONS ON BILLING AND COLLECTION PRACTICES .....	77
17)	MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES.....	78
18)	NON-DISCRIMINATION REQUIREMENTS .....	78
19)	PRIOR AUTHORIZATION AND UTILIZATION REVIEW .....	78
20)	RECORDS RETENTION .....	78
21)	SEVERABILITY .....	78
22)	SUBJECTION OF SUBCONTRACT.....	78
23)	TERMINATION OF SUBCONTRACT .....	78
24)	VOIDABILITY OF SUBCONTRACT .....	79
25)	WARRANTY OF SERVICES .....	79
26)	OFF SHORE PERFORMANCE OF WORK PROHIBITED .....	79
27)	FEDERAL IMMIGRATION AND NATIONALTY ACT .....	79
<b>ATTACHMENT B: MINIMUM NETWORK STANDARDS .....</b>		<b>80</b>
<b>ATTACHMENT F: PERIODIC REPORT REQUIREMENTS.....</b>		<b>84</b>
<b>ATTACHMENT H (1): ENROLLEE GRIEVANCE AND REQUEST FOR HEARING PROCESS AND STANDARDS.....</b>		<b>87</b>
<b>ATTACHMENT H(2): PROVIDER CLAIM DISPUTE STANDARDS AND POLICY .....</b>		<b>92</b>
<b>ATTACHMENT I: ENCOUNTER SUBMISSION REQUIREMENTS.....</b>		<b>94</b>

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**SECTION C: DEFINITIONS**

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<b>1931</b>	Eligible individuals and families under the 1931 provision of the Social Security Act, with household income levels at or below 100% of the FPL.
<b>ADHS</b>	Arizona Department of Health Services, the State agency mandated to serve the public health needs of all Arizona citizens.
<b>ADHS BEHAVIORAL HEALTH RECIPIENT</b>	A Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS and its subcontractors.
<b>ADJC</b>	Arizona Department of Juvenile Correction
<b>AGENT</b>	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
<b>AHCCCS</b>	Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.
<b>AHCCCS BENEFITS</b>	See "COVERED SERVICES".
<b>AHCCCS MEMBER</b>	See "MEMBER".
<b>AHCCCSA</b>	Arizona Health Care Cost Containment System Administration.
<b>ALTCS</b>	The Arizona Long Term Care System a program under AHCCCSA that delivers long term, acute, behavioral health and case management services to members, as authorized by A.R.S. § 36-2932.
<b>AMBULATORY CARE</b>	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.
<b>AMPM</b>	<i>AHCCCS Medical Policy Manual.</i>
<b>AOC</b>	Administrative Office of the Courts
<b>APPEAL RESOLUTION</b>	The written determination by the Contractor concerning an appeal.
<b>ARIZONA ADMINISTRATIVE CODE (A.A.C.)</b>	State regulations established pursuant to relevant statutes. For purposes of this solicitation, the relevant sections of the AAC are referred to throughout this document as "AHCCCS Rules".
<b>A.R.S.</b>	Arizona Revised Statutes.
<b>AT RISK</b>	Refers to the period of time that a member is enrolled with a Contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.
<b>BBA</b>	The Balanced Budget Act of 1997.
<b>BCCTP</b>	Breast and Cervical Cancer Treatment Program, a Title XIX eligibility expansion program for women who are not otherwise Title XIX eligible and are diagnosed as needing treatment for breast and/or cervical cancer or lesions.
<b>BIDDERS LIBRARY</b>	A repository of manuals, statutes, rules and other reference material located at the AHCCCS office in Phoenix.

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<b>BOARD CERTIFIED</b>	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
<b>CAPITATION</b>	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. § 36-2942 and § 36-2931.
<b>CATEGORICALLY LINKED TITLE XIX MEMBER</b>	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups. To be categorically linked, the member must be aged (65 or over), blind, disabled, a child under age 19, parent of a dependent child, or pregnant.
<b>CLAIM DISPUTE</b>	A dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
<b>CLEAN CLAIM</b>	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
<b>CMDP</b>	Comprehensive Medical and Dental Program
<b>CMS (formerly HCFA)</b>	Center for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.
<b>CRS ELIGIBLE</b>	An individual that has completed the CRS application process, as delineated in the <i>CRS Policy and Procedure Manual</i> , and has met all applicable criteria to be eligible to receive CRS related services.
<b>CRS RECIPIENT</b>	A CRS recipient is a CRS eligible individual that has completed the initial medical visit at an approved CRS Clinic, which allows the individual to participate in the CRS program.
<b>CONTRACT SERVICES</b>	See "COVERED SERVICES".
<b>CONTRACT YEAR (CY)</b>	The Contract Year 06 is 01/01/06– 12/31/06.
<b>CONTRACTOR</b>	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 the stated contract requirements, AHCCCS statute and rules and Federal law and regulations.
<b>CONVICTED</b>	A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.
<b>COVERED SERVICES</b>	Health care services to be delivered by a Contractor which are designated in Section D of this contract and also AHCCCS Rules R9-22, Article 2 and R9-31, Article 2.
<b>CPS</b>	Child Protective Services
<b>CRS</b>	Children's Rehabilitative Services, as defined in R9-22-114.

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<b>CSHCN</b>	Children with Special Health Care Needs, Children under age 19 who are: Blind/Disabled Children and Related Populations (eligible for SSI under Title XVI). Children eligible under section 1902 (e)(3) of the Social Security Act (Katie Beckett); In foster care or other out-of-home placement; Receiving foster care or adoption assistance; or receiving services through a family-centered, community-based coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V (CRS).
<b>CY</b>	See "CONTRACT YEAR".
<b>CYE</b>	Contract Year Ended; same as "CONTRACT YEAR".
<b>DAYS</b>	Calendar days unless otherwise specified as defined in the text, as defined in R9-22-101.
<b>DCYF</b>	The Division of Children, Youth and Families within DES
<b>DES</b>	Department of Economic Security
<b>DIRECTOR</b>	The Director of AHCCCSA.
<b>DISCLOSING ENTITY</b>	An AHCCCS provider or a fiscal agent.
<b>DISENROLLMENT</b>	The process by which a member is discontinued as a Title XIX or Title XXI funded member of the Contractor's health plan.
<b>DME</b>	Durable Medical Equipment, which is an item, or appliance that can withstand repeated use, is designated to serve a medical purpose, and is not generally useful to a person in the absence of a medical condition, illness or injury as defined in R9-22-102.
<b>DUAL ELIGIBLE</b>	A member who is eligible for both Medicare and Medicaid.
<b>ELIGIBILITY DETERMINATION</b>	A process of determining, through a written application, including required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI.
<b>EMERGENCY MEDICAL CONDITION</b>	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.
<b>EMERGENCY MEDICAL SERVICE</b>	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition.
<b>ENCOUNTER</b>	A record of a medically 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.
<b>ENROLLEE</b>	A Medicaid recipient who is currently enrolled with a contractor.
<b>ENROLLMENT</b>	The process by which an eligible person becomes a Title XIX or Title XXI funded member of Contractor's health plan



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<b>EPSDT</b>	Early and Periodic Screening, Diagnosis and Treatment; services for persons under 21 years of age as described in AHCCCS rules R9-22, Article 2.
<b>FAMILY PLANNING SERVICES EXTENSION PROGRAM</b>	A program that provides only family planning services for a maximum of 24 months to SOBRA women whose pregnancy has ended and the woman is not otherwise eligible for full Title XIX services.
<b>FEDERALLY QUALIFIED HEALTH CENTER (FQHC)</b>	An entity which meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian self-determination Act (PL 93-638) or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.
<b>FEE-FOR-SERVICE (FFS)</b>	A method of payment to registered providers on an amount-per service basis.
<b>FFP</b>	Federal financial participation (FFP) refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS as defined in 42 CFR 400.203.
<b>FISCAL YEAR (FY)</b>	The budget year - Federal Fiscal Year: October 1 through September 30; State fiscal year: July 1 through June 30.
<b>GATEKEEPER</b>	Primary care provider who is primarily responsible for all medical treatment rendered and who makes referrals as necessary and monitors the member's treatment.
<b>GEOGRAPHIC SERVICE AREA (GSA)</b>	A specific county or defined grouping of counties designated by the Administration within which a Contractor of record provides, directly or through subcontract, covered health care to members enrolled with that Contractor of record
<b>GROUP OF PROVIDERS</b>	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).
<b>HEALTH MAINTENANCE ORGANIZATION (HMO)</b>	Various forms of plan organization, including staff and group models, that meet the HMO licensing requirements of the Federal and/or State government and offer a full array of health care services to members on a capitated basis.
<b>HEALTH PLAN</b>	See "CONTRACTOR".
<b>HIFA PARENTS</b>	Parents of Medicaid (SOBRA) and KidsCare eligible children who are eligible for AHCCCS benefits under the HIFA Waiver. All eligible parents must pay an enrollment fee and a monthly premium based on household income.
<b>IBNR</b>	Incurred But Not Reported: Liability for services rendered for which claims have not been received.
<b>IHS</b>	Indian Health Services authorized as a Federal agency pursuant to 25 U.S.C. 1661.

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<b>IMD</b>	Institution For Mental Disease; An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. (42 CFR 435.1009)
<b>JPO</b>	Juvenile Probation Office
<b>KIDSCARE</b>	Individuals under the age of 19, eligible under the SCHIP program, in households with income at or below 200% FPL. Children, in households with incomes between 150% and 200% of the FPL, may participate in the program,.
<b>LIEN</b>	A legal claim filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
<b>MANAGED CARE</b>	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have significant financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality assurance and utilization review.
<b>MANAGEMENT SERVICES SUBCONTRACTOR</b>	A person or organization that agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to AHCCCSA under the terms of the contract.
<b>MANAGING EMPLOYEE</b>	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization or agency.
<b>MATERIAL OMISSION</b>	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
<b>MEDICAID</b>	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
<b>MEDICAL EXPENSE DEDUCTION (MED)</b>	Title XIX Waiver member whose income is more than 100% of the Federal Poverty Level, and has medical expenses that reduce income to or below 40% of the Federal Poverty Level. The 40% Federal Poverty Level will be adjusted annually to reflect annual Federal Poverty Level adjustments. MED's may have a categorical link to a Title XIX program; however, their income exceeds the limits of the Title XIX program.
<b>MEDICALLY NECESSARY SERVICES</b>	Those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability and other adverse health conditions or their progression or to prolong life.
<b>MEDICARE</b>	A Federal program authorized by Title XVIII of the Social Security Act, as amended.

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<b>MEDICARE PART D EXCLUDED DRUGS</b>	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 <i>AMPM</i> . 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.
<b>MEDICARE HMO</b>	A Health Maintenance Organization or Comprehensive Medical Plan, which provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.
<b>MEDICARE MODERNIZATION AND IMPROVEMENT ACT</b>	The Medicare Modernization and Improvement 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.
<b>MEMBER</b>	An eligible person who is enrolled in the system, as defined in A.R.S. § 36-2901 and A.R.S. §8-512.
<b>NON-CONTRACTING PROVIDER</b>	A person who provides services as prescribed in A.R.S. § 36-2939 and who does not have a subcontract with an AHCCCS Contractor.
<b>PERFORMANCE STANDARDS</b>	A set of standardized indicators designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors. Specific descriptions of health services measurement goals are found in Section D, Paragraph 13, Performance standards.
<b>PMMIS</b>	AHCCCSA's Prepaid Medical Management Information System.
<b>POTENTIAL ENROLLEE</b>	A Medicaid eligible recipient who is not enrolled with a contractor.
<b>POST STABILIZATION SERVICES</b>	Medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location.
<b>PRIMARY CARE PROVIDER (PCP)</b>	An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of a member's health care. A PCP may be a physician defined as a person licensed as allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.
<b>PRIOR PERIOD</b>	The period of time, prior to the member's enrollment, during which a member is eligible for covered services. The time frame is from the effective date of eligibility to the day a member is enrolled with a Contractor.
<b>PROVIDER</b>	Any person or entity who contracts with the AHCCCSA or a Contractor for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.

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<b>QUALIFIED MEDICARE BENEFICIARY (QMB)</b>	A person, eligible under A.R.S. § 36-2971(6), who is entitled to Medicare Part A insurance, meets certain income and residency requirements of the Qualified Medicare Beneficiary program. A QMB who is also eligible for Medicaid is commonly referred to as a QMB dual eligible.
<b>QISMC</b>	Quality Improvement System for Managed Care developed by the Centers for Medicare/Medicaid (CMS), formerly (HCFA), for use in evaluation and management of the quality of care provided by Medicare and Medicaid managed care contractors. QISMC serves as one of the key elements for the AHCCCS QM and UM requirements included in this contract.
<b>RATE CODE</b>	Eligibility classification for capitation payment purposes.
<b>REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)</b>	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.
<b>REINSURANCE</b>	A risk-sharing program provided by the Administration to Contractors for the reimbursement of certain contract service costs incurred by a member beyond a certain monetary threshold.
<b>RELATED PARTY</b>	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
<b>SCHIP</b>	State Children's Health Insurance Program under Title XXI of the Social Security Act.
<b>SCOPE OF SERVICES</b>	See "COVERED SERVICES".
<b>SOBRA</b>	Section 9401 of the Sixth Omnibus Budget and Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, 42 CFR U.S.C. 1396a(a)(10)(A)(ii)(IX), July 1, 1988.
<b>SPECIAL HEALTH CARE NEEDS</b>	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that required by members generally.
<b>STATE</b>	The State of Arizona.
<b>STATE PLAN</b>	The written agreements between the State and CMS which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
<b>SUBCONTRACT</b>	An agreement entered into by the Contractor with a provider of health care services who agrees to furnish covered services to members, or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCSA under the terms of this contract, as defined in R9-22-101.

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<b>SUBCONTRACTOR</b>	(1) A person, agency or organization with which the Contractor has contracted with or delegated some of its management functions or responsibilities to provide covered services to its members; or (2) A person, agency or organization that a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment or services provided under the AHCCCS agreement.
<b>SUPPLEMENTAL SECURITY INCOME (SSI)</b>	Federal cash assistance program under Title XVI of the Social Security Act.
<b>TEFRA RISK HMO</b>	A Health Maintenance Organization or Comprehensive Medical Plan, which provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.
<b>TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)</b>	Federal cash assistance program under the Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Act of 1996. It replaced Aid To Families With Dependent Children (AFDC).
<b>THIRD PARTY</b>	An individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member, as defined in R9-22-110.
<b>THIRD PARTY LIABILITY</b>	The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member, as defined in R9-22-110.
<b>TITLE XIX MEMBER</b>	Member eligible for Federally funded Medicaid programs under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act, Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI), SSI-related groups, Medicare Cost Sharing groups, Title XIX Waiver groups, Breast and Cervical Cancer Treatment program and Freedom to Work.
<b>TITLE XIX WAIVER MEMBER</b>	All MED (Medical Expense Deduction) members, and adults or childless couples at or below 100% of the Federal Poverty Level who are not categorically linked to another Title XIX program. This would also include Title XIX linked individuals whose income exceeds the limits of the categorical program.
<b>TITLE XXI MEMBER</b>	*Individual under the age of 19, eligible under the SCHIP program, in households with income at or below 200% FPL. Children, in households with incomes between 150% and 200% of the FPL may participate in the program, but are required to pay a premium amount based on the number of children in the family and gross family income.
<b>TRIBAL FACILITY (638 TRIBAL FACILITY)</b>	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.
<b>YEAR</b>	See "Contract Year".

[END OF DEFINITIONS]

**SECTION D: PROGRAM REQUIREMENTS**

**1. SCOPE OF SERVICES**

The Contractor shall provide covered services to AHCCCS members in accordance with all applicable Federal, State and local laws, rules, regulations and policies, including services listed in this document, listed by reference in attachments, and AHCCCS policies referenced in this document. The services are described in detail in AHCCCS Rules R9-22, Article 2 and, the *AHCCCS Medical Policy Manual (AMPM)*, all of which are incorporated herein by reference, except for provisions specific to the Fee-for-Service program, and may be found in the Bidder's Library. The covered services must be medically necessary and are briefly described below. Except for behavioral health and children's preventive dental services, covered services must be provided by, or coordinated with, a primary care provider. The Contractor must ensure the coordination of services it provides with services the member receives from other entities including behavioral health services the member receives through an ADHS/RBHA provider. The Contractor must ensure that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 Subparts A and E, to the extent that they are applicable. Services must be rendered by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider. The Contractor shall provide the same standard of care for all members regardless of the member's eligibility category. The Contractor must ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. The Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the service furnished can reasonably be expected to achieve the purpose.

**Authorization of Services:** For the processing of requests for initial and continuing authorizations of services, the Contractor shall have in place, and follow, written policies and procedures; The Contractor shall 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, shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

**Notice of Adverse Action:** The Contractor shall notify the requesting provider, and give the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, except for the requirement that the notice to the provider be in writing.

The Contractor shall ensure that its providers are not restricted or inhibited in any way from communicating freely with members regarding the members' health care, medical needs and treatment options even if needed services are not covered by the Contractor.

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

**Audiology** The Contractor shall provide audiology services to member under the age of 21 including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through medical or surgical means (i.e. hearing aids). Only the identification and evaluation of hearing loss are covered for member's 21 years of age and older unless the hearing loss is due to an accident or injury-related emergent condition.

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

***Behavioral Health:*** The Contractor shall provide behavioral health services as described in Section D, Paragraph 3, Behavioral Health Services.

***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 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 A.R.S. Title 36, Chapter 2, Article 3. Eligibility criteria and the referral process are described in the CRS Policy and Procedures Manual available in the Bidder's Library.

The Contractor shall monitor referrals to CRS to ensure covered services are provided in a timely manner to CRS recipients. Referral to CRS does not relieve the Contractor of the responsibility for providing medically necessary services not covered by CRS to CRS recipients. The Contractor is also responsible for initial care of newborn members, until those members become CRS recipients. The Contractor must require the member's Primary Care Provider (PCP) to coordinate their care with the CRS program.

A member with private insurance is not required to utilize CRS. If the member uses their private insurance network for a CRS covered condition, the Contractor is responsible for all-applicable deductibles and copays.

The Contractor remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition and emergency services related to a CRS condition rendered outside of the CRS network. The Contractor is not responsible for these services in instances for which the CRS eligible member 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 a recipient refuses to receive services from the CRS program, the Contractor shall proceed as outlined in R9-22-201(J).

***Chiropractic Services:*** The Contractor shall provide chiropractic services when prescribed by the member's PCP and approved by the Contractor in order to ameliorate the member's medical condition. Medicare approved chiropractic services shall also be covered, subject to limitations specified in CFR 410.22, for Qualified Medicare Beneficiaries if prescribed by the member's PCP and approved by the Contractor.

***Dental:*** The Contractor shall provide all members 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 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 13, Performance Standards. The Contractor shall ensure that members are notified when dental screenings are due if the member has not been scheduled for a visit. If no dental screening is received by the member, a second notice must be sent. Members may request dental services without referral and may choose a dental provider from the Contractor's provider network.

***Dialysis:*** The Contractor shall provide medically necessary dialysis, supplies, diagnostic testing and medication for all members when provided by Medicare-certified hospitals or Medicare-certified end stage renal disease (ESRD) providers. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services.

***Early and Periodic Screening, Diagnosis and Treatment (EPSDT):*** The Contractor shall provide comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by the screenings. The Contractor shall ensure that these members receive required health screenings, including developmental/behavioral health, in compliance with the AHCCCS periodicity schedule. The Contractor shall

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

submit all EPSDT reports to the AHCCCS Division of Health Care Management, as required by the *AMPM*. The Contractor is required to meet specific participation/utilization rates for members as described in Section D, Paragraph 13, Performance Standards. The Contractor shall ensure the initiation and coordination of a referral to the ADHS/RBHA system for members in need of behavioral health services. The Contractor shall follow up with the RBHA to monitor whether members have received behavioral health services.

**Emergency services:** The 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 the sudden onset of a medically emergent condition. Emergency medical services are covered without prior authorization. The Contractor is encouraged to contract with emergency service facilities for the provision of emergency services. The Contractor 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 Contractor shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. The Contractor shall monitor emergency service utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization;
- 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, 42 CFR 438.114, the following conditions apply with respect to coverage and payment of emergency services:

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

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

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

Additionally, the Contractor may not:

1. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
2. Refuse to cover emergency services based on the failure of the provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. This notification stipulation is only related to the provision of emergency services.

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

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



**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

**Eye Examinations/Optomety:** The Contractor shall provide all medically necessary emergency eye care, vision examinations, prescriptive lenses, and treatments for conditions of the eye for all members.

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

**Home Health:** This service shall be provided under the direction of a physician to prevent hospitalization or institutionalization and may include nursing, therapies, supplies and home health aide services. It shall be provided on a part-time or intermittent basis.

**Hospice:** These services are covered for members who are certified by a physician as being terminally ill and having six months or less to live. See the *AMPM* for details on covered hospice services.

**Hospital:** Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health emergency/crisis services. If the member's medical condition requires isolation; private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. Outpatient hospital services include any of the above services, which may be appropriately provided on an outpatient or ambulatory basis (i.e. laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis if determined reasonable and necessary, when deciding 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:** Immunization requirements include diphtheria, tetanus, pertussis vaccine (DTaP) or (DPT), inactivated polio vaccine (IPV), measles, mumps, rubella (MMR) vaccine, H. influenza, type B (HIB) vaccine, hepatitis B (Hep B) vaccine, and varicella zoster virus (VZV) vaccine, and pneumococcal conjugate vaccine (PCV) Immunizations for AHCCCS members younger than age 19 are provided under the Federal Vaccines for Children (VFC) program. The Contractor is required to meet specific immunization rates, which are described in Section 13 Performance Standards.

**Indian Health Services (IHS):** AHCCCSA will reimburse claims on a FFS basis to providers for acute care services that are medically necessary and eligible for 100% Federal reimbursement, and that are provided to Title XIX members in an IHS or a 638 tribal facility. The Contractor is responsible for reimbursement to IHS or tribal facilities for emergency services provided to Title XXI Native American members enrolled with the Contractor. The Contractor may choose to subcontract with and pay an IHS or 638 tribal facility as part of their provider network for delivery of covered services; however the Contractor will be liable for the cost of the care in the event they choose to do so.

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

Upon written request, a Contractor may obtain laboratory test data on members from a free-standing laboratory or hospital based laboratory subject to the requirements specified in A.R.S. § 36-2903(R) and (S).

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

The data shall be used exclusively for quality improvement activities and health care outcome studies required and/or approved by the Administration.

**Maternity:** The Contractor shall provide pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for female members.

All female CMDP members are considered to have high-risk pregnancy due to their age, therefore, services must be provided by a physician, physician assistants, nurse practitioners, or certified nurse midwives. Such members may select or be assigned to a PCP specializing in obstetrics. The Contractor shall allow mothers 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 48-hour minimum length of stay. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96-hour stay.

The Contractor shall inform all assigned AHCCCS pregnant members of voluntary prenatal HIV testing and the availability of medical counseling if the test is positive. The Contractor shall provide information in the member handbook and annually in the member newsletter to encourage pregnant members to be tested and provides instructions about where testing is available. Semi-annually, the Contractor shall report to AHCCCS the number of pregnant members 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 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.

**Nursing Facility:** The Contractor shall provide services in nursing facilities, including religious non-medical health care institutions, for members who require short-term convalescent care not to exceed 90 days per contract year. In lieu of a nursing facility, the member may be placed in an assisted living facility or alternative residential setting, or receive home and community based services (HCBS) as defined in R9-22, Article 2 and R9-28, Article 2 that meet the provider standards described in R9-28, Article 5, and subject to the limitations set forth in the *AMPM*.

Nursing facility services must be provided in a dually-certified Medicare/Medicaid nursing facility which includes in the per-diem rate: nursing services, basic patient care equipment and sickroom supplies, dietary services, administrative physician visits, non-customized DME, necessary maintenance and rehabilitation therapies, over-the-counter medications, social, recreational and spiritual activities, and administrative, operational medical direction services. See Paragraph 32, Nursing Facility Reimbursement, for further details.

The Contractor shall notify the Assistant Director of the Division of Member Services in writing when a member has been residing in a nursing facility for 75 days. This will allow AHCCCSA time to follow-up on the status of the ALTCS application and to prepare for potential fee-for-service coverage if the stay goes beyond the 90-day maximum.

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

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

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

**Podiatry:** The 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, and 42 CFR 422.113(c), the following conditions apply with respect to coverage and payment of post-stabilization care services:

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

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

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

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

**Pregnancy Terminations:** CMDP 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

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

to the CMDP 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 Drugs:** Medications ordered by a PCP, attending physician or dentist and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, Contractor formularies and prior authorization requirements. Contractors may include over-the-counter medications in their formulary. Appropriate over-the-counter medication may be prescribed when it is determined to be a lower-cost alternative to 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 gatekeeper and coordinator in referring the member for specialty medical services. 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 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. Physical therapy and occupational and speech therapies are covered on both an inpatient and outpatient basis if not used as a maintenance regimen.

**Respiratory Therapy:** This therapy is covered on an inpatient and outpatient setting 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. Such limitations include whether the stage of the disease is such that the transplant can affect the outcome; the member has no other conditions that substantially reduce the potential for successful transplantation; and whether the member will be able to comply with necessary and required regimens of treatment. Bone grafts are also covered under this service. 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 or has received 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 Contractor's use or the Contractor may select its own transplantation provider.

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

**Triage/Screening and Evaluation:** These are covered services when provided by acute care hospitals and IHS facilities to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine what services are necessary to alleviate or stabilize the emergent condition.

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

**2. SPECIAL HEALTH CARE NEEDS**

The Contractor shall have in place a mechanism to identify and stratify all members with special health care needs. The Contractor shall 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. The assessment mechanisms shall use appropriate health care professionals. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs.

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

The Contractor shall have a methodology to identify providers willing to provide medical home services and make reasonable efforts to offer access to these providers.

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

- Accessible
- Continuous
- Coordinated
- Family-centered
- Comprehensive
- Compassionate
- Culturally effective.

**3. BEHAVIORAL HEALTH SERVICES**

AHCCCS members are eligible for comprehensive behavioral health services. With the exception of the Contractor's providers' medical management of certain behavioral health conditions as described under "medication Management Services" below, the behavioral health benefit for these members is provided through the ADHS - Regional Behavioral Health Authority (RBHA) system. The Contractor shall be responsible for member education regarding these benefits; provision of limited emergency inpatient services; and screening and referral to the RBHA system of members identified as requiring behavioral health services.

**Member Education:** The Contractor shall be responsible for educating members in the member handbook and other printed documents about covered behavioral health services and where and how to access services. Covered services include:

- a. Behavior Management (behavioral health personal assistance, family support, peer support)
- b. Case Management Services
- c. Emergency/Crisis Behavioral Health Services
- d. Emergency Transportation
- e. Evaluation and Screening
- f. Group Therapy and Counseling
- g. Individual Therapy and Counseling
- h. Family Therapy and Counseling

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

- i. Inpatient Hospital
- j. Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
- k. Institutions for Mental Diseases (with limitations)
- l. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
- m. Non-Emergency Transportation
- n. Partial Care (Supervised day program, therapeutic day program, and medical day program)
- o. Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching and employment support)
- p. Psychotropic Medication
- q. Psychotropic Medication Adjustment and Monitoring
- r. Respite Care (with limitations)
- s. Therapeutic foster care services

**Referrals:** As specified in Section D, Paragraph 1, Scope of Services, EPSDT, the Contractor must provide developmental/behavioral health screenings in compliance with the AHCCCS periodicity schedule. The Contractor shall ensure the initiation and coordination of behavioral health referrals of these members to the RBHA when determined necessary through the screening process. The Contractor coordinates RBHA referrals and follow-up collaboration, as necessary, for other members identified as needing behavioral health evaluation and treatment.

Members may also access the RBHA system for evaluation by self-referral or be referred by schools, State agencies or other service providers. The Contractor is responsible for providing transportation to a member's first RBHA evaluation appointment if a member is unable to provide his/her own transportation.

**Emergency Services:** For those members who are not ADHS behavioral health recipients, the Contractor is responsible for up to three days of inpatient behavioral health services per emergency episode, not to exceed 12 days per contract year. A referral to the RBHA for evaluation and identification as an ADHS behavioral health recipient should be initiated as soon as possible after admission.

When members present in an emergency room setting, the Contractor is responsible for all emergency medical services including triage, physician assessment and diagnostic tests. For members who are not ADHS behavioral health recipients, the Contractor is responsible to provide medically necessary psychiatric consultations or psychological consultations in emergency room settings to help stabilize the member or determine the need for inpatient behavioral health services. ADHS is responsible for medically necessary psychiatric consultations provided to ADHS behavioral health recipients in emergency room settings.

**Coordination of Care:** The Contractor is responsible for ensuring that a medical record is established by the PCP when behavioral health information is received from the RBHA or provider about an assigned member even if the PCP has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established. The Contractor shall require the PCP to respond to RBHA/provider information requests pertaining to ADHS behavioral health recipients within 10 business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations. The Contractor shall require the PCP to document or initial signifying review of member behavioral health information received from a RBHA behavioral health provider who is also treating the member. For prior period coverage, the Contractor is responsible for payment of all claims for medically necessary covered behavioral health services to members who are not ADHS behavioral health recipients.

**Medication Management Services:** The Contractor shall allow PCPs to provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of depression, anxiety and

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

attention deficit hyperactivity disorder. The Contractor shall make available, on the Contractor's formulary, medications for the treatment of these disorders.

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

**Transfer of Care:** When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP or contractor that the member should be transferred to a RBHA prescriber for evaluation and/or continued medication management services, the Contractor will require and ensure that the PCP or contractor coordinates the transfer of care. The Contractor shall establish policies and procedures for the transition of members who are referred to the RBHA for ongoing treatment. The contractor shall ensure that PCPs maintain continuity of care for these members.

The policies and procedures must address, at a minimum, the following:

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

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

**4. AHCCCS POLICY MANUALS**

The *AHCCCS Medical Policy Manual (AMPM)* and the *AHCCCS Contractor Operations Manual (ACOM)* are hereby incorporated by reference into this contract. The Contractor is responsible for complying with the requirements set forth within. The *AMPM* and *ACOM* with search capability and linkages to AHCCCS rules, Statutes and other resources is available to all interested parties through the AHCCCS Home Page on the Internet ([www.azahcccs.gov](http://www.azahcccs.gov)). Upon adoption by AHCCCSA, *AMPM* and *ACOM* updates will be available through the Internet at the beginning of each month. The Contractor shall be responsible for maintaining such copies current with these updates.

**5. PEDIATRIC IMMUNIZATION AND VACCINE FOR CHILDREN PROGRAM**

Through the Vaccine for Children Program, the Federal and State governments purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. The Contractor shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. If vaccines are not available through, the VFC Program, the Contractor shall contact AHCCCS, 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 Contractor shall not reimburse providers for the administration of the vaccines in excess of the maximum allowable as set by CMS. The Contractor shall comply with all VFC requirements and monitor its providers to ensure that, if providing immunizations to AHCCCS members under the age of 19, the providers are 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 are encouraged to educate their provider network about these reporting requirements and the use of this resource.

**6. ENROLLMENT AND DISENROLLMENT**

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

DCYF is responsible for determining Title XIX eligibility for the children entitled to CMDP coverage. Upon notification from DCYF that a CMDP covered child qualifies for Title XIX, AHCCCSA will enroll the child with CMDP as the Title XIX health plan. AHCCCSA shall in turn notify CMDP of the child's AHCCCSA enrollment, and CMDP shall ensure that the member is enrolled in CMDP's Title XIX line of business. DCYF is responsible for notifying AHCCCSA when a member is no longer eligible for Title XIX or no longer meets the criteria for CMDP coverage as set forth in A.R.S. 8-512. AHCCCS shall notify CMDP when a member's Title XIX enrollment in CMDP has terminated, and CMDP shall disenroll the member from CMDP's Title XIX line of business. AHCCCSA is responsible for determining Title XXI eligibility. AHCCCSA shall notify CMDP when a child qualifies for Title XXI and CMDP coverage. CMDP shall ensure that the member is enrolled in CMDP's Title XXI line of business. AHCCCSA shall notify CMDP if a Title XXI child no longer meets the criteria for Title XXI eligibility, and CMDP shall disenroll such child from the Title XXI line of business. If a Title XXI eligible child no longer meets the criteria for CMDP coverage as set forth in A.R.S.



**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

8.512, CMDP shall notify AHCCCSA, and the child shall be disenrolled from CMDP, by AHCCCSA and CMDP. CMDP may not disenroll because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Eligibility for the various AHCCCS coverage groups is determined by one of the following agencies:

*Social Security Administration (SSA)* SSA determines eligibility for the Supplementary Security Income (SSI) cash program. SSI cash recipients are automatically eligible for AHCCCS coverage.

*Department of Economic Security (DES)* DES determines eligibility for the families with children, under section 1931 of the Social Security Act, pregnant women and children under SOBRA, the Adoptions Subsidy Program, Title IV-E foster care children, Young Adult Transition Insurance Program, the Federal Emergency Services program (FES), HIFA parents of SOBRA eligible children, the Title XIX Waiver Members.

*AHCCCSA* AHCCCSA determines eligibility for the SSI/MAO groups, including the FES program for this population (aged, disabled, blind), the Arizona Long-Term Care System (ALTCS), the Qualified Medicare Beneficiary program and other Medicare cost sharing programs, BCCTP, the Freedom to Work program, the Title XXI KidsCare program, and HIFA parents of KidsCare children.

AHCCCS acute care members are enrolled with contractors in accordance with the rules set forth in R9-22, Article 17, R9-31-306, 3-7, 309, and 1719.

***Prior Period Coverage:*** AHCCCS provides prior period coverage for the period of time, prior to the Title XIX 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 the Contractor. The Contractor receives notification from the Administration of the member's enrollment. The Contractor is responsible for payment of all claims for medically necessary covered services provided to members during prior period coverage. This may include services provided prior to the contract year (See Section D, Paragraph 33, Compensation, for a description of the Contractor's reimbursement from AHCCCSA for this eligibility time period.)

***Newborns:*** The Contractor is responsible for notifying AHCCCSA of a child's birth to an enrolled member. Capitation to the Contractor will begin on the date notification is received by AHCCCSA (except for cases of births during prior period coverage) if the newborn is eligible for CMDP. The effective date of AHCCCS eligibility will be the newborn's date of birth. The Contractor is responsible for all covered services to the newborn whether or not AHCCCS has received notification of the child's birth, for children who are eligible for CMDP coverage as set forth in A.R.S. 8-512. If the newborn meets statutory requirements for CMDP coverage, CMDP shall remain the newborn's health plan. AHCCCSA is currently available to receive notification 24 hours a day, 7 days a week via phone or the AHCCCS web site.

## **7. MAINSTREAMING OF AHCCCS MEMBERS**

To ensure mainstreaming of AHCCCS members, the Contractor shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, sex, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated. Contractors must take into account a member's culture, when addressing members and their concerns, and must take reasonable steps to encourage subcontractors to do the same. The Contractor must make interpreters of any language available free of charge for all members to ensure appropriate delivery of covered services. The Contractor must provide members with information instructing them about how to access these 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 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, sex, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental handicap of the participants to be served.

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

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

## **8. MEMBER INFORMATION**

The Contractor shall be accessible by phone for general member information during normal business hours. All enrolled members will have access to a toll free phone number. All informational materials, prepared by the Contractor, shall be approved by 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 Contractor is aware that a language is spoken by 3,000 or 10%, whichever is less, of the Contractor's members, who also have limited English proficiency (LEP).

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

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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

Oral interpretation services must be available and free of charge to all members regardless of the prevalence of the language. The Contractor must notify all member of their right to access oral interpretation services and how to access them. Refer to the AHCCCS, Division of Health Care Management *Member Information Policy*.

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written at a 4th grade level. Regardless of the format chosen by the Contractor, the member information must be printed in a type, style and size, which can easily be read by members with varying degrees of visual impairment. The Contractor must notify its members that alternative formats are available and how to access them.

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

The Contractor shall produce and provide the following printed information to each member or family within 10 days of receipt of notification of the enrollment date:

- I. A *member handbook* which, at a minimum, shall include the items listed in the AHCCCS, Division of Health Care Management *Member Information Policy*.

The Contractor shall review and update the Member Handbook at least once a year. The handbook must be submitted to AHCCCS, Division of Health Care Management for approval by September 1<sup>st</sup> of each contract year, or within four weeks of receiving the annual renewal amendment, whichever is later.

The Contractor must give written notice about termination of a 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.

**9. SURVEYS**

The Contractor shall perform its own annual general or focused member survey. All such contractor surveys, along with a timeline for the project, shall be approved in advance by AHCCCS DHCM. The results and the analysis of the results shall be submitted to the Health Plan Operations Unit within 45 days of the completion of the project. AHCCCSA may require inclusion of certain questions. The Contractor will not be required to conduct its own member survey during CYE '05.

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

**10. TRANSITION OF MEMBERS**

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

The Contractor shall comply with the *AMPM*, and the *Division of Health Care Management Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* for member transitions between health plans or GSA's, participation in or discharge from CRS, to or from an ALTCS Program Contractor, IHS, a PL 93-638 tribal entity, and upon termination or expiration of a contract. The Contractor shall develop and implement policies and procedures, which comply with these policies to address transition of members.

When relinquishing members, the Contractor is responsible for timely notification to the receiving Contractor regarding pertinent information related to any special needs of transitioning members. The Contractor, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor in order that services not be interrupted, and for providing the new member with health plan and service information, emergency numbers and instructions of how to obtain services.

**11. STAFF REQUIREMENTS AND SUPPORT SERVICES**

The Contractor shall have in place the organization, management and administrative systems capable of fulfilling all contract requirements. For 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 No 12549 or under guidelines implementing Executive Order 1254. The 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., j., m., n., o., and p. below. The Contractor must obtain for approval and must include a description of the processes in place that assure rapid responsiveness to effect change for contract compliance. The Contractor shall be responsible for any additional costs associated with on-site audits or other oversight activities which result from requirement system located outside the State of Arizona. At a minimum, the following staff is required.

- a. A full-time **Administrator/CEO/COO** who is available at all times to fulfill the responsibilities of the position and to oversee the entire operation of the health plan. The Administrator shall devote sufficient time to the Contractor's operations to ensure adherence to program requirements and timely response to AHCCCS Administration.
- b. A **Medical Director** who shall be an Arizona-licensed physician. The Medical Director shall be actively involved in all-major clinical programs and QM/UM components of the Contractor's health plan. The Medical Director shall devote sufficient time to the Contractor's health plan to ensure timely medical decisions, including after-hours consultation as needed.
- c. A **Chief Financial Officer/CFO** who is available at all times to fulfill the responsibilities of the position and to oversee the budget and accounting systems implemented by the Contractor.
- d. A **Quality Management/Utilization Management Coordinator** who is an Arizona-licensed registered nurse, physician or physician's assistant.
- e. A **Maternal Health/EPSTD Coordinator** who shall be an Arizona-licensed registered 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.
- f. A **Behavioral Health Coordinator** who shall be a behavioral health professional as described in Health Services Rule R9-20. The Behavioral Health Coordinator shall devote sufficient time to ensure that the Contractor's behavioral health referral and coordination activities are implemented per AHCCCSA requirements.
- g. **Prior Authorization staff** to authorize health care. This staff shall include 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 registered nurse, physician, physician's assistant or an Arizona-licensed practical nurse

**SECTION D:  
PROGRAM REQUIREMENTS**

**Contract/RFP No. YH02-0018**

- experienced in concurrent review and under the direct supervision of a registered nurse, physician or physician's assistant.
- i. **Member Services Manager and staff** to coordinate communications with members and act as member advocates. There shall be sufficient Member Service staff to enable members to receive prompt resolution to their problems, and to meet the Contractor's standards for telephone abandonment rates and telephone hold times.
  - j. **Provider Services Manager and staff** to coordinate communications between the Contractor and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the AHCCCS program.
  - k. A **Claims Administrator and Claims Processors** to ensure the timely and accurate processing of original claims, re-submissions and overall adjudication of claims.
  - l. **Encounter Processors** to ensure the timely and accurate processing and submission to AHCCCSA of encounter data and reports.
  - m. A **Grievance Manager** is responsible for the oversight of the Contractor's grievance system for members and providers.
  - n. **Compliance Officer** who will implement and oversee the Contractor's compliance program. The compliance officer shall be an, on-site management official, available to all employees, with designated and recognized authority to access records and make independent referrals to the AHCCCSA, Office of Program Integrity. See Paragraph 59, Corporate Compliance, for more information.
  - o. **Health Plan Staff** sufficient to implement and oversee compliance with both the Contractor's Cultural Competency Plan and the *AHCCCS Cultural Competency Policy*, and to oversee compliance with all AHCCCS requirements pertaining to limited English proficiency (LEP).
  - p. **Clerical and Support staff** to ensure appropriate functioning of the Contractor's operation.
  - q. **Business Continuity Planning Coordinator** as noted in the *DHCM Business Continuity and Recovery Policy*.

The Contractor shall inform AHCCCSA, DHCM, in writing, within seven days, when an employee leaves one of the key positions listed below. The name of the interim contact person should be included with the notification. The name and resume of the permanent employee should be submitted as soon as the new hire has taken place.

Administrator	Member Services Manager
Medical Director	Provider Services Manager
Chief Financial Officer	Claims Administrator
Maternal Health/ EPSDT Coordinator	Quality Management/Utilization Management
Grievance Manager	Coordinator
Compliance Officer	Behavioral Health Coordinator

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

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

The Contractor shall develop and maintain written policies, procedures and job descriptions for each functional area of its health plan, consistent in format and style. The Contractor shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the Contractor's written policies reflect current practices. Reviewed policies shall be dated and signed by the Contractor's appropriate manager, coordinator, director or administrator. All medical and quality management policies must be approved and

signed by the Contractor's Medical Director. Job descriptions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements.

### **13. PERFORMANCE STANDARDS**

#### **Administrative Measures:**

The Contractor shall meet the following standards for its Member Services telephone statistics. All calls to the line shall be included in the measure.

- a. First Contact Call Resolution shall be 70% or better; and
- b. Phone accessibility complaints.

The Contractor shall set standards for the above measures for all centralized provider lines, including but not limited to those used for Prior Authorization and Claims Inquiry/Research. These standards shall be submitted to AHCCCS for approval within 10 days of the beginning of this contract and prior to implementation of revisions to the approved standards.

First Contact Call Resolution Rate (FCCR) is:

Number of calls received in 24-hour period for which no follow up communication or internal phone transfer is needed, divided by Total number of calls received in 24-hour period

The daily FCCRs are then summed and divided by the number of days in the reporting period.

Note: Do **not** use average daily service levels divided by the days in the reporting period.

On a monthly basis the measures are to be reported for both the Member Services and Provider telephone lines. For each of the Administrative Measures, the Contractor shall also report the number of days in the reporting period that the standard was not met. The Contractor shall include in the report the instances of down time for the centralized telephone lines, the dates of occurrence and the length of time they were out of service. The reports should be sent to the Contractor's assigned Operations and Compliance Officer in the Health Plan Operations Unit of the Division of Health Care Management. The deadline for submission of the reports is the 15th day of the month following the reporting period (or the first business day following the 15th). Back up documentation for the report, to the level of measured segments in the 24-hour period, shall be retained for a rolling 12-month period.

AHCCCSA will review the performance measure calculation procedures and source data for this report.

#### **Performance Measures:**

All Performance Standards described below apply to all member populations.

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

Any statistically significant drop in the Contractor's performance level for any indicator must be explained by the Contractor in its annual quality management program evaluation. If a Contractor has a significant drop in any indicator without a justifiable explanation, it will be required to submit a corrective action plan and may be subject to sanctions.

AHCCCS has established three levels of performance:

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

**Minimum Performance Standard** – A Minimum Performance Standard is the minimal expected level of performance by the Contractor. If a Contractor does not achieve this standard, or any indicator 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 indicator for the Contract Year. If the Contractor has already met or exceeded the AHCCCS Minimum Performance Standard for any indicator, the Contractor must strive to meet the established Goal for the indicator(s).

**Benchmark** – A Benchmark is the ultimate standard to be achieved. Contractors that have already achieved or exceeded the Goal for any performance indicator must strive to meet the Benchmark for the indicator(s). Contractors that have achieved the Benchmark are expected to maintain this level of performance for future years.

A Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions on Contractors that do not meet the Minimum Performance Standard and do not show statistically significant improvement in an indicator rate and/or require those Contractors to demonstrate that they are allocating increased administrative resources to improving rates for a particular indicator or service area. AHCCCS also may require a corrective action plan of any 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 Indicators:** The Contractor shall comply with AHCCCS quality management requirements to improve performance for all AHCCCS established performance indicators. Complete descriptions of these indicators can be found in the most recently published Results and Analysis of Acute-care Performance Measures. The indicators for postpartum visits and low birth weight deliveries have been eliminated as contractual performance standards. The Contractor shall continue to monitor rates for postpartum visits and low birth weight deliveries and implement interventions as necessary to improve or sustain these rates. 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 indicators may be subject to change when these core measures are finalized and implemented.

In addition, AHCCCS has established standards for the following indicators:

**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.

**Pediatric immunizations:** The Contractor shall ensure members under age 21 receive age-appropriate immunizations as specified in the *AMPM*.

The Contractor shall participate in immunization audits, at intervals specified by AHCCCSA, based on random sampling to assess and verify the immunization status of two-year-old members. AHCCCS will provide the Contractor the selected sample, specifications for conducting the audit, the AHCCCSA reporting

**SECTION D:  
PROGRAM REQUIREMENTS**

**Contract/RFP No. YH02-0018**

requirements, and technical assistance. The Contractor shall identify each child’s PCP, conduct the assessment, and report to AHCCCSA, in the required format, all immunization data for the two-year-old children sampled. If medical records are missing for more than 5 percent of the sample group, the Contractor is subject to sanctions by AHCCCSA. An External Quality Review Organization (EQRO) may conduct a study to validate the Contractor’s reported rates.

The following table identifies the Minimum Performance Standards, Goals and Benchmarks for each indicator:

**Acute-care Contractor Performance Standards**

Performance Indicator	CYE 05 Minimum Standard	Performance	CYE 05 Goal	Benchmark (Healthy People Goals)
Immunization of Two-year-olds				
4:3:1 Series	80%		83%	90%
4:3:1:3:3 Series (1)	70%		75%	90%
DTaP - 4 doses	83%		86%	90%
Polio - 3 doses	89%		90%	90%
MMR - 1 dose	90%		90%	90%
Hib - 3 doses (1)	76%		77%	90%
HBV - 3 doses	82%		88%	90%
Varicella - 1 dose	77%		81%	90%
Adolescent Immunizations (2)	60%		63%	90%
Dental Visits	49%		56%	56%
Well-child Visits 15 Months	70%		72%	90%
Well-child Visits 3 - 6 Years	55%		67%	80%
Adolescent Well-care Visits (3)	32%		34%	50%
EPSDT Participation (4)	58%		80%	80%
Children's Access to PCPs	79%		82%	97%

- (1) New standards are based on 3 doses of Hib; MPS for Hib vaccination is based on NCQA 2002 Medicaid average of 74%.
- (2) New standard measures whether members had a second dose of MMR by their 13th birthdays; MPS is based on NCQA 2002 Medicaid average of 57%.
- (3) Current rate and new standards are based on at least one visit in a one-year period (currently measured but not reported).
- (4) MPS and Goal were left at CYE 2004 levels as these standards have not been reported by Contractor in the last two years.

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

**Quality Assessment Program**

The Contractor shall have an ongoing quality assessment program for the services it furnishes to members that includes the following:

1. The program shall 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 member satisfaction.
2. Annually, the Contractor shall:
  - a. If required, measure and report to the State its performance, using standard measures required by the State, or
  - b. Submit to the State, data specified by the State, that enables the State to measure the Contractor’s performance; or



**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

- c. Perform a combination of the activities.
3. The Contractor shall have in effect mechanisms to detect both underutilization and over utilization of services.
4. The Contractor shall have in effect mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs.

**Performance Improvement Program**

The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:

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

**14. QUALITY MANAGEMENT AND UTILIZATION MANAGEMENT (QM/UM)**

***Quality Management (QM):*** The Contractor shall provide quality medical care to members, regardless of payer source or eligibility category. The 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 Contractor shall execute processes to assess, plan, implement and evaluate quality management and performance improvement activities, as specified in the AMPM, that include at least the following [42CFR 438.240(a)(1) and (e)(2)]:

- Conducting Performance Improvement Projects (PIPs);
- QM monitoring and evaluation activities;
- Credentialing, recredentialing and provisional credentialing processes for provider and organizations [42 CFR 438.206(b)(6)].
- Investigation, analysis, tracking and trending of quality of care issues, abuse and/or complaints; and
- AHCCCS mandated performance measures.

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

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

The Contractor shall submit, within timelines specified in Attachment F, a written QM plan that addresses its strategies for performance improvement and conducting the quality management activities described in this section. The Contractor shall conduct performance improvement projects as required in the AMPM.

The Contractor may combine its quality management plan with the plan that addresses utilization management as described below.

The Contractor shall execute a process to assess, plan, implement and evaluate quality management activities, as specified in the AMPM, that include the Quarterly Quality Management Report.

**SECTION D:  
PROGRAM REQUIREMENTS**

**Contract/RFP No. YH02-0018**

**Utilization Management (UM):** The Contractor shall execute processes to assess, plan, implement and evaluate utilization management activities, as specified in the *AMPM*, that include at least the following:

- Pharmacy Management
- Prior Authorization
  - a. For the processing of requests for initial and continuing authorizations of services the 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)]
  - b. Adoption of Practice Guidelines [42 CFR 438.236(b)], that
    1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
    2. Consider the needs of the Contractor's members;
    3. Are adopted in consultation with contracting health care professionals;
    4. Are disseminated by the Contractor to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    5. 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)]
- Concurrent review;
- Continuity and coordination of care;
- Monitoring and evaluation of over and/or under utilization of services [42 CFR 438.240(b)(3)];
- Evaluation of new medical technologies, and new uses of existing technologies; Development and/or adoption of practice guidelines;
- Development and/or adoption of practice guidelines;
- Consistent application of review criteria;
- Disease Management Program results; and
- Quarterly Utilization Management Report (details in the *AMPM*).

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

**15. PHYSICIAN INCENTIVES**

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

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

1. A complete copy of the contract
2. A plan for the member satisfaction survey
3. Details of the stop-loss protection provided
4. A summary of the compensation arrangement that meets the substantial financial risk definition.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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

The Contractor shall also provide for compliance with physician incentive plan requirements as set forth in 42 CFR 422. These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

**16. APPOINTMENT STANDARDS**

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

- a. Emergency PCP appointments - same day of request
- b. Urgent care PCP appointments - within 2 days of request
- c. Routine care PCP appointments - within 21 days of request

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

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

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

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

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

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

If a member needs non-emergent medically necessary transportation, the Contractor shall require its transportation provider to schedule the transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; does not have to wait more than one hour after making the call to be picked up; nor have to wait for more than one hour after conclusion of the appointment for transportation home.

The Contractor shall actively monitor the adequacy of its appointment processes and reduce the unnecessary use of alternative methods such as emergency room visits. The Contractor shall actively monitor and ensure that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the provider is unavailable due to an emergency.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

The Contractor shall have written policies and procedures about educating its provider network regarding appointment time requirements. The Contractor must assign a specific staff member or unit within its organization to monitor compliance with appointment standards, and shall require a corrective action plan when appointment standards are not met. Appointment standards shall be included in the Provider Manual. The Contractor is encouraged to include the standards in the provider subcontract.

**17. REFERRAL PROCEDURES AND STANDARDS**

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

- a. Use of referral forms
- b. A system for resolving disputes regarding the referrals
- c. 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. 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. Any waiver of this requirement by the Contractor must be approved in advance by AHCCCSA.
- d. A process in place that ensures the member's PCP receives all specialist and consulting reports and a process to ensure PCP follow-up of all referrals including EPSDT referrals for behavioral health services
- e. A referral plan for any member who is about to lose eligibility and who requests information on low-cost or no-cost health care services
- f. Referral to Medicare HMO including payment of copayments
- 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.
- h. Specialty Physicians shall not begin a course of treatment for a medical condition other than that for which a member was referred, unless approved by the member's PCP.

The Contractor shall comply with all applicable physician referral requirements and conditions defined in Sections 1903(s) and 1877 of the Social Security Act. Upon finalization of the regulations, the 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 include:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Radiology services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

**18. PROVIDER MANUAL**

The Contractor shall develop, distribute and maintain a provider manual. The Contractor shall ensure that all providers within its Preferred Provider Network (PPN) and high volume providers outside of the PPN (as defined by the Contractor), are issued a copy of the Provider Manual. The Provider Manual will also be available on the Contractor's website. The 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 Contractor's provider manual must contain information on the following:

- a. Introduction to the Contractor which explains the Contractor's organization and administrative structure
- b. Provider responsibility and the Contractor's expectation of the provider
- c. Overview of the Contractor's Provider Service department and function
- d. Listing and description of covered and non-covered services, requirements and limitations including behavioral health services
- e. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
- f. EPSDT Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations
- g. Dental services
- h. Maternity/Family Planning services
- i. The Contractor's policy regarding PCP assignments
- j. Referrals to specialists and other providers, including access to behavioral health services provided by the ADHS/RBHA system.
- k. Grievance system process and procedures for providers and enrollees
- l. Billing and encounter submission information
- m. Information about policies and procedures relevant to the providers including, but not limited to, utilization management and claims submission
- n. Reimbursement, including reimbursement for dual eligible (i.e. Medicare and Medicaid) or members with other insurance
- o. Explanation of remittance advice
- p. Prior authorization and notification requirements
- q. Claims medical review
- r. Concurrent review
- s. Fraud and Abuse
- t. Formularies (with updates and changes provided in advance to providers, including pharmacies)
- u. AHCCCS appointment standards
- v. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable
- w. Eligibility verification
- 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. Peer review and appeal process
- z. Advance directives

**19. PRIMARY CARE PROVIDER STANDARDS**

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

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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

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

To the extent required by this contract, the Contractor shall offer members freedom of choice within its network in selecting a PCP. The Contractor may restrict this choice when a member has shown an inability to form a relationship with a PCP, as evidenced by frequent changes, or when there is a medically necessary reason. When a new member has been assigned to the Contractor, the Contractor shall inform the member in writing of his enrollment and of his PCP assignment no later than 10 days of the Contractor's receipt of notification of assignment by AHCCCSA. The Contractor shall include with the enrollment notification a list of all the Contractor's available PCPs, the process for changing the PCP assignment, should the member desire to do so, as well as the information required in the AHCCCS Division of Health Care Management *Member Information Policy*. The Contractor shall confirm any PCP change in writing to the member. Members may make both their initial PCP selection and any subsequent PCP changes either verbally or in writing.

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

- a. Supervision, coordination and provision of care to each assigned member
- 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.

The Contractor shall establish and implement policies and procedures to monitor PCP gatekeeping 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, dentists and other health care professionals. Contractor policies and procedures shall be subject to approval by AHCCCSA, Division of Health Care Management, and shall be monitored through operational audits.

**20. OTHER PROVIDER STANDARDS**

The Contractor shall develop and implement policies and procedures to:

- a. Recruit sufficient specialty physicians, dentists, health care professionals, health care institutions and support services to meet the medical needs of its members.
- b. 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.

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

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

For specialty services, the Contractor shall ensure that:

- a. PCP referral shall be required for specialty physician services, except that women shall have direct access to GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services. Any waiver of this requirement by the Contractor must be approved in advance by AHCCCSA.
- b. 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.
- c. The specialty physicians shall provide to the member's PCP complete documentation of all diagnostic services including copies of test results; if applicable; treatment services provided; and the resulting outcome for each.

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

- a. Arizona licensed allopathic and/or osteopathic physicians who are general practitioners or specialize in family practice or obstetrics
- b. Physician Assistants
- c. Nurse Practitioners
- d. Certified Nurse Midwives

Members may choose, or be assigned, a PCP who provides obstetric care. Such assignment shall be consistent with the freedom of choice requirements for selecting health care professionals while ensuring that the continuity of care is not compromised.

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

**21. NETWORK DEVELOPMENT**

The Contractor shall develop and maintain a provider network that is designed to support a medical home for members and sufficient to provide all covered services to AHCCCS members. The Contractor shall ensure that each provider in its network has signed a written provider participation agreement. Hospitalists may satisfy this requirement. Contractors in Maricopa or Pima Counties must have at least one hospital in each of the service districts specified in Attachment B. The 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 covered services, including emergency medical care on a 24-hour-a-day, 7-days-a-week basis. 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 and Tucson do not have to travel more than 5 miles to see a PCP, dentist or pharmacy. PCPs and specialists who provide inpatient services to the Contractor's members shall have admitting and treatment privileges in a minimum of one general acute care hospital that is located within the Contractor's service area. See Attachment B, Minimum Network Requirements, for details on network requirements by Geographic Service Area.

Contractors must provide a comprehensive provider network that ensures its membership has access at least equal to, or better than, community norms. Services shall be as accessible to AHCCCS members in terms of timeliness, amount, duration and scope as those services are to non-AHCCCS persons within the same service area. The Contractor is expected to consider the full spectrum of care when developing its network. The Contractor must also consider communities whose residents typically receive care in neighboring states. If the Contractor is unable to provide those services locally, it must so demonstrate to AHCCCSA and shall provide reasonable alternatives for members to access care. These alternatives must be approved by AHCCCSA. If the Contractor's network is unable to provide medically necessary services required under contract, the Contractor must adequately and timely cover these services through an out of network provider until a network provider is available. The Contractor and out of network provider must coordinate with respect to authorization and payment issues in these circumstances.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification. In addition, the Contractor must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs consistent with its responsibilities under this contract. If a Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. The Contractor may not include providers excluded from participation in Federal health care programs, under either section 1128 or section 1128A of the Social Security Act.

***Provider Network Development and Management Plan:*** The Contractor shall develop and maintain a provider network development and management plan, which ensures that the provision of covered services will occur as stated above. This plan shall be updated annually and submitted to AHCCCSA, Division of Health Care Management, 45 days from the start of each contract year. The plan shall identify the current status of the Contractor's network, 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 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. The plan, at a minimum, shall also include the following:



**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

- a. current network gaps;
- b. immediate short-term interventions when a gap occurs;
- c. interventions to fill network gaps and barriers to those interventions;
- d. outcome measures/evaluation of interventions;
- e. ongoing activities for network development;
- f. coordination between internal departments;
- g. coordination with outside organizations;
- h. a description of network design by GSA for the general population, including details regarding special populations, including, but not limited to, the developmentally delayed (Arizona Early Intervention Program (AzeIP)), the homeless and those in border communities.

The description should cover:

- i. how members access the system
  - ii. relationships between various levels of the system
  - iii. the plan for incorporating the medical home for members and the progress in its implementation
- i. A description of the adequacy of the geographic access to tertiary hospital services for the Contractor's membership.

**22. NETWORK MANAGEMENT**

The Contractor shall have policies and procedures in place that pertains to all service specifications described in the *AMPM*. In addition, the Contractor shall have policies on how the 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 Contractor, including compliance with all policies and procedures related to the grievance process and ensuring the member's care is not compromised during the grievance process;
- 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,
- f. Provide training for its providers and maintain records of such training,
- g. Verify credentialing of the provider;
- h. Recruit, select, verify credentials and contract with providers in a manner that incorporates quality management, utilization review, site visits and provider monitoring.

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

All material changes in the 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 Contractor's ability to meet the performance and network standards as described in this contract. The Division of Health Care Management must be notified of planned material changes in the provider network before the change process has begun, for example before issuing a 60-day termination notice to a provider. AHCCCSA will assess proposed changes in the Contractor's provider network for potential impact on members' health care and provide a written response to the Contractor. For emergency situations, AHCCCSA will expedite the approval process.

The Contractor shall notify AHCCCSA, Division of Health Care Management, within one working day of any unexpected changes that would impair its provider network. This notification shall include (1) information about

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

how the change will affect the delivery of covered services, and (2) the Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

**23. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) AND RURAL HEALTH CLINICS (RHC)**

The Contractor is encouraged to use FQHCs/RHCs in Arizona to provide covered services and must comply with the Federal mandates. Section 4712(b)(2) of the Balanced Budget Act requires that "rates of payment between FQHCs/RHCs and MCOs shall not be less than the amount of payment for a similar set of services with a non-FQHC/RHC." The intention of this provision is to ensure that contractors negotiate rates of payment with FQHCs/RHCs that are comparable to the rates paid to providers that provide similar services.

Contractors are required to submit member information for Title XIX members for each FQHC/RHC on a quarterly basis to the 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 following FQHCs are currently recognized by CMS:

- Canyonlands Community Health Care
- Chiricahua Community Health Centers, Inc.
- Clinica Adelante, Inc.
- Community Health Center of West Yavapai
- Copper Queen Medical Associates – Bisbee RHC
- Copper Queen Medical Associates – Douglas RHC
- Desert Senita Community Health Center
- El Rio Health Center
- Inter-Tribal Health Care Center
- Marana Health Center
- Mariposa Community Health Center, Inc.
- Morenci Health Care Center
- Mountain Park Health Center
- Native American Community Health Center, Inc.
- Native Americans for Community Action Family Health Center
- North Country Community Health Center
- Sun Life Family Health Center
- Sunset Community Health Center (formerly Valley Health Center, Inc.)
- United Community Health Center, Inc.

**24. PROVIDER REGISTRATION**

The Contractor shall ensure that all of its subcontractors register with AHCCCSA as an approved service provider and receive an AHCCCS Provider ID Number. A Provider Participation Agreement must be signed by each provider who does not already have a current AHCCCS ID number. The original shall be forwarded to AHCCCSA. This provider registration process must be completed in order for the Contractor to report services a subcontractor renders to enrolled members and for the Contractor to be paid reinsurance.

**25. PROVIDER AFFILIATION TRANSMISSION**

The Contractor shall submit information quarterly regarding its provider network. This information shall be submitted in the format described in the *Provider Affiliation Transmission User Manual* on October 15, January 15, April 15, and July 15 of each contract year. The *Manual* may be found in the Bidder's Library. If the provider affiliation transmission is not timely, accurate and complete, the Contractor may be required to submit a corrective action plan and may be subject to sanction.

**26. PERIODIC REPORT REQUIREMENTS**

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

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

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

The Contractor shall comply with all financial reporting requirements contained in the *Reporting Guide for Acute Health Care Contractors with the Arizona Health Care Cost Containment System*, The required reports, which are subject to change during the contract term, are summarized in Attachment F, Periodic Report Requirements.

**27. DISSEMINATION OF INFORMATION**

Upon request, the 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 Contractor. All advertisements, publications and printed materials that are produced by the Contractor and refer to covered services shall state that such services are funded under contract with AHCCCSA.

**28. REQUESTS FOR INFORMATION**

AHCCCSA may, at any time during the term of this contract, request financial or other information from the Contractor. Upon receipt of such requests for information, the 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.

**29. OPERATIONAL AND FINANCIAL REVIEWS**

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

In accordance with CMS requirements, AHCCCSA, or an external agent, will conduct regular Operational and Financial Reviews for the purpose of (but not limited to) ensuring operational and financial program compliance. The Reviews will identify areas where improvements can be made and make recommendations accordingly, monitor the Contractor's progress towards implementing mandated programs and provide the Contractor with technical assistance if necessary. The Contractor shall comply with all other medical audit provisions as required by AHCCCS Rule R9-22-521 and R9-31-521.

The type and duration of the Operational and Financial Review will be solely at the discretion of AHCCCSA. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCSA will give the Contractor at least three weeks advance notice of the date of the on-site review. In preparation for the on-site Operational and Financial Reviews, the Contractor shall cooperate fully with AHCCCSA and the AHCCCSA Review Team by forwarding in advance such policies, procedures, job descriptions, contracts, logs and other information that AHCCCSA may request. The Contractor shall have all requested medical records on-site. Any documents not requested in advance by AHCCCSA shall be made available upon request of the Review Team during the course of the review. The 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 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 Contractor has obtained accreditation from NCQA, JCAHO or any other nationally recognized accrediting body. The Contractor must submit the entire accreditation report to AHCCCSA for such waiver consideration.

The Contractor will be furnished a copy of the Operational and Financial Review Report and given an opportunity to comment on any review findings prior to AHCCCSA publishing the final report. Recommendations made by the Review Team to bring the Contractor into compliance with Federal, State, AHCCCS, and/or RFP requirements must be implemented by the Contractor. AHCCCSA may conduct a follow-up Operational and Financial Review to determine the Contractor's progress in implementing recommendations and achieving program compliance. Follow-up reviews may be conducted at any time after the initial Operational and Financial Review.

AHCCCSA may conduct an Operational and Financial Review in the event the Contractor undergoes a merger, reorganization, change in ownership or makes changes in three or more key staff positions within a 12-month period.

**30. CLAIMS PAYMENT/HEALTH INFORMATION SYSTEM**

The Contractor shall develop and maintain a claims payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §36-2904(H) and (J), AHCCCS Rules R9-22-705, and R9-22-709, a copy of which may be found in the Bidder's Library.

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 recoupment in excess of \$50,000 per provider within a contract year must be approved in advance by AHCCCSA, Division of Health Care Management. 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 from AHCCCSA, unless the recoupment is a result of fraud, reinsurance audit findings, data validation or audits conducted by the AHCCCSA Office of Program Integrity.

The 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.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

Unless a subcontract specifies otherwise, Contractors with 50,000 or more members shall ensure that 95% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Unless a subcontract specified otherwise, Contractors with fewer than 50,000 members shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 60 days of receipt of the clean claim. Additionally, unless a subcontract specifies otherwise, the Contractor shall not require providers to initially submit claims earlier than 6 months after date of service or to submit clean claims earlier than 12 months after date of service for which payment is claimed. The receipt date of the claim is the date stamp on the claim. The paid date of the claim is the date on the check or other form of payment. 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 Contractor's payments to providers must contain, at a minimum, 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 dispute.

Effective for all clean claims with dates of service October 1, 2004 and thereafter, 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 situations, interest shall be paid back to the date interest would have started to accrue beyond the applicable 45-day requirement. Interest shall be at the rate of ten per cent per annum, unless a different rate is stated in a written contract.

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

- Contractors must be able to make claims payments via electronic funds transfer by June 30, 2006.
- Contractors are required to receive and pay 30% of all claims (based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs)) electronically by June 30, 2006.

The Contractor shall submit a monthly Claims Processing Metrics Report to AHCCCS using the report format specified and defined by AHCCCS. The Monthly report must be received by the AHCCCSA, Division of Healthcare Management, no later than 15 days from the end of each month.

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

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

During the term of this contract, AHCCCSA anticipates requiring all health plans to use a standardized electronic format for electronic claims processing between the plan and its providers. AHCCCSA plans to require the formats outlined in the Technical Interface Guidelines under *Claims Processing*, which is the format adopted by CMS FFS providers and their billing agents who submit claims electronically to AHCCCS. The form UB-92 and 1500 layouts will be supplemented by a Form C layout. All formats are subject to changes as required by Federal law. Reasonable implementation timeframes will be negotiated with each plan.

**31. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT**

The Contractor shall reimburse hospitals for member care in accordance with AHCCCS Rule R9-22-705. The Contractor is encouraged to obtain contracts with hospitals in all GSA's and must submit copies of these

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

contracts, including amendments, to AHCCCSA, Division of Health Care Management, at least seven days prior to the effective dates thereof.

The Contractor may conduct prepayment and postpayment medical reviews of all hospital claims including outlier claims. Erroneously paid claims are subject to recoupment. If the Contractor fails to identify lack of medical necessity through concurrent review and/or prepayment medical review, lack of medical necessity identified during postpayment medical review shall not constitute a basis for recoupment by the Contractor. This prohibition does not apply to recoupments that are a result of an AHCCCS reinsurance audit. See also Section D, Paragraph 30, Claims Payment/Health Information System. For a more complete description of the guidelines for hospital reimbursement, please consult the Bidder's Library for applicable statutes and rules.

***For Out-of-State Hospitals:*** The Contractor shall reimburse out-of-state hospitals in accordance with AHCCCS Rule R9-22-705. Contractors serving border communities (excluding Mexico) are strongly encouraged to establish contractual agreements with those out-of-state hospitals that are identified by GSA in Attachment B.

***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).

**32. NURSING FACILITY REIMBURSEMENT**

The Contractor shall not deny nursing facility services if the nursing facility is unable to obtain prior authorization in situations where acute care eligibility and ALTCS eligibility overlap and the member is enrolled with an AHCCCS acute care Contractor. In such situations, the Contractor shall impose reasonable authorization requirements. The Contractor's payment responsibility described above applies only in situations where the nursing facility has not been notified in advance of the member's enrollment with an AHCCCS acute care Contractor. To further illustrate, when ALTCS eligibility overlaps AHCCCS acute care enrollment; the acute care enrollment takes precedence. Although the member could be ALTCS eligible for this time period, there is no ALTCS enrollment that occurs on the same days as AHCCCS acute enrollment.

The Contractor shall provide medically necessary nursing facility services for any member who has a pending ALTCS application, who is currently residing in a nursing facility and is eligible for services provided under this contract. If the member becomes ALTCS eligible and is enrolled with an ALTCS Contractor before the end of the maximum 90 days per contract year of nursing facility coverage, the Contractor is only responsible for nursing facility coverage during the time the member is enrolled with the Contractor. Nursing facility services covered by a third party insurer (including Medicare) while the member is enrolled with the Contractor shall be applied to the 90 day per contract year limitation.

The Contractor shall notify the Assistant Director of the Division of Member Services in writing, when a member has been residing in a nursing facility for 75 days. This will allow AHCCCSA time to follow-up on the status of the ALTCS application process and to prepare for potential fee-for-service coverage if the stay goes beyond the 90-day per contract year maximum.

**33. COMPENSATION**

The method of compensation under this contract will be prior period coverage (PPC) capitation, prospective capitation, delivery supplement, HIV-AIDS supplement, reinsurance (PPC and prospective), and third party liability, as described and defined within this contract and appropriate laws, regulations or policies.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

Actuaries establish the capitation rates using practices established by the Actuarial Standards Board. AHCCCS provides the following data to its actuaries to establish rates for the purposes of rebasing the capitation rates.

- a. Utilization and unit cost data derived from reported encounters
- b. Both audited and unaudited financial statements reported by Contractors
- c. Local market basket inflation trends
- d. AHCCCS fee for service schedule pricing adjustments
- e. Programmatic changes that affect reimbursement
- f. Additional administrative requirements for 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 may be included:

- a. Reinsurance (as described in Paragraph 35)
- b. HIV/AIDS supplemental payment
- c. Age/Gender for the 1931(b), SOBRA, KidsCare and BCCTP eligibility groups
- d. Medicare enrollment for SSI members
- e. Delivery supplemental payment
- f. Hospitalized supplemental payments for MED members
- g. Geographic Service Area adjustments
- h. Risk sharing for Title XIX Waiver Group reimbursement
- i. Risk sharing for PPC reimbursement
- j. Member choice statistic for Title XIX Waiver Group

The above information is reviewed by AHCCCS' actuaries in renewal years to determine if adjustments are necessary to maintain actuarially sound rates. A 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. 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 health plan upon initial enrollment versus those who are auto assigned to a health plan.

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

Where payments are made by electronic funds transfer, 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 Contractor. Except for adjustments made to correct errors in payment, and as otherwise specified in this section, any savings remaining to the Contractor as a result of favorable claims experience and efficiencies in service delivery at the end of the contract term may be kept by the Contractor.

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

Except for funds received from the collection of third-party liabilities, the only source of payment to Contractor for the services provided hereunder is the Arizona Health Care Cost Containment System Fund. An error discovered by the State with or without an audit in the amount of fees paid to Contractor will be subject to

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

adjustment or repayment by Contractor making a corresponding decrease in a current Contractor's payment or by making an additional payment by AHCCCSA to the Contractor.

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

The Contractor or its subcontractors shall not bill or attempt to collect any fee from, or for, a member for the provision of covered services.

Subject to the availability of funds, prior to the beginning of each year, AHCCCSA may increase or decrease one or more of the capitation rates payable under this contract.

**Prior Period Coverage (PPC) Capitation:** Except for KidsCare members and HIFA Parents, the Contractor will be paid capitation for all PPC member months, including partial member months. This capitation includes the cost of providing medically necessary covered services to members during prior period coverage. The PPC capitation rates will be set by AHCCCSA and will be paid to the Contractor along with the prospective capitation described below. Contractors will not receive PPC capitation for newborns of members who were enrolled at the time of delivery.

**Delivery Supplement:** When the Contractor has an enrolled woman who delivers during a prospective enrollment period, the Contractor will be entitled to a supplemental payment. Supplemental payments will not apply to women who deliver in a prior period coverage time period. AHCCCSA reserves the right at any time during the term of this contract to adjust the amount of this payment for women who deliver at home. The delivery supplement payment is not made if the hospitalized supplemental payment has already been made.

**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 the supporting pharmacy log. The report shall be submitted, along with the quarterly financial reporting package, within 60 days after the end of each quarter. 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 Division of Health Care Management *HIV/AIDS Supplemental Payment and Review Policy* for further details and requirements.

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

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

- a. death of a member
- b. member's incarceration (not eligible for AHCCCS benefits from the date of incarceration)
- c. duplicate capitation to the same contractor
- d. adjustment based on change in member's contract type



**SECTION D:  
PROGRAM REQUIREMENTS**

e. child was not eligible for CMDP as described in A.R.S. 8- 512

If a member is enrolled concurrently with the same 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.

**35. REINSURANCE**

Reinsurance is a stop-loss program provided by AHCCCSA to the Contractor for the partial reimbursement of covered services, as described below, for a member with an acute medical condition beyond an annual deductible level. AHCCCSA “self-insures” the reinsurance program through a deduction to capitation rates that is intended to be budget neutral. Refer to the *AHCCCSA Reinsurance Claims Processing Manual* for further details on the Reinsurance Program.

*Inpatient Reinsurance*

Inpatient reinsurance covers partial reimbursement of covered inpatient facility medical services. See the table below for applicable deductible levels and coinsurance percentages. The coinsurance percent is the rate at which AHCCCSA will reimburse the Contractor for covered inpatient services incurred above the deductible. The deductible is the responsibility of the Contractor. Per diem rates paid for nursing facility services provided within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year shall be eligible for reinsurance coverage. The following table represents the deductible and co insurance for CYE 06:

<i>Statewide Plan Enrollment</i>	<i>Annual Deductible*</i>	<i>Title XIX Waiver Group Annual Deductible</i>	
	<i>Prospective Reinsurance</i>	<i>Combined PPC and Prospective Reinsurance</i>	<i>Coinsurance</i>
0-34,999	\$20,000	\$15,000	75%

\*applies to all members except for Title XIX Waiver Group members

a) ***Prospective Reinsurance:*** This coverage applies to prospective enrollment periods. The deductible level is based on the Contractor’s statewide AHCCCS acute care enrollment (not including SOBRA Family Planning Extension services) as of October 1st each contract year for all rate codes and counties, as shown in the table above. The deductible levels are subject to change by AHCCCSA during the term of this contract. Any change would have a corresponding impact on capitation rates.

b) ***Prior Period Coverage Reinsurance:*** Effective October 1, 2003, AHCCCSA will no longer cover PPC inpatient expenses under the reinsurance program for any members except Title XIX Waiver Group members. See section c) below for additional information.

c) ***Title XIX Waiver Members:*** A separate reinsurance deductible for the Title XIX Waiver Group applies for both the prospective and prior period coverage time periods. There can only be one reinsurance case for prior period and prospective enrollment.

*Catastrophic Reinsurance*

The reinsurance program includes a special Catastrophic Reinsurance program. This program encompasses members diagnosed with hemophilia, Von Willebrand’s Disease, and Gaucher’s Disease. For additional detail

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

and restrictions refer to the *AHCCCS Reinsurance Claims Processing Manual* and the *AMPM*. There are no deductibles for catastrophic reinsurance cases. All medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of the AHCCCS allowed amount or the Contractor's paid amount, depending on subcap code. Reinsurance coverage for anti-hemophilic blood factors will be limited to 85% of the AHCCCS contracted amount or the Contractor's paid amount, whichever is lower. Capitation rates may be adjusted to reflect any cost savings resulting from the implementation of the AHCCCS anti-hemophilic blood factor contract. All catastrophic claims are subject to medical review by AHCCCSA.

The Contractor shall notify AHCCCSA, Division of Health Care Management, Reinsurance Unit, of cases identified for catastrophic non-transplant reinsurance coverage within 30 days of (a) initial diagnosis, (b) enrollment with the 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 who are non-DDAVP responders and dependent on Plasma Factor VIII.

*GAUCHER'S DISEASE*: Catastrophic reinsurance is available for members diagnosed with Gaucher's Disease classified as Type 1 and are dependent on enzyme replacement therapy.

**Transplants**

This program covers members who are eligible to receive covered major organ and tissue transplantation including bone marrow, heart, heart/lung, lung, liver, kidney, and other organ transplantation. Bone grafts and cornea transplantation services are not eligible for transplant reinsurance coverage but are eligible under the regular inpatient reinsurance program. Refer to the *AMPM* for covered services for organ and tissue transplant. Reinsurance coverage for transplants is limited to 85% of the AHCCCS contract amount for the transplantation service rendered, or 85% of the Contractor's paid amount, whichever is lower. The AHCCCS contracted transplantation rates may be found in the Bidder's Library. When a member is referred to a transplant facility for an AHCCCS-covered organ transplant, the Contractor shall notify AHCCCSA, DHCM.

**Other Information**

For all reinsurance case types other than transplants, Contractors will be reimbursed 100% for all medically necessary covered expenses provided in a contract year, after any type of reinsurance cases reaches \$650,000. Transplant case types have another risk limitation methodology described in the *AHCCCSA Reinsurance Claims Processing Manual*.

**Encounters Submission and Payments for Reinsurance**

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

The Contractor must maintain evidence that costs incurred have been paid by the Contractor before submitting reinsurance encounters. This information is subject to AHCCCSA review. Collection from 1<sup>st</sup> and 3<sup>rd</sup> parties should be reflected by the Contractor as reductions in the encounters submitted on a dollar-for-dollar basis. For purposes of AHCCCSA reinsurance, payments made by Contractor-purchased reinsurance are not considered 1<sup>st</sup> and 3<sup>rd</sup> 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 within 90 calendar days of the date of the claim dispute or hearing decision. Failure to submit the encounter within this timeframe will result in the loss or any related reinsurance dollars.

- b) ***Encounter Processing:*** AHCCCSA will accept for processing only those encounters that are submitted directly by an AHCCCS Contractor and that comply with the *AHCCCSA Encounter Reporting User Manual*.
- c) ***Payment of Inpatient and Catastrophic Reinsurance Cases:*** AHCCCSA will reimburse a Contractor for costs incurred in excess of the applicable deductible level, subject to coinsurance percentages. Amounts in excess of the deductible level shall be paid based upon costs paid by the Contractor, minus the coinsurance 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.

Reimbursement for these reinsurance benefits will be made to the Contractor each month. AHCCCSA will also provide for a reconciliation of reinsurance payments in the case where encounters used in the calculation of reinsurance benefits are subsequently adjusted or voided.

When a member changes Contractors within a contract year, for reinsurance purposes, all eligible inpatient costs, nursing facility costs and inpatient psychiatric costs incurred for that member will follow the member to the receiving Contractor. Therefore, all submitted encounters from the Contractor the member is leaving (for dates of service within the current contract year) will be applied towards, but not exceed, the receiving Contractor's deductible level. For further details regarding this policy and other reinsurance policies refer to the *AHCCCS Reinsurance Claims Processing Manual*.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

- d) ***Payment of Transplant Reinsurance Cases:*** Reinsurance benefits are based upon the lower of the AHCCCS contract amount or the Contractor's paid amount, subject to coinsurance percentages. Effective for dates of service on or after October 1, 2004, Contractors are required to submit all supporting service encounters for transplant services. Reinsurance payments will 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 Contractor each month.

**Reinsurance Audits**

For CYE 2002, CYE 2003, CYE 2004, and CYE 2005, the Reinsurance Audit Process as described in contract is discontinued. No audit related recoupments will be made on reinsurance payments made for services delivered in the above listed contract years.

***Pre-Audit:*** Beginning in CYE 2006 medical audits on prospective and prior period coverage 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.

***Audit:*** AHCCCSA will give the Contractor at least 45 days advance notice of any on-site audit. The 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 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 Contractor shall provide the Audit Team with workspace, access to a telephone, electrical outlets and privacy for conferences.

Audit may be completed without an on-site visit. For these audits, the Contractor will be asked to send the required documentation to AHCCCSA. The documentations will then be reviewed by AHCCCSA.

***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.

Per diem rates may be paid for nursing facility and rehabilitation services provided the services are rendered within 30 days of an acute hospital stay, including room and board, provided in lieu of hospitalization for up to 90 days in any contract year. The services rendered in these sub-acute settings must be of an acute nature and, in the case of rehabilitative or restorative services, steady progress must be documented in the medical record.

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

**36. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY**

Pursuant to federal and state law, AHCCCSA is the payer of last resort. This means AHCCCSA shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The Contractor shall coordinate benefits in accordance with 42 CFR 433.135 et seq., ARS 36-2909, 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 first or third-party payer. The Contractor may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this contract.

*Members with CRS Condition:* A member with private insurance is not required to utilize CRSA. If the member uses the private insurance network for a CRS covered condition, the Contractor is responsible for all applicable deductibles and copayments. When the private insurance is exhausted with respect to CRS covered conditions, the Contractor shall refer the member to CRSA for determination for CRS services.

The two methods used in the coordination of benefits are cost avoidance and post payment recovery. The Contractor shall use these methods as described in A.A.C. R9-22-1001 et. Seq. and federal and state law. See also Section D, paragraph 60, Medicare Services and Cost Sharing.,

*Cost Avoidance:* The Contractor shall take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services. The contractor shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claims at the time the claim is filed, the Contractor must process the claim

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. (The Contractor must decide whether it is more cost-effective to provide the service within its network or pay coinsurance and deductibles for a service outside its network. For continuity of care, the Contractor may also choose to provide the service within its network..) 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.

If the Contractor knows that the third party insurer will not pay the claim for a covered service due to untimely claim filing or as a result of the underlying insurance coverage (e.g. the service is not a covered benefit), the Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The Contractor shall communicate any known change in health insurance information, including Medicare, to AHCCCS Administration, Division of Member Services, not later than 10 days from the date of discovery using the approved AHCCCS correspondence. Failure to report these cases may result in one of the remedies specified in Section D, Paragraph 52, Sanctions.

If the Contractor does not know whether a particular service is covered by the third party, and the service is medically necessary, the Contractor shall contact the third party and determine whether or not such service is covered rather than requiring the member to do so. In the event that the service is not covered by the third party, the Contractor shall arrange for the timely provision of the service. (See also Section D, Paragraph 60, Medicare Services and Cost Sharing.)

The requirement to cost-avoid applies to all AHCCCS covered services. For prenatal care and preventive pediatric services, AHCCCS may require the Contractor to provide such service and then coordinate payment with the potentially liable third party (“pay and chase”). In emergencies, the Contractor shall provide the

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

necessary services and then coordinate payment with the third-party payer. The Contractor shall also provide medically necessary transportation so the member can receive medical benefits. Further, if a service is medically necessary, the Contractor shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member shall not be required to pay any coinsurance or deductibles for use of the other insurer's providers.

**Postpayment Recoveries:** Post-payment recovery is necessary in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost-avoid. The Contractor shall identify, 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 Contractor shall notify AHCCCSA's authorized representative within 10 business days of the identification of a third-party liability 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 52, Sanctions. The Contractor shall identify all potentially liable third parties and pursue reimbursement from them except in the circumstances below.

The Contractor shall not pursue reimbursement in the following circumstances unless the case has been referred to the Contractor by AHCCCSA or AHCCCSA's authorized representative:

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

The Contractor shall report any cases involving the above circumstances to AHCCCSA's authorized representative should the Contractor identify such a situation. The Contractor shall cooperate with AHCCCSA's authorized representative in all collection efforts. In joint cases involving both AHCCCS fee-for-service or reinsurance and the Contractor, AHCCCSA's 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 AHCCCSA's authorized representative by the Contractor. AHCCCSA's 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 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 AHCCCSA remitting the settlement to the Contractor. For total plan cases involving only payments made the Contractor, the Contractor is responsible for performing all research, investigation, the mandatory filing of initial liens on cases that exceed \$250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916. The Contractor shall use AHCCCS approved casualty recover correspondence when filing liens and when corresponding to others in regard to casualty recovery. The Contractor may retain up to 100% of its third-party collections if all of the following conditions exist:

- a. Total collections received do not exceed the total amount of the Contractor's 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, and contingency fees, etc.); and,
- c. Such recovery is not prohibited by state or Federal law.

**Reporting:** The Contractor may be required to report the amount of third-party collections and cost avoidance. In addition, upon AHCCCSA's request, the Contractor shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: the member's first and last name; AHCCCS ID; date of incident; claimed amount; paid/recovered amount; and case status. The AHCCCSA TPL Section shall provide the format and reporting schedule for this information to the

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

Contractor. Prior to negotiating a settlement on a total plan case, the Contractor shall notify AHCCCA to ensure that there is no reinsurance or fee for service payments that have been made by AHCCCS. For total plan cases, the Contractor shall report settlement information to AHCCCS, utilizing the AHCCCS approved casualty recovery Notification of Settlement form, within 10 business days from the settlement date. Failure to report these cases may result in one of the remedies specified in Section D. Paragraph 52, Sanctions.

AHCCCSA will provide the Contractor, on an agreed upon schedule, with a complete file of all third-party coverage information (other than Medicare) for the purpose of updating the Contractor's files. The Contractor shall notify AHCCCSA of any known changes in coverage within deadlines and in a format prescribed by AHCCCSA.

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

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

**37. MEDICARE SERVICES AND COST SHARING**

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

**38. RECORDS RETENTION**

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

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

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

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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 Contractor for a period of five years after the date of final disposition or resolution thereof.

**39. 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 Contractor shall have written policies and procedures to maintain the confidentiality of all medical records.

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

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

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

The Contractor shall have written plans for providing training and evaluating providers' compliance with the Contractor's medical record 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 working 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 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 working 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. §36-664I)

**40. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS**

The Contractor shall not, without the prior approval of AHCCCSA, make any advances to a related party or subcontractor. The Contractor shall not, without similar prior approval, make any distribution, loan or loan guarantee to any entity, when the distribution, loan or loan guarantee involves program funds associated with AHCCCS members. A distribution to another fund or line of business by the Contractor within its own organization that does not involve program funds associated with AHCCCS members does not require the prior approval of AHCCCSA. All investments, other than investments in U.S Government securities or Certificates of Deposit, also require AHCCCSA prior approval. All requests for prior approval are to be submitted to the AHCCCSA Division of Health Care Management.



**41. RESERVED**

**42. DATA EXCHANGE REQUIREMENT**

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

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

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

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

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

***Health Insurance Portability and Accountability Act (HIPAA):*** The Contractor shall comply with the Administrative Simplification requirements of Subpart F of the HIPAA of 1996 (Public Law 104-109 110 Statutes 1936) and all Federal regulations implementing that Subpart that are applicable to the operations of the Contractor by the dates required by implementing Federal Regulations. Failure to comply with the requirements of this paragraph constitute grounds for the termination of this contract.

**43. ENCOUNTER DATA REPORTING**

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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 Contractor shall submit encounter data to AHCCCSA for all services for which the Contractor incurred a financial liability and claims for services eligible for processing by the Contractor where no financial liability was incurred, including services provided during prior period coverage. This requirement is a condition of the CMS grant award.

A Contractor shall prepare, review, verify, certify, and submit, encounters for consideration to AHCCCSA. Upon submission, the 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 must be submitted in the PMMIS AHCCCSA supplied formats. Specific requirements for encounter data are described in the *AHCCCSA Encounter Reporting User Manual*, a copy of which may be found in the Bidder's Library. The *Encounter Submission Requirements* are included herein as Attachment I.

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 Contractor. Further information regarding the Encounter Submission Tracking Report may be found in *The AHCCCS Encounter Reporting User's Manual*.

Each month AHCCCSA provides the Contractor with full replacement files containing provider and medical procedure coding information. These files should be used to assist the Contractor in accurate Encounter Reporting. Refer to Paragraph 42, Data Exchange Requirements, for further information.

**44. ENROLLMENT AND CAPITATION TRANSACTION UPDATE**

AHCCCSA produces daily enrollment transaction updates identifying new members and changes to members' demographic, eligibility and enrollment data, which the 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 enrollment transaction update due to internal edits. The Contractor shall use the Manual Payment Transaction in addition to the daily enrollment transaction update to update its member records. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCSA Division of Health Care Management. Refer to paragraph 42, Data Exchange Requirement for further information.

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

The monthly enrollment and monthly capitation transaction updates are generally produced two days before the end of every month. The update will identify the total active population for the Contractor as of the first day of the next month. These updates contains the information used by AHCCCSA to produce the monthly capitation payment for the next month. The Contractor will reconcile their member files with the AHCCCS monthly update. After reconciling the monthly update information, the Contractor resumes posting daily updates

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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.

Refer to the *AHCCCS Contracted Health Plan Technical Interface Guidelines* available in the Bidder's Library for additional information.

**45. TERM OF CONTRACT AND OPTION TO RENEW**

The initial term of this contract shall be December 1, 2002 through December 31, 2003. The terms and conditions of any such contract extension shall remain the same as the original contract, as amended except that contract extensions shall not affect the maximum contracting period of five years. Any contract extension shall be through contract amendment. AHCCCSA shall issue amendments prior to the end date of the contract when there is an adjustment to capitation rates and/or changes to the scope of service contained herein. Changes to scope of service include but are not limited to changes in the enrolled population, changes in covered services, changes in GSA's. When AHCCCSA issues an amendment to extend the contract, the provisions of such extension will be deemed to have been accepted 60 days from the date of mailing by AHCCCSA, even if the extension has not been signed by CMDP, unless within the time CMDP notifies AHCCCSA in writing that it refuses to sign the extension. Any disagreement between the parties regarding the extension of the contract or the terms of its renewal will be considered a dispute within the meaning of Section E, Paragraph 19, Disputes, and administered accordingly.

**Contract Termination:** In the event the contract, or any portion thereof, is terminated for any reason, or expires, the Contractor shall assist AHCCCSA in the transition of its members. 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 Contractor shall make provision for continuing all management and administrative services until the transition of all members is completed and all other requirements of this contract are satisfied. The Contractor shall be responsible for providing all reports set forth in this contract and necessary for the transition process and shall be responsible for the following:

- a. Notification of subcontractors and members.
- b. Payment of all outstanding obligations for medical care rendered to members.
- c. Until AHCCCSA is satisfied that the Contractor has paid all such obligations, the 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;
  - (3) Copies of all bank statements received by the Contractor.
- d. Such reports shall be due on the fifth day of each succeeding month for the prior month.
- e. In the event of termination or suspension of the contract by 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 Contractor's performance of this contract and for which the Contractor would otherwise be liable under this contract.
- f. Any dispute by the Contractor, with respect to termination or suspension of this contract by AHCCCSA, shall be exclusively governed by the provisions of Section E, Paragraph 19, Disputes.
- g. Any funds, advanced to the 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.

**46. SUBCONTRACTS**

The Contractor shall be legally responsible for contract performance whether or not subcontracts are used. No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

required to be provided by the Contractor pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing. See the AHCCCS *Claims Processing by Subcontracted Providers Policy* in the Bidder's Library.

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

- a. Automated data processing
- b. Third-party administrators
- c. Management Services (See also Section D, Paragraphs 48 & 49)
- d. Capitated or other risk subcontracts requiring claims processing by the subcontractor
- e. Requests for Proposal issued by the Contractor for the procurement of medical services.

The Contractor shall maintain a fully executed original of all subcontracts, which shall be accessible to AHCCCSA within two working days of request by AHCCCSA. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

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

Before entering into a subcontract which delegates Contractor duties or responsibilities to a subcontractor, the Contractor must evaluate the prospective subcontractor's ability to perform the activities to be delegated. If the Contractor delegates duties or responsibilities such as utilization management or claims processing to a subcontractor, then the Contractor shall establish a written agreement that specifies the activities and reporting responsibilities delegated to the subcontractor. The written agreement shall also provide for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. In order to determine adequate performance, the Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule. The schedule for review shall be submitted to AHCCCSA, Division of Health Care Management for prior approval. 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 correction plan shall be communicated to AHCCCS upon completion.

The Contractor must submit annually (within 90 days from the start of the contract year) a statement whether any Contractor duties or responsibilities have been delegated to subcontractors. If duties or responsibilities have been delegated to a subcontractor, the 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 and responsibilities of the subcontractor
- Next scheduled review date
- Identified areas of deficiency
- Contractor's corrective action plan

The 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.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

Each subcontract must contain verbatim all the provisions of Attachment A, Minimum Subcontract Provisions. In addition, each subcontract must contain the following:

- a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor.
- b. Identification of the name and address of the subcontractor.
- c. Identification of the population, to include patient capacity, to be covered by the subcontractor.
- d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
- e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation.
- f. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability.
- g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third party liability payment before submitting claims to the Contractor.
- h. A description of the subcontractor's patient, medical 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 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 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 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 Contractor to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.
- p. A provision that the subcontractor may provide the member with factual information, but is prohibited from recommending or steering a member in the member's selection of a Contractor.

**47. SPECIALTY CONTRACTS**

AHCCCSA may at any time negotiate or contract on behalf of the Contractor and AHCCCSA for specialized hospital and medical services. AHCCCSA will consider existing Contractor resources in the development and execution of specialty contracts. AHCCCSA may require the Contractor to modify its delivery network to accommodate the provisions of specialty contracts. Specialty contracts shall take precedence over and supersede existing and future subcontracts for services that are subject to specialty contracts. AHCCCSA may consider waiving this requirement in particular situations if such action is determined to be in the best interest of the State; however, in no case shall reimbursement exceed that payable under the relevant AHCCCSA specialty contract.

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

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

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

**48. MANAGEMENT SERVICES SUBCONTRACTORS**

All proposed management services subcontracts and/or corporate cost allocation plans must be approved in advance by AHCCCSA Division of Health Care Management as described in Section D, Paragraph 46, 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 actually paid out are determined to be unjustified or excessive, amounts may be subject to repayment to the Contractor. In addition, sanctions may be imposed.

**49. MANAGEMENT SERVICES SUBCONTRACTOR AUDITS**

All management services subcontractors that have oversight responsibilities for the Contractor's program operations (such as third-party administrators) are required to have an annual financial audit. A copy of this audit shall be submitted to AHCCCSA, Division of Health Care Management, within 120 days of the subcontractor's fiscal year end. If services billed by a consultant or actuary are less than \$50,000 annually, AHCCCSA will waive the requirement for an audit of that consultant or actuary.

**50. FINANCIAL VIABILITY STANDARDS/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 Financial Viability Standard, the Current Ratio, is the standard that best represent the financial solvency of the Contractor. Therefore, the Contractor must comply with the financial viability standard.

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 may not be imposed if the Contractor does not meet these performance guidelines. AHCCCSA takes into account the Contractor's unique program for managing care and improving the health status of members when analyzing medical expense and administrative ration results. However, if a critical combination of the Financial Viability Standards and Performance Guidelines are not met, additional monitoring, such as monthly reporting, may be required.

***FINANCIAL VIABILITY STANDARDS:***

**SECTION D:  
PROGRAM REQUIREMENTS**

**Contract/RFP No. YH02-0018**

<b><i>Current Ratio</i></b>	Current assets* divided by current liabilities. "Current assets" includes any long-term investments that can be converted to cash within 24 hours without significant penalty (i.e., greater than 20%). <i>Standard: At least 1.00</i>
	*if current assets includes a receivable from a parent company, the parent company must have liquid assets that support the amount of the inter-company loan.
<b>PERFORMANCE GUIDELINES:</b>	
<b><i>Medical Expense Ratio</i></b>	Total medical expenses divided by total capitation + Delivery Supplement + TPL + Reinsurance + HIV/AIDS Supplement <i>Standard: At least 75%</i>
<b><i>Administrative Cost Percentage</i></b>	Total administrative expenses (excluding income taxes), divided by total capitation + Delivery Supplement + TPL + reinsurance + HIV/AIDS Supplement. <i>Standard: No more than 20%</i>
<b><i>RBUCs</i></b>	Received but unpaid claims divided by the average daily medical expenses for the period, net of subcapitation expense. <i>Standard: No more then 30 days</i>

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

A proposed reorganization for the Contractor health plan shall require prior approval of AHCCCSA and a subsequent contract amendment. The Contractor must submit a detailed merger, reorganization and/or transition plan to AHCCCSA DHCM, for AHCCCSA review. The purpose of the plan review is to ensure uninterrupted services to members, evaluate the new entity's ability to support the provider network, 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.

**52. 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 and the terms of this contract and applicable Federal or State law and regulations. Written notice will be provided to the Contractor specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of capitation prepayment to be withheld. The Contractor may dispute the decision to impose a sanction in accordance with 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 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 of 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 or provider.
- f. Failure to comply with the requirement for physician incentive plan as delineated in Paragraph 15.

**SECTION D:  
PROGRAM REQUIREMENTS**

---

**Contract/RFP No. YH02-0018**

- 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 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 36, Coordination of Benefits/Third Party Liability.

AHCCCSA may impose the following types of intermediate sanctions:

- a. Civil monetary penalties
- b. 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.
- c. Additional sanctions allowed under statute or regulation that address areas of noncompliance.

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

*Refer to the DHCM Sanctions Policy for details.*

**53. GRIEVANCE SYSTEM**

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

The Contractor may delegate the grievance system to subcontractors, however, the 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 Contractor shall remain responsible for compliance with all requirements. The Contractor shall also ensure that it timely provides written information to both enrollees and providers, which clearly explains the grievance system requirements. This information must include a description of: the right to a State fair hearing, a method for obtaining a State fair hearing, the rules that govern representation at the hearing, the right to file grievance and appeals, the requirements and timeframes for filing grievance and appeals, the availability of assistance in the filing process, the toll-free numbers that the 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 which is timely filed, that the enrollee may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the enrollee, and that a provider may file an appeal on behalf of an enrollee with the enrollee's written consent.



**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 8, Member Information and Paragraph 56, Cultural Competency.

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

**54. QUARTERLY GRIEVANCE SYSTEM REPORT**

The Contractor shall submit a Quarterly Grievance System Report to AHCCCSA, Office of Legal Assistance, using the Quarterly Grievance System Report Format. The Quarterly Grievance System Report must be received by the AHCCCSA, Office of Legal Assistance, no later than 45 days from the end of the quarter.

**Enrollee Grievance Report:** The Contractor shall accept, resolve and track enrollee grievances as required in the AHCCCS Enrollee Grievance Policy. The Contractor shall submit an Enrollee Grievances report quarterly. The deadline for submission of this report is 45 days following the end of the quarter. The report shall include the following:

- A. Number of grievances received in the reporting period
  - i. Total
  - ii. By the categories used in the Contractor's executive summary reports
- B. Number of days to resolution
  - i. Number resolved within 10 days
  - ii. Number resolved in 11 or more days, but less than 29 days
  - iii. Number resolved in 30 or more days, but less than 59 days
  - iv. Number resolved in 60 to 90 days
  - v. Average days to resolution

Report A. and B. above by the current quarter, prior quarter and current quarter for the previous year.

The Contractor shall trend and analyze grievance, appeals and claim disputes at least quarterly; any identified trends and corrective action plans should be reported to AHCCCSA, Division of Health Care Management.

**55. MEDICARE MODERNIZATION ACT OF 2003**

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

**Drugs Excluded from Medicare Part D:** AHCCCS will continue to 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 Plans formulary are not considered excluded drugs and will not be covered by AHCCCS.

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

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.

**56. CULTURAL COMPETENCY**

The Contractor shall have a Cultural Competency Plan that meets the requirements of the *AHCCCS Cultural Competency Policy*. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, Operations Unit, no later than 45 days after the start of each contract year. This plan should address all services and settings. The Contractor must identify a staff member responsible for the cultural competency plan and inform the Division of Health Care Management of that person's identity.

**57. MEDICAID SCHOOL BASED CLAIMING**

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

SBC services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other SBC approved alternative setting. Currently, services include therapies (occupational, physical and speech/language); behavioral health evaluation and counseling; nursing and attendant care; and specialized transportation. The Contractor's evaluations and determinations, about whether services are medically necessary, should be made independent of the fact that the child is receiving SBC services.

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

**58. BUSINESS CONTINUITY AND RECOVERY PLAN**

The Contractor shall adhere to all elements of the AHCCCS, Division of Health Care Management *Business Continuity and Recovery Plan Policy*. The Contractor shall develop a Business Continuity 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 Contractor's main place of business
- Complete loss of use of the main site
- Loss of primary computer system/records
- Communication between the Contractor and AHCCCSA in the event of a business disruption
- Periodic Testing

The Business Continuity Plan shall be updated annually. All key staff shall be trained and familiar with the Plan.

**59. CORPORATE COMPLIANCE**

In accordance with A.R.S. Section 36-2918.01, all contractors are required to notify the AHCCCS, Office of Program Integrity immediately (OPI) of all suspected fraud or abuse. The Contractor agrees to promptly (within ten business days of discovery) inform OPI in writing of instances of suspected fraud or abuse. 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 Contractor agrees to permit and cooperate with any onsite review. A review by AHCCCS, OPI may be conducted without notice and for the purpose of ensuring program compliance. The Contractor also agrees to respond to electronic, telephonic or written requests for information within the timeframe specified by AHCCCSA.

Effective October 1, 2003, the Contractor shall be in compliance with 42 CFR 438.608. The Contractor must have a mandatory compliance program, supported by other administrative procedures, that is designed to guard against fraud and abuse. The Contractor shall have written criteria for selecting a Compliance Officer and a job description that clearly outlines the responsibilities and the authority of the position. The Compliance Officer shall have the authority to access records and independently refer suspected member fraud, provider fraud and member abuse cases to AHCCCS, OPI or other duly authorized enforcement agencies.

The compliance program, which shall both prevent and detect suspected fraud or abuse, must include:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to and processes for complying with all applicable Federal and State standards.
2. The written designation of a compliance committee who are accountable to the Contractor's top management.
3. The Compliance Officer must be an onsite management official who reports directly to the Contractor's top management. Any exceptions must be approved by 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 will 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 with monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of compliance reporting.

The Contractor is required to research potential overpayments identified by AHCCCS, OPI. After conducting a cost benefit analysis to determine if such action is warranted, the Contractor should attempt to recover any overpayments identified. AHCCCS OPI shall be advised of the final disposition of the research and advised of actions, if any, taken by the Contractor.

**60. TECHNOLOGICAL ADVANCEMENT**

The Contractor shall implement the following technological measures according to the applicable time frame:

May 1, 2005:

- Contractors must have a website with links to the following information:
  1. Formulary
  2. Provider manual
  3. Member handbook
  4. Provider listing
- Contractors must have enrollment verification via website fully operational
- Contractors must have claims inquiry via website fully operational

#### **61. PENDING LEGISLATIVE / OTHER ISSUES**

The following constitute pending items that may be resolved after the issuance of this contract. Any program changes due to the resolution of the issues will be reflected in future amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of program changes.

***Arizona Early Intervention Program:*** 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.

***Transportation:*** AHCCCSA is evaluating its methodology, under capitation, for providing transportation services to its members. Options may include contracting with a centralized transportation broker to provide services to all AHCCCS members.

***Medicare Modernization Act:*** 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. Additionally, AHCCCS is pursuing a Medicare waiver that would allow AHCCCS contractors to become Medicare contractors. Contractors will be kept informed of AHCCCS progress on the waiver.

***Hemophilia Request for Proposal:*** The AHCCCS Office of Pharmacy Program Administrator plans to issue a Request for Proposal (RFP) during contract year '05 for a single-source contract for anti-hemolytic blood factors and case management for the treatment of all AHCCCS members with hemophilia or other bleeding disorders. Implementation of the single-source contract is expected to provide cost savings for the blood factor and may also provide savings through improved case management and prophylactic therapy. Capitation rates may be adjusted to reflect any cost savings resulting from this RFP.

#### **62. BALANCED BUDGET ACT OF 1997 (BBA)**

**SECTION D:  
PROGRAM REQUIREMENTS**

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**Contract/RFP No. YH02-0018**

In August 2002, CMS issued final regulations for the implementation of the BBA. AHCCCS continues to review all areas of the regulations to ensure full compliance with the BBA; however, there are some issues that may require further clarification from CMS. Any program changes due to the resolution of the issues will be reflected in amendments to the contract. Capitation rates may also be adjusted to reflect the financial impact of the program changes.

**63. ADVANCE DIRECTIVES**

In accordance with 42 CFR 422.128, the Contractor shall maintain policies and procedures addressing advanced directives for adult members that specify items a through c below. For the purposes of the advanced directives, an adult CRS recipient is an individual who is eighteen (18) years of age or older.

- 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 each individual's rights under State law to make decisions regarding medical care, and the health care provider's written policies concerning advance directives (including any conscientious objections). [42 CFR 438.6(i)(3)]
  - (3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
  - (4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
  - (5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- b. Contractors shall require subcontracted PCPs, which have agreements with the entities described in paragraph a. above, to comply with the requirements of subparagraphs a. (2) through (5) above. Contractors shall also encourage health care providers specified in subparagraph a. to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.
- c. The Contractor shall provide written information to adult members that describe the following:
  - (1) A member's rights under State law, including a description of the applicable State law
  - (2) The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
  - (3) The member's right to file complaints directly with 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)]

[END OF SECTION D]

**SECTION E: CONTRACT CLAUSES**

**1) APPLICABLE LAW**

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

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

**2) AUTHORITY**

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

**3) ORDER OF PRECEDENCE**

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable Federal regulations; the terms of the CMS 1115 waiver for the State of Arizona; the Constitution and laws of Arizona, and applicable State rules; the terms of this contract, including all attachments and executed amendments and modifications; 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 Contractor under this contract is an independent contractor. Neither party to this contract shall be deemed to be the employee or agent of the other party to the contract.

**7) ASSIGNMENT AND DELEGATION**

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

**8) COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS**

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Executive Order 13166, Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973 (regarding education programs and activities); 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.

**9) RIGHT TO ASSURANCE**

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

**10) 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 Contractor receives written notice of the cancellation unless the notice specifies a later time.

**11) GRATUITIES**

AHCCCSA may, by written notice to the Contractor, immediately terminate this contract if it determines that employment or a gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the contract, an amendment to the contract, or favorable treatment concerning the contract, including the making of any determination or decision about contract performance. 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 Contractor.

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

**13) TERMINATION FOR DEFAULT**

AHCCCSA reserves the right to terminate this contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the contract or failure to take corrective action as required by AHCCCSA to comply with the terms of the contract. If the 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 Contractor by certified mail, return receipt requested.

**SECTION E:  
CONTRACT CLAUSES**

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**Contract/RFP No. YH02 0018**

In the event the Contractor requests a hearing prior to termination, AHCCCSA is required by the Balanced Budget Act of 1997 to oversee the operation of the Contractor entity through appointment of temporary management prior to the hearing.

Upon termination under this paragraph, all documents, data, and reports prepared by the Contractor under the contract shall become the property of and be delivered to 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 Contractor shall be liable for any excess costs incurred by AHCCCSA in re-procuring the materials or services.

**14) 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.

**15) RIGHT OF OFFSET**

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

**16) NON-EXCLUSIVE REMEDIES**

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

**17) NON-DISCRIMINATION**

The Contractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act and Title VI. The 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, sex, national origin or disability.

**18) EFFECTIVE DATE**

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

**19) DISPUTES**

The exclusive manner for the Contractor to assert any claim, grievance, dispute or demand against AHCCCSA shall be in accordance with Title 9 A.A.C. Chapter 34, Article 4. Pending the final resolution of any disputes involving this contract, the 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.

**20) 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 Contractor or subcontractor that is related to the performance of this contract, in accordance with A.R.S. §41-2547.

**21) INCORPORATION BY REFERENCE**

This solicitation and all attachments and amendments, the Contractor's proposal, best and final offer accepted by AHCCCSA, and any approved subcontracts are hereby incorporated by reference into the contract.

**22) COVENANT AGAINST CONTINGENT FEES**

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



**23) CHANGES**

AHCCCSA may at any time, by written notice to the Contractor, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, the Contractor may assert its right to an adjustment in compensation paid under this contract. The Contractor must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 19, 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 Contractor, unless within that time the Contractor notifies AHCCCSA in writing that it refuses to sign the amendment. If the Contractor provides such notification, AHCCCSA will initiate termination proceedings.

**24) TYPE OF CONTRACT**

Firm Fixed-Price

**25) 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 calling Michael Veit at (602) 417-4762.

**26) WARRANTY OF SERVICES**

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

**27) NO GUARANTEED QUANTITIES**

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

**28) CONFLICT OF INTEREST**

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

**29) DISCLOSURE OF CONFIDENTIAL INFORMATION**

The 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 Contractor by AHCCCSA.

**30) COOPERATION WITH OTHER CONTRACTORS**

AHCCCSA may award other contracts for additional work related to this contract and 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. Contractor shall not commit or permit any act, which will interfere with the performance of work by any other contractor or by AHCCCSA employees.

**31) OWNERSHIP OF INFORMATION AND DATA**

Any data or information system, including all software, documentation and manuals, developed by 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 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 Contractor's use of public funds in collecting or preparing such data, information and reports. These items shall not be used by Contractor for any independent project of Contractor or publicized by 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, 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 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. Contractor shall additionally be subject to the applicable provisions of 45 CFR Part 74 and 45 CFR Parts 6 and 8.

**32) AHCCCSA RIGHT TO OPERATE CONTRACTOR**

If, in the judgment of AHCCCSA, Contractor's performance is in material breach of the contract or Contractor is insolvent, AHCCCSA may directly operate Contractor to assure delivery of care to members enrolled with Contractor until cure by 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 Contractor, AHCCCS, through designees appointed by the Director, shall be vested with full and exclusive power of management and control of the Contractor as necessary to ensure the uninterrupted care to persons and accomplish the orderly transition of persons to a new or existing Contractor, or until the Contractor corrects the Contract Performance failure to the satisfaction of AHCCCS. AHCCCS shall have the power to employ any necessary assistants, to execute any instrument in the name of the Contractor, to commence, defend and conduct in its name any action or proceeding in which the Contractor may be a party.

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

**33) AUDITS AND INSPECTIONS**

The Contractor shall comply with all provisions specified in applicable AHCCCS Rule R9-22-519, -520 and -521 and AHCCCS policies and procedures relating to the audit of Contractor's records and the inspection of Contractor's facilities. Contractor shall fully cooperate with AHCCCSA staff and allow them reasonable access to Contractor's staff, subcontractors, members, and records.

At any time during the term of this contract, the 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.

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

**34) LOBBYING**

No funds paid to the 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 Contractor shall disclose if any funds other than those paid to the 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.

**35) SUSPENSION OR DEBARMENT**

The Contractor shall not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from Federal procurement activity. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from Federal procurement activity.

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

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

**36) DATA CERTIFICATION**

The Contractor shall certify that financial and encounter data submitted to AHCCCS is complete, accurate and truthful. Certification of financial data must be submitted concurrent with the data. Encounter data must be certified at least once per contract year. Certification may be provided by the Contractor CEO, CFO or an individual who is delegated authority to sign for, and who report directly to the CEO or CFO. 42 CFR 438.604.606.

**37) OFF SHORE PERFORMANCE OF WORK PROHIBITED**

Due to security and identity protection concerns, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers

**38) FEDERAL IMMIGRATION AND NATIONALITY ACT**

The Contractor shall comply with all federal, state and local immigration laws and regulations relating to the immigration status of their employees during the term of the contract. Further, the Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to

**SECTION E:  
CONTRACT CLAUSES**

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**Contract/RFP No. YH02 0018**

perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the contractor.

[END OF SECTION E]

**ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS**

*[The following provisions must be included verbatim in every subcontract if the State procurement process is not used. These sections do not apply to Contracts between State budget units.]*

**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. (Requirement for FFP, 42 CFR 434.70)

**8) CONFIDENTIALITY REQUIREMENT**

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

**9) CONFLICT IN INTERPRETATION OF PROVISIONS**

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

**10) CONTRACT CLAIMS AND DISPUTES**

Contract claims and disputes arising under A.R.S. § Title 36, Chapter 29 shall be adjudicated in accordance with AHCCCS Rules. (A.R.S. § Title 36, Chapter 29; AAC R2-7-916; AAC R9-22-802)

**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**

The Arizona Health Care Cost Containment System Administration (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. (ARS 36-2903. C., (8.); ARS 36-2903.02; AAC 9-22-522)

**13) FRAUD AND ABUSE**

If the Subcontractor discovers, or is made aware, that an incident of potential 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. (ARS 36-2918.01; AAC R9-22-511.)

**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 AHCCCS 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)

**16) LIMITATIONS ON BILLING AND COLLECTION PRACTICES**

The Subcontractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services. (AAC R9-22-702 and R9-22-201(J))

**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, sex, national origin or political affiliation, shall have equal access to employment opportunities, and all other applicable Federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI. 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 & AAC R9-22-513)

**19) PRIOR AUTHORIZATION AND UTILIZATION REVIEW**

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. (AAC R9-22-522)

**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.

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. (45 CFR 74.53; 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, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers.

**27) FEDERAL IMMIGRATION AND NATIONALITY ACT**

**All subcontracts must contain the following provision by January 1, 2007.**

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 Contractor shall flow down this requirement to all subcontractors utilized during the term of the contract. The State shall retain the right to perform random audits of contractor and subcontractor records or to inspect papers of any employee thereof to ensure compliance. Should the State determine that the contractor and/or any subcontractors be found noncompliant, the State may pursue all remedies allowed by law, including, but not limited to; suspension of work, termination of the contract for default and suspension and/or debarment of the contractor.



**ATTACHMENT B: MINIMUM NETWORK STANDARDS**

*(By Geographic Service Area)*

INSTRUCTIONS:

Contractors shall have in place an adequate network of providers capable of meeting contract requirements. The information that follows describes the minimum network requirements by Geographic Service Area (GSA).

In some GSA's there are required service sites located outside of the geographical boundary of a GSA. The reason for this relates to practical access to care. In certain instances, a member must travel a much greater distance to receive services within their assigned GSA, if the member were not allowed to receive services in an adjoining GSA or state.

Split zip codes occur in some counties. Split zip codes are those which straddle two different counties. Enrollment for members residing in these zip codes is based upon the county and GSA to which the entire zip code has been assigned by AHCCCS. The Contractor shall be responsible for providing services to members residing in the entire zip code that is assigned to the GSA for which the Contractor has agreed to provide services. The split zip codes GSA assignments are as follows:

ZIP CODE	SPLIT BETWEEN THESE COUNTIES	COUNTY ASSIGNED TO	ASSIGNED GSA
85220	Pinal and Maricopa	Maricopa	12
85242	Pinal and Maricopa	Maricopa	12
85292	Gila and Pinal	Gila	8
85342	Yavapai and Maricopa	Maricopa	12
85358	Yavapai and Maricopa	Maricopa	12
85390	Yavapai and Maricopa	Maricopa	12
85643	Graham and Cochise	Cochise	14
85645	Pima and Santa Cruz	Santa Cruz	10
85943	Apache and Navajo	Navajo	4
86336	Coconino and Yavapai	Yavapai	6
86351	Coconino and Yavapai	Coconino	4
86434	Mohave and Yavapai	Yavapai	6
86340	Coconino and Yavapai	Yavapai	6

If outpatient specialty services (OB, family planning, and pediatrics) are not provided by the primary care provider, at least one provider is required for each of these specialties in the service sites specified. General surgeons must be available within 50 miles of service sites.

In Tucson (GSA 10) and Metropolitan Phoenix (GSA 12), the Contractor must demonstrate its ability to provide PCP, dental and pharmacy services so that 95% of members don't need to travel more than 5 miles from their residence. Metropolitan Phoenix is defined on the Minimum Network Standard page specific to GSA # 12.

At a minimum, the Contractor shall have a physician with admitting and treatment privileges with each hospital in its network. Contractors in GSA 10 and/or GSA 12 must have at least one hospital contract in each service district. A list of Phoenix and Tucson area hospitals are included.

**ATTACHMENT B:  
MINIMUM NETWORK STANDARDS**

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**Contract/RFP No. YH02 0018**

Provider categories required at various service delivery sites included in the Service Area Minimum Network Standards are indicated as follows:

- H** Hospitals
- P** Primary Care Providers (physicians, certified nurse practitioners and physician assistants)
- D** Dentists
- Ph** Pharmacies

**HOSPITALS IN PHOENIX METROPOLITAN AREA (By service district, by zip code)**

**DISTRICT 1**

85006 Good Samaritan Regional Medical Center  
St. Luke's Medical Center  
85008 Maricopa Medical Center  
85013 St. Joseph's Hospital & Medical Center  
85020 John C. Lincoln Hospital – North Mountain

**DISTRICT 2**

85015 Phoenix Baptist Hospital & Medical Center  
85027 John C. Lincoln Hospital – Deer Valley  
85306 Thunderbird Samaritan Medical Center  
85308 Arrowhead Community Hospital & Medical Center  
85351 Walter O. Boswell Memorial Hospital  
85375 Del E. Webb Memorial Hospital  
85031 Maryvale Hospital Medical Center

**DISTRICT 3**

85032 Paradise Valley Hospital  
85054 Mayo Clinic Hospital  
85251 Scottsdale Healthcare – Osborn  
85261 Scottsdale Healthcare – Shea

**DISTRICT 4**

85201 Mesa General Hospital Medical Center  
Mesa Lutheran Hospital  
85202 Desert Samaritan Medical Center  
85206 Valley Lutheran Hospital  
85224 Chandler Regional Hospital  
85281 Tempe St. Luke's Hospital

**HOSPITALS IN TUCSON METROPOLITAN AREA (By service district, by zip code)**

**DISTRICT 1**

85719 University Medical Center  
85741 Northwest Hospital  
85745 Carondelet St. Mary's Hospital

**DISTRICT 2**

85711 Carondelet St. Joseph's Hospital  
85712 El Dorado Hospital  
Tucson Medical Center  
85713 Kino Community Hospital

**ATTACHMENT F: PERIODIC REPORT REQUIREMENTS**

The following table is a summary of the periodic reporting requirements for AHCCCS acute care contractors and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit the Contractor’s responsibilities in any manner. “Reporting Guide” refers to the *Reporting Guide for Acute Health Care Contractors with the Arizona Health Care Cost Containment System*.

<b>REPORT</b>	<b>WHEN DUE</b>	<b>SOURCE/REFERENCE</b>	<b>AHCCCS CONTACT:</b>
Monthly Financial Reporting Package	30 days after the end of the month, as applicable	Reporting Guide	Financial Manager
Quarterly Financial Reporting Package	120 days after the quarter ending September 30 <sup>th</sup> otherwise 60 days after the end of each quarter	Reporting Guide	Financial Manager
Draft Annual Audit Reporting Package	90 days after the end of each fiscal year	Reporting Guide	Financial Manager
Final Annual Audit Reporting Package	120 days after the end of each fiscal year	Reporting Guide	Financial Manager
Management Services Subcontractor Audit Report (if services > \$50,000)	120 days after the end of the subcontractor’s fiscal year	Reporting Guide	Financial Manager
Report of all subcontracts which delegate Contractor duties and responsibilities	90 days after the beginning of the contract year	Section D, Paragraph 46	DHCM, Health Plan Operations, Operations and Compliance Officer
Physician Incentive Plan (PIP) reporting	To be determined	Section D, Paragraph 15	Financial Manager
Provider Affiliation Transmission (PAT)	15 business days after the beginning of each quarter	PAT Manual , submitted to PMMIS Provider-to-Health Plan FTP	DHCM Health Plan Operations, Operations and Compliance Officer
Claims Reporting	15 <sup>th</sup> day of each month following the reporting period	Section D, Paragraph 30	DHCM, Health Plan Operations, Operations and Compliance Officer
Administrative Measures	15 <sup>th</sup> day of each month following the reporting period	Section D, Paragraph 13	DHCM, Health Plan Operations, Operations and Compliance Officer
Corrected Pended Encounter Data	Monthly, according to established schedule	Encounter Manual	Encounter Administrator
New Day Encounter Data	Monthly, according to established schedule	Encounter Manual	Encounter Administrator
Medical Records for Data Validation	90 days after the request received from	Attachment I, Encounter Submission Requirements	Data Validation Manager

**ATTACHMENT F:  
PERIODIC REPORT REQUIREMENTS**

**Contract/RFP No. YH02 0018**

<i>REPORT</i>	<i>WHEN DUE</i>	<i>SOURCE/REFERENCE</i>	<i>AHCCCS CONTACT:</i>
	AHCCCSA		
Quarterly Grievance and Appeals Report	45 days after the end of each quarter	Section D, Paragraph 54	OLA Administrative Assistant
Comprehensive EPSDT Plan including Dental	Annually on December 15 <sup>th</sup>	Section D, Paragraph 13	DHCM/CQM
EPSDT Progress Report including Dental - Quarterly Update	15 days after the end of each quarter	AMPM, Chapter 400	DHCM/CQM
Quarterly Inpatient Hospital Showing	15 days after the end of each quarter	State Medicaid Manual and the AMPM, Chapter 1000	DHCM/CQM Senior Administrator
Quality Management/ Utilization Management Plan and Evaluation	Annually on November 15 <sup>th</sup>	AMPM, Chapter 900	DHCM/CQM
Monthly Pregnancy Termination Report	End of the month following the pregnancy termination	AMPM, Chapter 400	DHCM/CQM
Maternity Care Plan	Annually on December 15 <sup>th</sup>	AMPM, Chapter 400	DHCM/CQM
Semi-annual report of number of pregnant women who are HIV/AIDS positive	30 days after the end of the 2 <sup>nd</sup> and 4 <sup>th</sup> quarter of each contract year	AMPM, Chapter 400	DHCM/CQM
Provider Network Development and Management Plan	45 days after the first day of a new contract year	Section D, Paragraph 21	DHCM, Health Plan Operations. Operations and Compliance Officer
Cultural Competency Plan	45 days after the first day of a new contract year	Section D, Paragraph 56 AHCCCS <i>Cultural Competency Policy</i>	DHCM, Health Plan Operations, Operations and Compliance Officer
HIV/AIDS Network Lists	Annually on December 15 <sup>th</sup>	AMPM	DHCM/CQM
Performance Improvement Project Proposal (initial/baseline year of the project)	Annually on November 15 <sup>th</sup>	AMPM, Chapter 900	DHCM/CQM
Performance Improvement Project Interim Report	Annually on December 15 <sup>th</sup>	AMPM, Chapter 900	DHCM/CQM
Performance Improvement Project Final Report	Within 180 days of the end of the project, as defined in the project proposal approved by AHCCCS DHCM	AMPM Chapter 900	DHCM/CQM
QM Quarterly Report	45 Days after the end of each quarter	Section D, Paragraph 14	DHCM/CQM
UM Quarterly Report	45 Days after the end of	Section D, Paragraph 14	DHCM/CQM

**ATTACHMENT F:  
PERIODIC REPORT REQUIREMENTS**

**Contract/RFP No. YH02 0018**

<i>REPORT</i>	<i>WHEN DUE</i>	<i>SOURCE/REFERENCE</i>	<i>AHCCCS CONTACT:</i>
	each quarter		
Provider Fraud/Abuse Report	Immediately following discovery	Section D, Paragraph 59	Office of Program Integrity Manager
Eligible Person Fraud/Abuse Report	Immediately following discovery	Section D, Paragraph 59	Office of Program Integrity Manager
Non-Transplant Catastrophic Reinsurance covered Diseases	Annually, within 30 days of the beginning of the contract year, enrollment to the plan, and when newly diagnosed.	Section D, Paragraph 35	DHCM Reinsurance Manager
Prescription Drug Utilization Report	Quarterly, within 45 days of end of the quarter	<i>AMPM</i>	Pharmacy Program Administrator
Business Continuity and Recovery Plan	15 days after the beginning of each contract year	Business Continuity and Recovery Plan Policy	DHCM, Health Plan Operations, Operation and Compliance Officer

**ATTACHMENT H (1): ENROLLEE GRIEVANCE AND REQUEST FOR HEARING PROCESS AND STANDARDS**

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

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

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

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

1. That the Contractor shall maintain records of all grievances and appeals.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes describing the right to hearing, the method for obtaining a hearing, the rules which govern representation at the hearing, the right to file grievances and appeals and the requirements and timeframes for filing a grievance or appeal.
3. The availability of assistance in the filing process and the Contractor's toll-free numbers that an enrollee can use to file a grievance or appeal by phone if requested by the enrollee.
4. That the Contractor shall acknowledge receipt of each grievance and appeal. For Appeals, the Contractor shall acknowledge receipt of standard appeals in writing within five business days of receipt and within one business day of receipt of expedited appeals.
5. That the Contractor shall permit both oral and written appeals and grievances and that oral inquiries appealing an action are treated as appeals.
6. That the Contractor shall ensure that individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making and that individuals who make decisions regarding: 1) appeals of denials based on lack of medical necessity, 2) a grievance regarding denial of expedited resolution of an appeal or 3) grievances or appeals involving clinical issues are health care professionals as defined in 42 CFR 438.2 with the appropriate clinical expertise in treating the enrollee's condition or disease.



7. The resolution timeframes for grievances, standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.
8. That if the Contractor extends the timeframe for resolution of a grievance or appeal when not requested by the enrollee, the Contractor shall provide the enrollee with written notice of the reason for the delay.
8. The definition of grievance as a member's expression of dissatisfaction with any aspect of their care, other than the appeal of actions.
9. That an enrollee must file a grievance with the Contractor and that the enrollee is not permitted to file a grievance directly with the State.
10. That the Contractor must dispose of each grievance in accordance with the Division of Health Care Management *Enrollee Grievance System Policy*, but in no case shall the timeframe exceed 90 days unless an extension is in effect.
11. The definition of action as the:
  - a. Denial or limited authorization of a requested service, including the type or level of service;
  - b. Reduction, suspension, or termination of a previously authorized service;
  - c. Denial, in whole or in part, of payment for a service;
  - d. Failure to provide services in a timely manner;
  - e. Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or
  - f. Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the contractor is the only Contractor in the rural area.
12. The definition of a service authorization request as an enrollee's request for the provision of a service.
13. The definition of appeal as the request for review of an action, as defined above.
14. Information explaining that a provider acting on behalf of an enrollee and with the enrollee's written consent, may file an appeal.
15. That an enrollee may file an appeal of: 1) the denial or limited authorization of a requested service including the type or level of service, 2) the reduction, suspension or termination of a previously authorized service, 3) the denial in whole or in part of payment for service, 4) the failure to provide services in a timely manner, 5) the failure of the Contractor to comply with the timeframes for dispositions of grievances and appeals and 6) the denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii) when the Contractor is the only Contractor in the rural area.
16. The definition of a standard authorization request and that for standard authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 14 days following the receipt of the authorization with a possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's best interest.
17. The definition of an expedited authorization request and that for expedited authorization decisions, the Contractor must provide a Notice of Action to the enrollee as expeditiously as the enrollee's health condition requires, but not later than 3 business days following the receipt of the authorization with a

possible extension of up to 14 days if the enrollee or provider requests an extension or if the Contractor establishes a need for additional information and delay is in the enrollee's interest.

18. That the Notice of Action for a service authorization decision not made within the standard or expedited timeframes, whichever is applicable, will be made on the date that the timeframes expire. If the Contractor extends the timeframe to make a standard or expedited authorization decision, the contractor must give the enrollee written notice of the reason to extend the timeframe and inform the enrollee of the right to file a grievance if the enrollee disagrees with the decision. The Contractor must issue and carry out its decision as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
19. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.
20. The definition of a standard appeal and that the Contractor shall resolve standard appeals no later than 30 days from the date of receipt of the appeal unless an extension is in effect.
21. The definition of an expedited appeal and that the Contractor shall resolve all expedited appeals not later than three business days from the date the Contractor receives the appeal (unless an extension is in effect) where the Contractor determines (for a request from the enrollee), or the provider (in making the request on the enrollee's behalf indicates) that the standard resolution timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. The Contractor shall make reasonable efforts to provide oral notice to an enrollee regarding an expedited resolution appeal.
22. That if the Contractor denies a request for expedited resolution, it must transfer the appeal to the 30-day timeframe for a standard appeal. The Contractor must make reasonable efforts to give the enrollee prompt oral notice and follow-up within two days with a written notice of the denial of expedited resolution.
23. That an enrollee shall be given 60 days from the date of the Contractor's Notice of Action to file an appeal.
24. That the Contractor shall mail a Notice of Action: 1) at least 10 days before the date of a termination, suspension or reduction of previously authorized AHCCCS services, except as provided in (a)-(f) 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 request for a standard service authorization which has been denied or reduced unless an extension is in effect; 5) within three business days from receipt of an expedited service authorization request unless an extension is in effect. As described below, the Contractor may elect to mail the Notice of Action no later than the date of action when:
  - a. The Contractor receives notification of the death of an enrollee;
  - b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
  - c. The enrollee is admitted to an institution where he is ineligible for further services;
  - d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
  - e. The enrollee has been accepted for Medicaid in another local jurisdiction;
25. That the Contractor include, as parties to the appeal, the enrollee, the enrollee's legal representative, or the legal representative of a deceased enrollee's estate.

**ATTACHMENT H (1):  
ENROLLEE GRIEVANCE SYSTEM STANDARDS AND POLICY**

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**Contract/RFP No. YH02 0018**

26. That the Notice of Action must explain: 1) the action the Contractor has taken or intends to take, 2) the reasons for the action, 3) the enrollee's right to file an appeal with the Contractor, 4) the procedures for exercising these rights, 5) circumstances when expedited resolution is available and how to request it and 6) the enrollee's right to request continued benefits pending resolution of the appeal, how to request continued benefits and the circumstances under which the enrollee may be required to pay for the cost of these services.
27. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the Contractor's action, 2) a) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment or b) the appeal involves a denial and the physician asserts the requested service/treatment is necessary continuation of a previously 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.

28. That for appeals, the Contractor provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person and in writing and that the Contractor informs the enrollee of the limited time available in cases involving expedited resolution.
29. That for appeals, the Contractor provides the enrollee and his representative the opportunity before and during the appeals process to examine the enrollee's case file including medical records and other documents considered during the appeals process.
30. That the Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an enrollee's appeal.
31. That the Contractor shall provide written Notice of Appeal Resolution to the enrollee and the enrollee's representative or the representative of the deceased enrollee's estate which must contain: 1) the results of the resolution process, including the legal citations or authorities supporting the determination, and the date it was completed, and 2) for appeals not resolved wholly in favor of enrollees: a) the enrollee's right to request a State fair hearing (including the requirement that the enrollee must file the request for a hearing in writing) no later than 30 days after the date the enrollee receives the Contractor's notice of appeal resolution and how to do so, b) the right to receive benefits pending the hearing and how to request continuation of benefits and c) information explaining that the enrollee may be held liable for the cost of benefits if the hearing decision upholds the Contractor.
32. That the Contractor continues extended benefits originally provided to the enrollee until any of the following occurs: 1) the enrollee withdraws appeal, 2) the enrollee has not specifically requested continued benefits pending a hearing decision within 10 days of the Contractor mailing of the appeal resolution notice, or 3) the AHCCCS Administration issues a state fair hearing decision adverse to the enrollee.
33. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCSA, Office of Legal Assistance (OLA) as specified by OLA. The file provided by the Contractor must contain a cover letter that includes:
  - a. Enrollee's name
  - b. Enrollee's AHCCCS I.D. number
  - c. Enrollee's address
  - d. Enrollee's phone number (if applicable)
  - e. Date of receipt of the appeal

- f. Summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution
35. The following material shall be included in the file sent by the Contractor:
    1. The Enrollee's written request for hearing
    2. Copies of the entire appeal file which includes all supporting documentation including pertinent findings and medical records;
    3. The Contractor's Notice of Appeal Resolution
    4. Other information relevant to the resolution of the appeal
  36. That if the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished while the appeal was pending, the Contractor shall authorize or provide the services promptly and as expeditiously as the enrollee's health condition requires.
  37. That if the Contractor or State fair hearing decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor shall pay for those services, as specified in policy and/or regulation.
  38. That if the Contractor or State fair hearing decision upholds a decision to deny authorization of services and the disputed services were received pending appeal, the Contractor may recover the cost of those services from the enrollee.

**ATTACHMENT H(2): PROVIDER CLAIM DISPUTE STANDARDS AND POLICY**

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

1. The Provider Claim Dispute Policy shall be provided to all subcontractors at the time of contract. For providers without a contract, the claim 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, with the exception of those challenging claim denials, must be filed with the Contractor no later than 60 days from the date of the adverse action. Claim disputes challenging claim denials must be filed in writing with the Contractor no later than 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the date of a timely claim submission, whichever is later.
3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the claim dispute process.
4. A log is maintained for all claim disputes containing sufficient information to identify the Complainant, date of receipt, nature of the claim dispute and the date the claim dispute is resolved. Separate logs must be maintained for provider and behavioral health recipient claim disputes
5. Within five business days of receipt, the Complainant is informed by letter that the claim dispute has been received.
6. Each claim dispute is thoroughly investigated using the applicable statutory, regulatory, contractual and policy provisions, ensuring that facts are obtained from all parties.
7. All documentation received by the Contractor during the claim dispute process is dated upon receipt.
8. All claim disputes are filed in a secure designated area and are retained for five years following the Contractor's decision, the Administration's decision, judicial appeal or close of the claim dispute, whichever is later.
9. A copy of the 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 claim dispute
  - b. the issues involved
  - c. the reasons supporting the Contractor's Decision, including references to applicable statute, rule, applicable contractual provisions, policy and procedure
  - d. the Provider's right to request a hearing by filing the request for hearing to the Contractor no later than 30 days after the date the Provider receives the Contractor's decision.
  - e. If the claim dispute is upheld, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.
10. If the Provider files a request for hearing, the 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 Contractor receives the verbal or written request from AHCCCSA, Office of Legal Assistance. The file sent by the Contractor must contain a cover letter that includes:

- a. Provider's name
  - b. Provider's AHCCCS ID number
  - c. Provider's address
  - d. Provider's phone number (if applicable)
  - e. the date of receipt of claim dispute
  - f. a summary of the Contractor's actions undertaken to resolve the claim dispute and basis of the determination
11. The following material shall be included in the file sent by the Contractor:
- a. written request for hearing filed by the Provider
  - b. copies of the entire file which includes pertinent records; and the Contractor's Decision
  - c. other information relevant to the Notice of Decision of the claim dispute
12. If the Contractor's Decision regarding a claim dispute is reversed through the 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.

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**ATTACHMENT I: ENCOUNTER SUBMISSION REQUIREMENTS**

The 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 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 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 per month	\$ 10 per month	\$ 15 per month	\$ 20 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 Contractor notifies AHCCCSA in writing that the resolution of a pended encounter depends on AHCCCSA rather than the 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 Contractor's notification and asks the Contractor to research the issue and provide additional substantiating documentation, or if AHCCCSA disagrees with the 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 Contractor may be sanctioned retroactively.

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

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

**Encounter Validation Studies**

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

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

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 Contractor in writing of the sanction amounts and of the selected data needed for encounter validation studies. The Contractor will have 90 days to submit the requested data to AHCCCSA. In the case of medical record requests, the 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 Contractor to select a statistically valid sample for a study, the Contractor may be sanctioned up to 5% of its annual capitation payment.

The criteria used in encounter validation studies may include timeliness, correctness, and omission of encounters. These criteria are defined as follows:

*Timeliness:* The time elapsed between the date of service and the date that the encounter is received at AHCCCSA. Ninety-five percent (95%) of all encounters must 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 enrollment with the Contractor, whichever is later. 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 date determined above. 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 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 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 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 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 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 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*, which is available in the Bidders Library. This document also provides



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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 Contractor for review and comment. The 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 Contractor's documentation and may revise study results if warranted. Written final results of the study will then be sent to the Contractor and communicated to CMS, and any sanctions will be assessed.

The Contractor may file a written challenge to sanctions assessed by AHCCCSA not more than 35 days after the 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 claim dispute and request for hearing pursuant to A.A.C. R9-34-401 et seq. Sanction amounts will be deducted from the Contractor's capitation payment.

#### **Encounter Corrections**

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