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

AHCCCS

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

SECTION A. CONTRACT AMENDMENT

1. AMENDMENT NUMBER:	2. CONTRACT NO:	3. EFFECTIVE DATE OF AMENDMENT:	4. PROGRAM
9	***YH02-0018*** E4403002	**January 1, 2007**	**DHCM - CMDP**

5. CONTRACTOR/PROVIDER NAME AND ADDRESS:

Arizona Department of Economic Security
Comprehensive Medical and Dental Program (CMDP)
PO Box 29202, Site Code 942C
Phoenix, Arizona 85038-9202

6. PURPOSE OF AMENDMENT: To Amend Sections B, D and E and Attachments A, B, F, H, I and L.

7. THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

A. CHANGES IN REQUIREMENTS: In accordance with Section D, Paragraph 30, "Changes", various changes in contract requirements are indicated in this contract restatement.
B. By signing this contract amendment, the Contractor is agreeing to the terms of the contract as amended.
C. Extend the contract term from January 1, 2007 to December 31, 2007.
D. Change the capitation rate as indicated in Section B.

NOTE: Please sign, date and return all originals to: Jamey Schultz, M/D 5700
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. SIGNATURE OF AUTHORIZED REPRESENTATIVE:	10. SIGNATURE OF AHCCCSA CONTRACTING OFFICER**:**
TYPED NAME:	**MICHAEL VEIT**
TITLE:	**CONTRACTS & PURCHASING ADMINISTRATOR**
DATE:	DATE:

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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, 2007 through December 31, 2007:

Prospective:	$ 255.08
Prior Period Coverage:	$ 340.66

[END OF SECTION B]

SECTION C: DEFINITIONS

638 TRIBAL FACILITY	A facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.
1931	Eligible individuals and families under the 1931 provision of the Social Security Act, with household income levels at or below 100% of the FPL.
ACOM	*AHCCCS Contractor Operations Manual*, available on the AHCCCS Website at www.azahcccs.gov.
ADHS	Arizona Department of Health Services, the State agency mandated to serve the public health needs of all Arizona citizens.
ADHS BEHAVIORAL HEALTH RECIPIENT	A Title XIX or Title XXI acute care member who is eligible for, and is receiving, behavioral health services through ADHS and its subcontractors.
AJUDICATED CLAIMS	Claims which have been received and processed by the Contractor which resulted in a payment or denial of payment.
ADJC	Arizona Department of Juvenile Correction.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS	Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person, as defined by A.R.S. § 36-2902, et seq.
AHCCCS BENEFITS	See "COVERED SERVICES".
AHCCCS MEMBER	See "MEMBER".
AHCCCSA	Arizona Health Care Cost Containment System Administration.
ALTCS	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.
AMBULATORY CARE	Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.
AMPM	*AHCCCS Medical Policy Manual.*
AOC	Administrative Office of the Courts.
APPEAL RESOLUTION	The written determination by the Contractor concerning an appeal.
ARIZONA ADMINISTRATIVE CODE (A.A.C.)	State regulations established pursuant to relevant statutes. For purposes of this solicitation, the relevant sections of the AAC are referred to throughout this document as "AHCCCS Rules".
A.R.S.	Arizona Revised Statutes.

AT RISK	Refers to the period of time that a member is enrolled with a Contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.
BBA	The Balanced Budget Act of 1997.
BCCTP	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.
BIDDERS LIBRARY	A repository of manuals, statutes, rules and other reference material located on the AHCCCS website at www.azahcccs.gov .
BOARD CERTIFIED	An individual who has successfully completed all prerequisites of the respective specialty board and successfully passed the required examination for certification.
CAPITATION	Payment to Contractor by AHCCCSA of a fixed monthly payment per person in advance for which the Contractor provides a full range of covered services as authorized under A.R.S. § 36-2942 and § 36-2931.
CATEGORICALLY LINKED TITLE XIX MEMBER	Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act, 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.
CLAIM DISPUTE	A dispute, filed by a provider or contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
CLEAN CLAIM	A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.
CMDP	Comprehensive Medical and Dental Program.
CMS	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.
CONTRACT SERVICES	See "COVERED SERVICES".
CONTRACT YEAR (CY)	A calendar year: January 1 through December 31.
CONTRACTOR	An 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.
CONVICTED	A judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

COPAYMENT	A monetary amount specified by the Director that the member pays directly to a Contractor or provider at the time covered services are rendered, as defined in R9-22-107.
COVERED SERVICES	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.
CPS	Child Protective Services
CRS	Children's Rehabilitative Services, as defined in R9-22-114.
CRS ELIGIBLE	An individual that has completed the CRS application process, as delineated in the *CRS Policy and Procedure Manual,* and has met all applicable criteria to be eligible to receive CRS related services.
CRS RECIPIENT	A CRS recipient is a CRS eligible individual that has completed the initial medical visit at an approved CRS Clinic, which allows the individual to participate in the CRS program.
CSHCN	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).
CY	See "CONTRACT YEAR".
CYE	Contract Year Ended; same as "CONTRACT YEAR".
DAYS	Calendar days unless otherwise specified as defined in the text, as defined in R9-22-101.
DCYF	The Division of Children, Youth and Families within DES
DELEGATED AGREEMENT	An agreement with a qualified organization or person to perform one or more functions required to be provided by the Contractor pursuant to this contract.
DES	Department of Economic Security
DIRECTOR	The Director of AHCCCSA.
DISCLOSING ENTITY	An AHCCCS provider or a fiscal agent.
DISENROLLMENT	The discontinuance of a member's ability to receive covered services through a Contractor.
DME	Durable Medical Equipment, 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.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
ELIGIBILITY DETERMINATION	A process of determining, through a written application, including required documentation, whether an applicant meets the qualifications for Title XIX or Title XXI.

EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. [42 CFR 438.114(a)]
EMERGENCY MEDICAL SERVICE	Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. [42 CFR 438.114(a)]
ENCOUNTER	A record of a 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.
ENROLLEE	A Medicaid recipient who is currently enrolled with a contractor. [42 CFR 438.10(a)]
ENROLLMENT	The process by which an eligible person becomes a Title XIX or Title XXI funded member of Contractor's health plan
EPSDT	Early and Periodic Screening, Diagnosis and Treatment; services for persons under 21 years of age as described in AHCCCS rules R9-22, Article 2.
FAMILY PLANNING SERVICES EXTENSION PROGRAM	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.
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	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.
FEE-FOR-SERVICE (FFS)	A method of payment to registered providers on an amount-per service basis.
FFP	Federal financial participation (FFP) refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS as defined in 42 CFR 400.203.
FISCAL YEAR (FY)	The budget year - Federal Fiscal Year: October 1 through September 30; State fiscal year: July 1 through June 30.
GEOGRAPHIC SERVICE AREA (GSA)	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
GROUP OF PROVIDERS	Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

HEALTH PLAN	See "CONTRACTOR".
HIFA PARENTS	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.
IBNR	Incurred But Not Reported: Liability for services rendered for which claims have not been received.
IHS	Indian Health Services authorized as a Federal agency pursuant to 25 U.S.C. 1661.
IMD	Institution For Mental Disease; An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. (42 CFR 435.1009)
JPO	Juvenile Probation Office
KIDSCARE	Individuals under the age of 19, eligible under the SCHIP program, in households with income at or below 200% FPL. All members, except Native American members, are required to pay a premium amount based on the number of children in the family and the gross family income. Also referred to as Title XXI.
LIEN	A legal claim filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.
MANAGED CARE	Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have significant financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, utilization management and the coordination of care.
MANAGEMENT SERVICES AGREEMENT	An agreement with an entity in which the owner of the Contractor delegates some or all of the comprehensive management and administrative services necessary for the operation of the Contractor.
MANAGEMENT SERVICES SUBCONTRACTOR	An entity to which the Contractor delegates the comprehensive management and administrative services necessary for the operation of the Contractor.
MANAGING EMPLOYEE	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization or agency.
MAJOR UPGRADE	Any upgrade or changes that may result in a disruption to the following: Loading of contracts, providers, members, issuing prior authorizations or the adjudication of claims.

MATERIAL OMISSION	A fact, data or other information excluded from a report, contract, etc. the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.
MEDICAID	A Federal/State program authorized by Title XIX of the Social Security Act, as amended.
MEDICAL EXPENSE DEDUCTION (MED)	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.
MEDICAL MANAGEMENT	An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).
MEDICALLY NECESSARY SERVICES	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.
MEDICARE	A Federal program authorized by Title XVIII of the Social Security Act, as amended.
MEDICARE MANAGED CARE PLAN	A managed care entity that has a Medicare contract with CMS to provide services to Medicare beneficiaries, including Medicare Advantage Prescription Drug Plan (MAPDP), MAPDP Special Needs Plan, or Medicare Prescription Drug Plan.
MEDICARE MODERNIZATION AND IMPROVEMENT ACT	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.
MEDICARE PART D EXCLUDED DRUGS	Medicare Part D is the Prescription Drug Coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit will not be covered by AHCCCS post January 1, 2006. There are certain drugs that are excluded from coverage by Medicare, and will continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the *AMPM*. Prescription medications that are covered under Medicare, but are not on a Part D Health Plan's formulary are not considered excluded drugs, and will not be covered by AHCCCS.
MEMBER	An eligible person who is enrolled in the system, as defined in A.R.S. § 36-2901, and A.R.S. §8-512. A.R.S. § 36-2981 and A.R.S. § 36-2981.01.
NON-CONTRACTING PROVIDER	A person who provides services as prescribed in A.R.S. § 36-2939 and who does not have a subcontract with an AHCCCS Contractor.
PERFORMANCE STANDARDS	A set of standardized indicators designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors. Specific descriptions of health services measurement goals are found in Section D, Paragraph 24, Performance standards.

PMMIS	AHCCCSA's Prepaid Medical Management Information System.
POST STABILIZATION SERVICES	Medically necessary services, related to an emergency medical condition, provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve the member's condition so that the member could alternatively be safely discharged or transferred to another location. [42 CFR 438.114(a)]
POTENTIAL ENROLLEE	A Medicaid eligible recipient who is not enrolled with a contractor. [42 CFR 438.10(a)]
PRIMARY CARE PROVIDER (PCP)	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.
PRIOR PERIOD	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.
PROVIDER	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.
QUALIFIED MEDICARE BENEFICIARY (QMB)	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.
RATE CODE	Eligibility classification for capitation payment purposes.
REGIONAL BEHAVORIAL HEALTH AUTHORITY (RBHA)	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.
REINSURANCE	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.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RISK GROUP	Grouping of rate codes that are paid at the same capitation rate.

SCHIP	State Children's Health Insurance Program under Title XXI of the Social Security Act. The Arizona version of SCHIP is referred to as "Kidscare". See Kidscare.
SCOPE OF SERVICES	See "COVERED SERVICES".
SERVICE LEVEL AGREEMENT	An agreement with a corporate owner, or any of its Divisions or Subsidiaries, that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCSA under the terms of this contract, as defined in R9-22-101.
SOBRA	Section 9401 of the Sixth Omnibus Budget and Reconciliation Act, 1986, amended by the Medicare Catastrophic Coverage Act of 1988, U.S.C. 1396a(a)(10)(A)(ii)(IX), November 5, 1990.
SPECIAL HEALTH CARE NEEDS	Members with special health care needs are those members who have serious and chronic physical, developmental or behavioral conditions, and who also require medically necessary health and related services of a type or amount beyond that required by members generally.
STATE	The State of Arizona.
STATE PLAN	The written agreements between the State and CMS which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.
SUBCONTRACT	An agreement entered into by the Contractor with 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.
SUBCONTRACTOR	(1) A provider of health care who agrees to furnish covered services to members. (2) A person, agency or organization with which the Contractor has contracted with or delegated some of its management/administrative functions or responsibilities (3) 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.
SUPPLEMENTAL SECURITY INCOME (SSI)	Federal cash assistance program under Title XVI of the Social Security Act.
TEFRA RISK HMO	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.
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)	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).

THIRD PARTY	An individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member, as defined in R9-22-110.
THIRD PARTY LIABILITY	The resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member, as defined in R9-22-110.
TITLE XIX MEMBER	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.
TITLE XIX WAIVER MEMBER	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.
TITLE XXI MEMBER	Member eligible for acute care services under Title XXI of the Social Security Act, referred to in Federal legislation as the "State Children's Health Insurance Program" (SCHIP and HIFA). The Arizona version of SCHIP is referred to as "KidsCare."
YEAR	See "Contract Year".

[END OF SECTION C, DEFINITIONS]

SECTION D: PROGRAM REQUIREMENTS

1. 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 26, 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.

2. RESERVED

3. ENROLLMENT AND DISENROLLMENT

In accordance with A.R.S. 8-512, CMDP provides comprehensive medical and dental care for each child who is: a) placed in a foster home; b) in the custody of 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. Children who are enrolled with CMDP when placed temporarily in detention may remain Title XIX or Title XXI eligible. When it is determined that the child does not meet the "inmate of a public institution" status as determined by the Children in Detention Policy, AHCCCS enrollment will remain with CMDP.

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. 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, 307, 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 even though the newborn may not be under the custody of the Contractor. 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.

4. RESERVED

5. RESERVED

6. RESERVED

7. RESERVED

8. 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, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information, or physical or mental handicap, except where medically indicated. Contractors must take into account a member's literacy and culture, when addressing members and their concerns, and must take reasonable steps to encourage subcontractors to do the same. The Contractor must make interpreters, including assistance for the visual or hearing impaired, 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.

9. TRANSITION OF MEMBERS

The Contractor shall comply with the *AMPM*, and the *ACOM Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* for member transitions between contractors or participation in or discharge from CRS or CMDP, to or from an ALTCS Program Contractor, and upon termination a contract. The Contractor shall develop and implement policies and procedures, which comply with these policies to address transition of:.

a. Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.;
b. Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;
c. Members who have received prior authorization for services such as scheduled surgeries, out-of-area specialty services, nursing home admission;
d. Prescriptions, DME and medically necessary transportation ordered for the transitioning member by the relinquishing contractor; and
e. Medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing AHCCCS contractor).

When relinquishing members, the 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.

10. 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. [42 CFR 438.210(a)(3)]

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. [42 CFR 438.210(b)]

Notice of Action: The Contractor shall notify the requesting provider, and give the member written notice of any decision by the Contractor to deny, reduce, suspend or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, except for the requirement that the notice to the provider be in writing. [42 CFR 438.210(c)]

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.

Anti-hemophilic Agents and Related Services: The Contractor shall provide services for the treatment of hemophilia and Von Willebrands disease (See Paragraph 57, REINSURANCE, *Catastrophic Reinsurance*). AHCCCSA holds a single-source specialty contract for anti-hemophilic agents and related services for hemophilia. Non-hemophilia related services are not covered under this contract. Non-hemophilia-related care is defined as any care that is provided not related to the hemophilia services.

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

Audiology The 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.

Behavioral Health: The Contractor shall provide behavioral health services as described in Section D, Paragraph 12, 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. The Contractor is responsible for care of members until Children's Rehabilitative Services Administration (CRSA) determines those members eligible. In addition, the Contractor is responsible for covered services for CRS eligible members unless and until the Contractor has received written confirmation from CRSA that CRSA will provide the requested service. The Contractor shall require the member's Primary Care Provider (PCP) to coordinate the member's care with the CRS Program. For more detailed information regarding eligibility criteria, referral practices, and contractor-CRS coordination issues, refer to the CRS Policy and Procedures Manual and the ACOM, including Section 409 "Notices of Action."

The Contractor shall respond to requests for services potentially covered by CRSA in accordance with Section 409 "Notices of Action" of the ACOM. The Contractor is responsible to address prior authorization requests if CRSA fails to comply with the timeframes specified in Section 409. The Contractor remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition, emergency services related to a CRS condition rendered outside the CRS network, and AHCCCS covered services denied by CRSA for the reason that it is not a service related to a CRS condition.

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

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

***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 42 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 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 24, 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 emergency room provider, hospital, or fiscal agent to notify the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. Claims submission by the hospital within 10 calendar days of presentation for the emergency services constitutes notice to the Contractor. This notification stipulation is only related to the provision of emergency services.
3. Require notification of Emergency Department treat and release visits as a condition of payment unless the plan has prior approval of the AHCCCS Administration.

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

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

For additional information and requirements regarding emergency services, refer to AHCCCS Rules R9-22-201 et seq..

Eye Examinations/Optometry: 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 and Community Based Services (HCBS): Assisted living facility, alternative residential setting, or 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.* This service is covered in lieu of a nursing facility.

***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 24 Performance Standards. (Please refer to the AMPM for current immunization requirements.)

***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). 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.

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, except where otherwise noted in the contract.

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

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. This form must be submitted to the 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, other authorized prescriber 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, as defined in the AMPM. Appropriate over-the-counter medication may be prescribed when it is determined to be a lower-cost alternative to prescription drugs.

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

11. SPECIAL HEALTH CARE NEEDS

The Contractor shall have in place a mechanism to identify and stratify all members with special health care needs [42 CFR 438.240(b)(4)]. 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 [42 CFR 438.208(c)(2)]. The Contractor shall share with other entities providing services to that member the results of its identification and assessment of that member's needs so that those activities need not be duplicated [42 CFR 438.208(b)(3)].

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have procedures in place to allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. [42 CFR 438.208(c)(4)]

The Contractor shall have a methodology to identify providers willing to provide 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

12. BEHAVIORAL HEALTH SERVICES

AHCCCS members, except for SOBRA Family Planning 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/home care training, self-help/peer support)
b. Behavioral Health Case Management Services (limited)
c. Behavioral Health Nursing Services
d. Emergency Behavioral Health Care
e. Emergency and Non-Emergency Transportation
f. Evaluation and Assessment
g. Individual, Group and Family Therapy and Counseling
h. Inpatient Hospital Services
i. Non-Hospital Inpatient Psychiatric Facilities (Level I residential treatment centers and sub-acute facilities)
j. Behavioral Health Residential Services, Level 2 and Level 3
k. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
l. Opioid Agonist Treatment
m. Partial Care (Supervised day program, therapeutic day program, and medical day program)
n. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
o. Psychotropic Medication
p. Psychotropic Medication Adjustment and Monitoring
q. Respite Care (with limitations)

r. Rural Substance Abuse Transitional Agency Services
s. Screening
t. Therapeutic Foster Care Services

Referrals: As specified in Section D, Paragraph 10, 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: Contractors are responsible for providing up to 72 hours inpatient emergency behavioral health services to members with psychiatric or substance abuse diagnoses who are not behavioral health recipients in accordance with AHCCCS Rule R9-22-210.01. For additional information regarding behavioral health services refer to Title 9 Chapter 22 Articles 2 and 12. It is expected that Contractors initiate a referral to the RBHA for evaluation and behavioral health recipient eligibility 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 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.

13. AHCCCS GUIDELINES, POLICIES AND MANUALS

All AHCCCS guidelines, policies and manuals are hereby incorporated by reference into this contract. All guidelines, policies and manuals are available on the AHCCCS Home Page on the Internet at www.azahcccs.gov or upon request. The Contractor is responsible for complying with the requirements set forth within. In addition, linkages to AHCCCS rules (Arizona Administrative Code), Statutes and other resources is available to all interested parties through the AHCCCS Home Page. Upon adoption by AHCCCS, updates will be available to the Contractor. Once notification to the Contractor has taken place, the Contractor shall be responsible for implementing and maintaining current copies of updates.

14. MEDICAID SCHOOL BASED CLAIMING PROGRAM (MSCB)

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

MSBC services are provided in a school setting or other approved setting specifically to allow children to receive a public school education. They do not replace medically necessary services provided outside the school setting or other MSBC approved alternative setting. Currently, 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 MSBC services.

Contractors and their providers must coordinate with schools and school districts that provide MSBC services to the Contractor's enrolled members. Services should not be duplicative. Contractor case managers, working with special needs children, should coordinate with 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.

15. PEDIATRIC IMMUNIZATIONS AND THE VACCINES 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, a physician if acting as primary care physician (PCP) AHCCCS members under the age of 19, 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.

16. 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 [42 CFR 438.610(a) and (b)]. 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., g., i., k., n., o. p., and q 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/Coordinator*** who is an Arizona-licensed registered nurse, physician or physician's assistant.

e. A ***Utilization Management/Medical Management Coordinator*** who is an Arizona-licensed registered nurse, physician or physician's assistant.

f. A ***Maternal Health/EPSDT 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.

g. 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.

h. ***Prior Authorization staff*** to authorize health care. This staff shall include an Arizona-licensed registered nurse, physician or physician's assistant.

i. ***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 experienced in concurrent review and under the direct supervision of a registered nurse, physician or physician's assistant.

j. ***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.

k. ***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.

l. *A* ***Claims Administrator and Claims Processors*** to ensure the timely and accurate processing of original claims, re-submissions and overall adjudication of claims.

m. ***Encounter Processors*** to ensure the timely and accurate processing and submission to AHCCCSA of encounter data and reports.

n. *A* ***Grievance Manager*** who will manage and adjudicate member and provider disputes arising under the Grievance System including member grievances, appeals and requests for hearing and provider claim dispute.

o. ***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 62, Corporate Compliance, for more information.

p. ***Contractor Staff*** sufficient to implement and oversee compliance with both the Contractor's Cultural Competency Plan and the *ACOM Cultural Competency Policy*, and to oversee compliance with all AHCCCS requirements pertaining to limited English proficiency (LEP).

q. ***Clerical and Support staff*** to ensure appropriate functioning of the Contractor's operation.

r. ***Business Continuity Planning Coordinator*** as noted in the ACOM *Business Continuity and Recovery Policy.*

s. ***A Pharmacy Coordinator/Director*** who is Arizona licensed pharmacist or physician who oversees and administers the prescription drug and pharmacy benefits. The Pharmacy Coordinator/Director may be an employee or contractor of the Plan.

t. ***Dental Director/Coordinator*** who is responsible for coordinating dental activities of the health plan and providing required communication between the plan and AHCCCS. The Dental Director/Coordinator

may be an employee or contractor of the plan and must be licensed in Arizona if they are required to review or deny services.

The Contractor shall inform AHCCCSA, Division of Health Care Management (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 Coordinator
Grievance Manager	Behavioral Health Coordinator
Compliance Officer	

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

17. 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.

18. 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, Notice of Action, vital information from the member handbooks and consent forms.

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

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

The Contractor shall make every effort to ensure that all information prepared for distribution to members is written using an easily understood language and format and as further described in the ACOM *Member Information Policy*. 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. [42 CFR 438.10(d)]

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

The 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 [42 CFR 438.10(f)(3)]:

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

The 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 45 days prior to the contact begin date or within four weeks of receiving the annual renewal amendment, whichever is later.

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

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 [42 CFR 438.10(f)(4) and (5)].

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

- Educational information on chronic illnesses and ways to self-manage care
- Reminders of flu shots and other prevention measures at appropriate times
- Cultural Competency
- Contractor specific issues

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

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

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

19. SURVEYS

The Contractor may be required to 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 Acute Care Operations Unit within 45 days of the completion of the project. AHCCCSA may require inclusion of certain questions.

AHCCCSA may periodically 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.

20. CULTURAL COMPETENCY

The Contractor shall have a Cultural Competency Plan that meets the requirements of the *ACOM Cultural Competency Policy*. An annual assessment of the effectiveness of the plan, along with any modifications to the plan, must be submitted to the Division of Health Care Management, no later than 45 days after the start of each contract year. This plan should address all services and settings. [42 CFR 438.206(c)(2)]

21. 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)

22. RESERVE

23. QUALITY MANAGEMENT AND MEDICAL MANAGEMENT (QM/MM)

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)]:

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

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, QM evaluation of the previous year's QM program and Quarterly Quality Management Report 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.

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

1. Pharmacy Management; including the evaluation, reporting, analysis and interventions based on the data and reported through the MM Committee
2. Prior Authorization and Referral Management;

For the processing of requests for initial and continuing authorizations of services the Contractor shall:

a) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and
b) Consult with the requesting provider when appropriate [42 CFR 438.210(b)(2)]
c) Monitor and ensure that all enrollees with special health care needs have direct access to care

3. Development and/or Adoption of Practice Guidelines [42 CFR 438.236(b)], that
    a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
    b) Consider the needs of the Contractor's members;
    c) Are adopted in consultation with contracting health care professionals;
    d) Are reviewed and updated periodically as appropriate;
    e) Are disseminated by Contractors to all affected providers and, upon request, to enrollees and potential enrollees [42 CFR 438.236(c)]; and
    f) Provide a basis for consistent decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply [42 CFR 438.236(d)]
4. Concurrent review;
    a) Consistent application of review criteria; Provide a basis for consistent decisions for utilization management, coverage of services, and other areas to which the guidelines apply;
    b) Discharge planning
5. Continuity and coordination of care;
6. Monitoring and evaluation of over and/or under utilization of services [42 CFR 438-240(b)(3)];
7. Evaluation of new medical technologies, and new uses of existing technologies;
8. Disease Management or Chronic Care Program that reports results and provides for analysis of the program through the MM Committee; and,
9. Quarterly Utilization Management Report (details in the *AMPM*).

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

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

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

24. PERFORMANCE STANDARDS

Administrative Measures:

The maximum allowable speed of answer (SOA) is 45 seconds. The SOA is defined as the on line wait time in seconds that the member/provider waits from the moment the call is connected in the Contractor's phone switch until the call is picked up by a contractor representative or Interactive Voice Recognition System (IVR). If the Contractor has IVR capabilities, callers must be given the choice of completing their call by IVR or by contractor representative.

The Contractor shall meet the following standards for its member services and centralized provider telephone line statistics. All calls to the line shall be included in the measure.

a. The Monthly Average Abandonment Rate shall be 5% or less;
b. First Contact Call Resolution shall be 70% or better; and
c. The Monthly Average Service Level shall be 75% or better.

The Monthly Average Abandonment Rate (AR) is:

Number of calls abandoned in a 24-hour period
Total number of calls received in a 24-hour period

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

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.

The Monthly Average Service Level (MASL) is:

Calls answered within 45 seconds for the month reported
Total of month's answered calls + month's abandoned calls + (if available) month's calls receiving a busy signal

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 a. through c., 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 [42 CFR 438.240(a)(2), (b)(2) and (c)].

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

AHCCCS has established three levels of performance:

Minimum Performance Standard – A Minimum Performance Standard is the minimal expected level of performance by the 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.

The Contractor must show demonstrable and sustained improvement toward meeting AHCCCS Performance Standards. In addition to corrective action plans, AHCCCS may impose sanctions when the Contractor does not meet the Minimum Performance Standard and does not show statistically significant improvement in an indicator rate and/or require the Contractor to demonstrate that it is allocating increased administrative resources to improving rates for a particular indicator or service area. AHCCCS also may require a corrective action plan if the 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 Measures: 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, or upon request from AHCCCSA. The measures 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 measures:

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.

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

Acute Care Contractor Performance Standards

Performance	CYE 07	CYE 07	Benchmark

Indicator	Minimum Performance Standard	Goal	(Healthy People Goals)
Immunization of Two-year-olds			
4:3:1 Series	84%	90%	90%
4:3:1:3:3 Series	74%	80%	80%
DTaP - 4 doses	85%	90%	90%
Polio - 3 doses	90%	90%	90%
MMR - 1 dose	90%	90%	90%
Hib - 3 doses	86%	90%	90%
HBV - 3 doses	90%	90%	90%
Varicella - 1 dose	86%	90%	90%
Adolescent Immunizations (1)	60%	63%	90%
Dental Visits	51%	57%	57%
Well-child Visits 15 Months (2)	70%	72%	90%
Well-child Visits 3 - 6 Years	56%	58%	80%
Adolescent Well-care Visits	37%	38%	50%
EPSDT Participation	68%	69%	80%
Children's Access to PCPs 12-24 Months	85%	86%	97%
Children's Access to PCPs 25 months-6 Years	78%	80%	97%
Children's Access to PCPs 7-11 Years	77%	79%	97%
Children's Access to PCPs 12-19 Years	79%	81%	97%

(1) This measure cannot be reliably generated through administrative data, and current AHCCCS data is not yet available. MPS and Goal are based on NCQA Medicaid average
(2) CYE 2007 Minimum Performance Standard and Goal for Well-child Visits in the First 15 Months of Life is unchanged from the CYE 2006 contract because validated data for this measure was not available in time to be incorporated into the contract renewal.

Quality Improvement:

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

A. 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. The Contractor must [42 CFR 438.240(b)(2) and (c)]::
    a. Measure and report to the State its performance, using standard measures required by the State, or as required by CMS,
    b. Submit to the State, data specified by the State, that enables the State to measure the Contractor's performance; or
    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.
5. The Contractor must have in place a process for internal monitoring of Performance Measure rates, using standard methodology established or adopted by AHCCCS, for each required Performance Measure. The Contractor's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its administration. It also will report this Performance Measure data to AHCCCSA in conjunction with its Quarterly EPSDT Progress Report, according to a format developed by AHCCCS.

B. Performance Improvement Program

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

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.

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

C. Data Collection Procedures:

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

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

25. GRIEVANCE SYSTEM

The Contractor shall have in place a written grievance system for subcontractors, enrollees and non-contracted 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. Information to enrollees must meet cultural competency and limited English proficiency requirements as specified in Section D, Paragraph 18, Member Information and Paragraph 20, 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.

26. QUARTERLY GRIEVANCE SYSTEM REPORTS

Enrollee Appeal and Provider Claim Dispute Report: The Contractor must submit the Enrollee Appeal and Provider Claim Dispute Report to AHCCCSA, Division of Health Care Management, using the Quarterly Grievance System Report Format, no later than 45 days from the end of each 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 no later than 45 days from the end of each quarter. The report must 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 shall be reported to AHCCCSA, Division of Health Care Management with the Enrollee Appeal and Provider Claim Dispute Report.

27. 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 [42 CFR 438.206(b)(1)]. 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 [42 CFR 438.206(c)(1)(iii)] . 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 [42 CFR 438.210(a)(2)]. 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 [42 CFR 438.206(b)(4) and (5)].

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

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

AHCCCS encourages plans to work with the many residency programs currently operating in the state and to investigate opportunities for resident participation in contractor medical management and committee activities.

The Contractor shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider based solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)]. In addition, the Contractor must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)]. This provision, however, does not prohibit the Contractor from limiting provider participation to the extent necessary to meet the needs of the Contractor's members. This provision also does not interfere with measures established by the Contractor to control costs consistent with its responsibilities under this contract [42 CFR 438.12(b)(1)]. 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 [42 CFR 438.12(a)(1)]. 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 [42 CFR 438.214(d)].

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 [42 CFR 438.207(b)]. 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 [42 CFR 438.206(b)(1)]. The plan, at a minimum, shall also include the following:

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.
j. The assistance provided to PCPs when they refer members to specialists. The methods used to communicate the availability of this assistance to the providers.
k. The methodology (ies) the Contractor uses to collect and analyze provider feedback about the network designs and implementation. When specific provider issues are identified, the protocols for handling them.

The plan must include answers to the following questions:

a. How does the Contractor assess the medical and social needs of new members to determine how the contractor may assist the member in navigating the network more efficiently?
b. What assistance is provided to members with a high severity of illness or higher utilization to better navigate the provider network?
c. Does the Contractor utilize any of the following strategies to reduce unnecessary emergency department utilization by the membership? If so, how are members educated about these options?
   i. Physician coverage/call availability after-hours and on weekends
   ii. Same-day PCP appointments
   iii. Nurse call-in centers/information lines
   iv. Urgent Care facilities
d. Are members with special health care needs assigned to specialists for their primary care needs?
e. What are the most significant barriers to efficient network deployment within the Contractor's service area? How can AHCCCS best support the Contractor's efforts to improve its network and the quality of care delivered to its membership?

28. PROVIDER AFFIIATION 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.

29. 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 [42 CFR 438.214(a)]:

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. A material change in Contractor policy or process requires 30 days advance notice to affected providers and members. A material change is defined as any change in overall business practice that could have an impact on 5% or more of the members, providers, or AHCCCS program, or may significantly impact the delivery of services provided by an AHCCCS Contractor. Contractors are required to submit the member notices to AHCCCS for approval 30 days prior to the notice being sent. Upon receipt of the member notice for review, AHCCCSA may comment on the material change or may intervene if the policy/process change will have an adverse affect to the overall system.

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

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

All material changes in the Contractor's provider network must be approved in advance by AHCCCSA, Division of Health Care Management [42 CFR 438.207(c)]. 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. 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 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.

30. 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 midwifes; or physician's assistants [42 CFR 438.206(b)(2)].

The Contractor shall assess the PCP's ability to meet AHCCCS appointment availability and other standards, when determining the appropriate number of its members to be assigned to 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 that 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 [42 CFR 438.6(m) and 438.52(d)]. 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 ACOM *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 [42 CFR 438.208(b)(1)]:

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. Services requiring medical follow up, including oral health/dental services, must be documented and included in the medical record.

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.

31. 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.

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.

32. REFERRAL MANAGEMENT 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 clearly identifying the Contractor
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 [42 CFR 438.206(b)(2)]. In addition, for members with special health care needs determined to need a specialized course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow such members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. Any waiver of this requirement by the Contractor must be approved in advance by AHCCCSA.
d. 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.
e. 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

f. 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
g. Referral to Medicare Managed Care Plan including payment of copayments
h. 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.

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:

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

33. 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 [42 CFR 438.206(c)(1)(i)]. 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.

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. The Contractor must develop a corrective action plan when appointment standards are not met; if appropriate, the corrective action plan should be developed in conjunction with the provider [42 CFR 438.206(c)(1)(iv), (v) and (vi)]. Appointment standards shall be included in the Provider Manual. The Contractor is encouraged to include the standards in the provider subcontract.

34. 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.

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 FQHCs/RHCs registered with AHCCCS are listed on the AHCCCS website (www.azahcccs.gov).

35. PROVIDER MANUAL

The Contractor shall develop, distribute and maintain a provider manual. The Contactor 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. EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children program;
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. Cost sharing responsibilities;
p. Explanation of remittance advice;
q. Prior authorization and notification requirements;
r. Claims medical review EPSDT providers must document immunizations into ASIIS and enroll every year in the Vaccine for Children program;
s. Concurrent review;
t. Fraud and Abuse;
u. Formularies, including updates and changes occur, must be provided in advance to providers, including pharmacies. The Contractor is not required to send a hard copy, unless requested, of the formulary each time it is updated. A memo may be used to notify providers of updates and changes, and refer providers to view the updated formulary on the Contractor's website;
v. AHCCCS appointment standards;
w. Americans with Disabilities Act (ADA) requirements and Title VI, as applicable;
x. Eligibility verification;
y. 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;
z. Peer review and appeal process;
aa. Medication management services as described in Section D, Paragraph 12;
bb. Information about a member's right to be treated with dignity and respect as specified in 42 CFR 438.100;
cc. Notification that the contractor has no policies which prevent the provider from advocating on behalf of the member; and,
dd. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

36. PROVIDER REGISTERATION

The Contractor shall ensure that all of its subcontractors register with AHCCCSA as an approved service provider. A Provider Participation Agreement must be signed by each provider who is not already an AHCCCS registered provider. 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.

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

37. SUBCONTRACTS

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

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 types of subcontracts shall be submitted to AHCCCS, Division of Health Care Management, for prior approval at least 30 days prior to the beginning date of the subcontract:

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

The 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 requested subcontracts must have full disclosure of all terms and conditions and must fully disclose all financial or other requested information. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. All subcontracts shall comply with the applicable provisions of Federal and State laws, regulations and policies.

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 [42 CFR 438.230(b)].

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.

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, except for cost sharing requirements, the Contractor shall not enter into subcontracts that contain compensation terms that discourage providers from serving any specific eligibility category.

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

38. CLAIMS PAYMENT / HEALTH INFORMATION SYSTEM

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, claim disputes and appeals. [42 CFR 438.242(a)]

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

The Contractor shall develop and maintain a claims payment system capable of processing, cost avoiding and paying claims in accordance with A.R.S. §§ 36-2903 and 2904 and AHCCCS Rules R9-28 Article 7. This system must produce a remittance advice related to the Contractor's payments to providers and must contain, at a minimum:

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

The related remittance advice must be sent with the payment, unless the payment is made by electronic funds transfer (EFT). The remittance advice sent related to an EFT must be mailed, or sent to the provider, no later than the date of the EFT.

The Contractor's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any individual recoupment in excess of $50,000 per provider within a contract year must be approved in advance by AHCCCSA, Division of Health Care Management, Acute Care Operations Unit. 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.

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 adjudicated 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 adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim. Additionally, unless a subcontract specifies otherwise, the Contractor shall not pay a claim initially submitted more than 6 months after date of service or to pay a claim submitted more than 12 months after date of service. The receipt date of the claim is the date stamp on the claim

or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address. The paid date of the claim is the date on the check or other form of payment [42 CFR 447.45(d)]. Claims submission deadlines shall be calculated from the date of service or the effective date of eligibility posting, whichever is later. Remittance advices accompanying the 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 non-hospital clean claims with dates of service January 1, 2005 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. In the absence of interest payment terms in a subcontract, interest shall accrue starting on the first day after a clean claim is contracted to be paid. For hospital clean claims, a slow payment penalty shall be paid in accordance with A.R.S. § 36-2903.01. When interest is paid, the Contractor must report the interest as directed in the Encounter Manual.

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

- Receive and pay 50% of all claims [based on volume of actual claims excluding claims processed by Pharmacy Benefit Managers (PBMs)] electronically by July 1, 2006.

The Contractor shall submit a monthly Claims Dashboard as specified in AHCCCS Claims Reporting Guide. Beginning January 1, 2007, the Contractor shall submit: 1) Claims Dashboard reporting claims received on a UB92 or 837I 2) Claims Dashboard reporting claims received on a CMS1500, dental claim form, 837P or 837D 3) Claims Dashboard combining all claims. The Monthly report must be received by the AHCCCSA, Division of Healthcare Management, no later than 15 days from the end of each month.

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.

39. 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.

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.

40. 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 contracts, including amendments, to AHCCCSA, Division of Health Care Management.

For Out-of-State Hospitals: The Contractor shall reimburse out-of-state hospitals in accordance with AHCCCS Rule 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. For non-contracted out-of-state providers of emergency services, Contractors shall pay no more than the AHCCCS Fee-For-Service rates, pursuant to Section 6085 of the Federal Deficit Reduction Act.

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).

Hospital Recouptments: 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.

41. 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. 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.

42. PHYSICIAN INCENTIVES / PAY FOR PERFORMANCE

Physician Incentives
Reporting of Physician Incentive Plans has been suspended by CMS until further notice. No reporting is required until suspension is lifted.

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 [42 CFR 438.6(g)]::

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.

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 422.208, 422.210 and 438.6(h). . These regulations apply to contract arrangements with subcontracted entities that provide utilization management services.

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

43. MANAGEMENT SERVICES AND COST ALLOCATION PLAN

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

44. RESERVED

45. RESERVED

46. RESERVED

47. RESERVED

48. RESERVED

49. ADVANCES, DISTRIBUTIONS, LOANS AND INVESTMENTS

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

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 two financial viability standards, the Current Ratio and Equity per Member, are 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 will not automatically 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, or if a Contractor's experience differs significantly from other Contractors', additional monitoring, such as monthly reporting, may be required.

FINANCIAL VIABILITY STANDARDS:

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

51. RESERVED

52. MERGER, REORGANIZATION AND CHANGE OF OWNERSHIP

A proposed merger, reorganization or change in ownership 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, Division of Health Care Management, for 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.

53. COMPENSATION

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

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 57)
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 (if applicable)
i. Risk sharing for PPC reimbursement
j. Member choice statistic for Title XIX Waiver Group
k. Member share of cost amount

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 [42 CFR 438.6(e)]. In addition to the above data used to review the appropriateness of capitation rates, during renewal years, AHCCCS may look at other factors that potentially impact appropriate reimbursement including the medical cost experience of members who exercise their right to choose a health plan upon initial enrollment versus those who are auto assigned to a contractor.

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

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.

Reconciliation of PPC Costs to Reimbursement: AHCCCSA will reconcile the Contractor's PPC medical cost expenses to PPC capitation paid to the Contractor during the year. This reconciliation will limit the Contractor's profits and losses to 2%. Any losses in excess of 2% will be reimbursed to the Contractor, and likewise, profits in excess of 2% will be recouped. Encounter data will be used to determine medical expenses. Refer to the ACOM *PPC Reconciliation Policy* for further details.

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. The approved HIV/AIDS drug list is located on the AHCCCS website at www.azahcccs.gov.

Refer to the ACOM *HIV/AIDS Supplemental Payment and Review Policy* for further details and requirements.

54. PAYMENT TO CONTRACTOR

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 or indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Contractor. Except for adjustments made to correct errors in payment, and as otherwise specified in this 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 permitted copayments and 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 adjustment or repayment by AHCCCS making a corresponding decrease in a current Contractor's payment or by making an additional payment to the Contractor. When a Contractor identifies an overpayment, AHCCCSA must be notified and reimbursed within 30 days of identification.

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

55. 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. inmate of public institution
c. duplicate capitation to the same contractor
d. adjustment based on change in member's contract type
e. child was not eligible for CMDP as described in A.R.S. 8- 512

If a member is in county detention and it is determined that the member does meet the inmate of public institution definition, then the disenrollment is effective no earlier than the date following the date of notification to the AHCCCSA of the member's inmate status.

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.

56. RESERVED

57. 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 coinsurance for CYE 07:

Statewide Plan Enrollment	*Annual Deductible**	*Title XIX Waiver Group Annual Deductible*	
	Prospective Reinsurance	*Combined PPC and Prospective Reinsurance*	*Coinsurance*
0-34,999	$20,000	$15,000	75%
35,000-49,999	$35,000	$15,000	75%
50,000 and over	$50,000	$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. AHCCCSA will adjust the Contractor's deductible level at the beginning of a contract year if the Contractor's enrollment changes to the next enrollment level. A Contractor at the $35,000 or $50,000 deductible level may elect a lower deductible prior to the beginning of a new contract year. 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.

c) Title XIX Waiver Members: A separate reinsurance deductible for the Title XIX Waiver Group applies for the prospective coverage time period.

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 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 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, Division of Health Care Management.

Other

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.

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 1st and 3rd party liability before submitting the encounter for reinsurance consideration, unless the encounter involves underinsured or uninsured motorist liability insurance, 1st and 3rd party liability insurance or a tort feasor.

   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 1st and 3rd 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 1st and 3rd party collections.

   All reinsurance claims must reach a clean claim status within fifteen months from the end date of service, or date of eligibility posting, whichever is later. Encounters for reinsurance claims that have passed the fifteen month deadline and are being adjusted due to a claim dispute or hearing decision must be submitted within 90 calendar days of the date of the claim dispute decision or hearing decision, whichever is applicable. Failure to submit the encounter within this timeframe will result in the loss 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 and Medicare/TPL payment, less any applicable quick pay discounts, slow payment penalties and interest. Amounts in excess of the deductible level shall be paid based upon costs paid by the Contractor, minus the coinsurance and Medicare/TPL payment, unless the costs are paid under a subcapitated arrangement. In

subcapitated arrangements, the Administration shall base reimbursement of reinsurance encounters on the lower of the AHCCCS allowed amount or the reported health plan paid amount, minus the coinsurance and Medicare/TPL payment and applicable quick pay discounts, slow payment penalties and interest. . Reimbursement for these reinsurance benefits will be made to the Contractor each month.

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.*

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 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 Administrative Legal Services. 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 Post-Audit Results letter approximately 45 days after the audit and given an opportunity to comment and provide additional medical or financial documentation on any audit findings. AHCCCSA may limit reinsurance reimbursement to a lower or alternative level of care if the Director or designee determines that the less costly alternative could and should have been used by the 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.

58. 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.

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. 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 72, *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 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.

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

Postpayment Recoveries: 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 72, *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
First-and third-party liability insurance
Tortfeasors, including casualty
Special Treatment Trust recovery
Restitution Recovery
Worker's Compensation
Estate 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, 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 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 72, *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.

59. COPAYMENTS

Most of the AHCCCS members remain exempt from copayments while others are subject to an optional copayment. Those populations exempt or subject to optional copayments may not be denied services for the inability to pay the copayment. (42 CFR 438.108)

Any copayments collected shall belong to the Contractor or its subcontractors.

Attachment L provides detail of the populations and their related copayment structure.

60. 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 *ACOM 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.

When a person with Medicare who is also eligible for Medicaid (dual eligible) is in a medical institution that is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay co-payments for their Medicare covered prescription medications for the remainder of the calendar year. To ensure appropriate information is communicated for these members to the Center for Medicare and Medicaid Services (CMS), effective January 1, 2006 the Contractor must, using the approved form, notify the AHCCCS Member File Integrity Section (MFIS), via fax at (602) 253-4807 as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:

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

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

61. RESERVED

62. CORPORATE COMPLIANCE

In accordance with A.R.S. Section 36-2918.01, all contractors are required to notify the AHCCCS, Office of Program Integrity (OPI) immediately 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 [42 CFR 455.1(a)(1)]. This shall include acts of suspected fraud or abuse that were resolved internally but involved AHCCCS funds, contractors or sub-contractors.

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

The 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.

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.

Pursuant to the Deficit Reduction Act of 2005 (DRA) the contractor will not be entitled to payment for services unless they establish a compliance program which shall both prevent and detect suspected fraud or abuse and 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.
10. The Contractor must establish written policies for employees detailing:
    a. The federal False Claims Act provisions;
    b. The administrative remedies for false claims and statements;
    c. Any state laws relating to civil or criminal penalties for false claims and statements;
    d. The whistleblower protections under such laws.
11. The Contractor must establish a process for training existing staff and new hires on the compliance program and on the items in section 10. All training must be conducted in such a manner that can be verified by AHCCCS.
12. The Contractor must require, through policies documented in the Provider Manual and subsequent contract amendments, that providers train their staff on the following aspects of the Federal False Claims Act provisions;
    - The administrative remedies for false claims and statements;
    - Any state laws relating to civil or criminal penalties for false claims and statements;
    - The whistleblower protections under such laws.

The Contractor Provider Manual must be updated to include the requirements listed above on or before April 1, 2007. Contracts must be amended according to the Contractor contract update schedule, but no later than July1, 2007

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.

63. 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 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. HIPAA related documents must be retained for a period of six years per 45 CFR 164.530(j).

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

64. DATA EXCHANGE REQUIREMENTS

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 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 [42 CFR 438.606]. The Contractor further agrees to indemnify and hold harmless the State of Arizona and AHCCCSA from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the 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 107-191, 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.

65. ENCOUNTER DATA REPORTING

The accurate and timely reporting of encounter data is crucial to the success of the AHCCCS program. AHCCCSA uses encounter data to pay reinsurance benefits, set fee-for-service and capitation rates, determine disproportionate share payments to hospitals, and to determine compliance with performance standards. The 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. [42 CFR 438.242(b)(1)]

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 [42 CFR 455.1(a)(2)]. The encounters must be submitted in the format prescribed by AHCCCSA.

Encounter data must be provided to AHCCCSA by electronic media and should be received by AHCCCSA no later than 240 days after the end of the month in which the service was rendered, or the effective date of the enrollment with the Contractor, whichever date is later. Requirements for encounter data are described in the *AHCCCSA Encounter Manual* and the AHCCCSA *Encounter Companion Document*. The *Encounter Submission Requirements* are included herein as Attachment I. Refer to Paragraph 64, Data Exchange Requirements, for further information.

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

Twice 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 64, Data Exchange Requirements, for further information.

66. 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..

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 contain 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 beginning with the last two days of the month. The last two daily updates are different from the regular daily updates in that they pay and/or recoup capitation into the next month. If the Contractor detects an error through the monthly update process, the Contractor shall notify AHCCCSA, Division of Health Care Management.

Refer to Paragraph 64, Data Exchange Requirements, for further information.

67. PERIODIC REPORT REQUIREMENS

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*, a copy of which may be found in the Bidder's Library. The required reports, which are subject to change during the contract term, are summarized in Attachment F, Periodic Report Requirements.

68. REQUEST FOR INFORMATION

AHCCCSA may, at any time during the term of this contract, request financial or other information from the Contractor. Responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from AHCCCS as proprietary. Information designated as confidential may not be disclosed by AHCCCS without the prior written consent of the Contractor except as required by law. 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.

69. 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.

70. RESERVED

71. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with CMS requirements, AHCCCSA, or an independent external agent, will conduct annual Operational and Financial Reviews for the purpose of (but not limited to) ensuring operational and financial program compliance [42 CFR 438.204]. The review 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.

The Contractor shall not distribute or otherwise make available the Operational and Financial Review Tool, draft Operational and Financial Review Report nor final report to other AHCCCS Contractors.

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

72. SANCTIONS

AHCCCSA may impose monetary sanctions, suspend, deny, refuse to renew, or terminate this contract or any related subcontracts in accordance with AHCCCS Rules R9-22-606, ACOM *Sanctions Policy* and the terms of this contract and applicable Federal or State law and regulations. [42 CFR 422.208, 42 CFR 438.700, 702, 704 and 45 CFR 92.36(i)(1)] Written notice will be provided to 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 the process outlined in A.A.C. R9-34-401 et. seq. Intermediate sanctions may be imposed, but are not limited to the following actions:

a. Substantial failure to provide medically necessary services that the 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 42.
g. Distribution directly, or indirectly through any agent or independent contractor, of marketing materials that have not been approved by AHCCCSA or that contain false or materially misleading information.
h. Failure to meet AHCCCS Financial Viability Standards.
i. Material deficiencies in the 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 58, *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 statue 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.*

73. BUSINESS CONTINUITY AND RECOVERY PLAN

The Contractor shall adhere to all elements of the ACOM *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. The Contractor shall submit a summary of the plan as specified in the ACOM *Business Continuity and Recovery Plan Policy* 15 days after the start of the contract year. All key staff shall be trained and familiar with the Plan.

74. TECHNOLOGICAL ADVANCEMENT

Contractors must have a website with links to the following information:

1. Formulary
2. Provider manual
3. Member handbook
4. Preferred Provider listing
5. When available, Member and Provider Survey Results

Contractors must be able to perform the following functions electronically:

1. Enrollment Verification
2. Claims inquiry
3. Accept HIPAA compliant electronic claims transactions (See paragraph 38)
4. Make claims payments via electronic funds transfer (See paragraph 38)

The Contractor must also provide searchable preferred provider directories on its web site. Web based directories must include the following search functions and must be updated at least monthly, if necessary:

1. Name
2. Specialty/Service
3. Languages spoken by Practitioner
4. Office locations (e.g. county, city or zip code)

By September 1, 2007, the Contractor must provide searchable preferred provider directories on its web site to include the search function by language spoken by Practitioner and must be update at least monthly, if necessary.

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

Arizona Health-e Connection

AHCCCS supports the Governor executive order # 2005-25 on Arizona Health-e Connection Roadmap. This executive order directs the development of an electronic health information data exchange (HIE) of personal

health information between providers, payers and members and the deployment of necessary health information technology to facilitate electronic health records in provider offices.

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

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

1) Encourage lab, pharmacy and ancillary subcontractors to develop common electronic interfaces for the exchange of data in standard file formats.

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

3) Contractors will cooperate in passing on any AHCCCS professional fee or facility reimbursement rate adjustments to primary care providers, nursing facility contractor, hospitals and any other providers determined by AHCCCS to be eligible for reimbursement for participation in the health information data exchange.

AHCCCS will continually work to enhance the functionality of the health information exchange and web based applications. AHCCCS health plan and program contractors are expected to deploy upgrades and enhancements as necessary to contracted providers.

75. 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.

1115 Waiver Changes:
AHCCCS is in negotiations with CMS to renew the 1115 waiver that enables AHCCCS to operate a mandatory managed care program. These negotiations may result in changes to the program. AHCCCS will either amend the contract or incorporate changes in policies incorporated in the contract by reference.

76. BALANCED BUDGET ACT OF 1997 (BBA)

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.

77. RESERVED

78. MEDICARE MODERNIZATION ACT (MMA)

The Medicare Modernization Act of 2003 created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B. Beginning January 1, 2006, AHCCCS 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 reflect this coverage.

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

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

[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. GENERAL INDEMNIFICATION

Contractor/Vendor Indemnification (Public Agency)

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

9. INDEMNIFICATION – PATENT AND COPY RIGHT

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

10. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The Contractor shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; 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.

11. ADVERTISING AND PROMATION OF CONTRACT

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

12. PROPTERTY OF THE STATE

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

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

13. THIRD PARTY ANTITRUST VIOLATIONS

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

14. 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.

15. TERMINATION FOR CONFLICT OF INTEREST

AHCCCSA may cancel this contract without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of AHCCCSA is, or becomes at any time while the contract or any extension of the contract is in effect, an employee of, or a consultant to, any other party to this contract with respect to the subject matter of the contract. The cancellation shall be

effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time.

16. 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.

17. 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.

18. TERMINATION FOR CONVENIENCE

AHCCCSA reserves the right to terminate the contract in whole or in part at any time for the convenience of the State without penalty or recourse. The Contracting Officer shall give written notice by certified mail, return receipt requested, to the 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.

19. RESERVED

20. TERMINATION – AVAILABILITY OF FUNDS

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

21. 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.

22. NON-EXCLUSIVE REMEDIES

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

23. 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.

24. EFFECTIVE DATE

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

25. RESERVED

26. DISPUTE

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.

27. 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.

28. 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.

29. 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.

30. 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.

31. TYPE OF CONTRACT

Firm Fixed-Price

32. 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.

33. 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.

34. NO GUARANTEED QUANTITIES

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

35. 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.

36. 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.

37. 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.

38. RESERVED

39. 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.

40. 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.

41. AUDITS AND INSPECTIONS

The Contractor shall comply with all provisions specified in applicable AHCCCS Rule R9-22- -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. [42 CFR 438.6(g)]

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

42. 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.

43. CHOICE OF FORUM

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

44. 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.

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

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

46. FEDERAL IMMIGRATION AND NATIONALITY ACT

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

47. IRS W-9 Form

In order to receive payment under any resulting contract, the Contractor shall have a current IRS W-9 Form on file with the State of Arizona.

48. CONTINUATION OF PERFORMANCE THROUGH TERMINATION

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

[END OF SECTION E]

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

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

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

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

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

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

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

16) LIMITATIONS ON BILLING AND COLLECTION PRACTICES

Except as provided in federal and state law and regulations, the Subcontractor shall not bill, nor attempt to collect payment from a person who was AHCCCS eligible at the time the covered service(s) were rendered, or from the financially responsible relative or representative for covered service(s) that were paid or could have been paid by the System.

17) MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

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

18) NON-DISCRIMINATION REQUIREMENTS

The Subcontractor shall comply with State Executive Order No. 99-4, which mandates that all persons, regardless of race, color, religion, 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)

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, dental records, prescription files and other records specified by AHCCCSA.

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

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

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

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

21) SEVERABILITY

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

22) SUBJECTION OF SUBCONTRACT

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

23) TERMINATION OF SUBCONTRACT

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

24) VOIDABILITY OF SUBCONTRACT

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

25) WARRANTY OF SERVICES

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

26) OFF SHORE PERFORMANCE OF WORK PROHIBITED

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

27) FEDERAL IMMIGRATION AND NATIONALTY ACT

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

[END OF ATTACHMENT A]

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. This requirement is part of the Hospital Subcontracting and Reimbursement Pilot Program,

described more fully in Section D, Paragraph 35, Hospital Reimbursement. A list of Phoenix and Tucson area hospitals are included.

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
85037	Banner Estrella Medical Center
85306	Banner Thunderbird Medical Center
85308	Arrowhead Community Hospital & Medical Center
85338	West Valley Hospital
85351	Walter O. Boswell Memorial Hospital
85375	Del E. Webb Memorial Hospital

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
	Banner Mesa Medical Center
85202	Banner Desert 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

[END OF ATTACHMENT B]

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.*

REPORT	***WHEN DUE***	***SOURCE/REFERENCE***	***SEND TO:***
DHCM Finance			
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 30th 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
Physician Incentive Plan (PIP) reporting	To be determined	Section D, Paragraph 15	Financial 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

REPORT	***WHEN DUE***	***SOURCE/REFERENCE***	***SEND TO:***
DHCM Health Plan Operations			
Report of all subcontracts which delegate Contractor duties and responsibilities	90 days after the beginning of the contract year	Section D, Paragraph 37	Operations and Compliance Officer
Provider Affiliation Transmission (PAT)	15 days after the end of each quarter	Provider Affiliation Transmission Manual, submitted to PMMIS Provider-to-Contractor FTP	Operations and Compliance Officer
Claims Dashboard	15th day of each month following the reporting period	Section D, Paragraph 38	Operations and Compliance Officer
Claim recoupments >$50,000	Upon identification by Contractor	Section D, Paragraph 38	Operations and Compliance Officer
Administrative Measures	15th day of each month following the reporting period	Section D, Paragraph 24	Operations and Compliance Officer

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
Enrollee Appeal and Provider Claim Dispute Report	45 days after the end of each quarter	Section D, Paragraph 26	Operations and Compliance Officer
Enrollee Grievance Report	45 days after the end of each quarter	Section D, Paragraph 26	Operations and Compliance Officer
Provider Network Development and Management Plan	45 days after the first day of a new contract year	Section D, Paragraph 27	Operations and Compliance Officer
Cultural Competency Plan	45 days after the first day of a new contract year	ACOM *Cultural Competency Policy*	Operations and Compliance Officer
Business Continuity and Recovery Plan	15 days after the beginning of each contract year	ACOM *Business Continuity and Recovery Plan Policy*	Operations and Compliance Officer
Member Handbook	By September 1 of contract year, or within 4 weeks of receiving annual amendment, whichever is later.	Section D, Paragraph 18	Operations and Compliance Officer
Provider Network – Material Change	Submit change for approval prior to effective date	Section D, Paragraph 29	Operations and Compliance Officer
Provider Network – Unexpected Change	Within one business day	Section D, Paragraph 29	Operations and Compliance Officer
System Change Plan	Six months prior to implementation	Section D, Paragraph 38	Operations and Compliance Officer

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
DHCM Data Analysis and Research			
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 AHCCCSA	Attachment I, Encounter Submission Requirements	Encounter Administrator

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
DHCM Clinical Quality Management			
Comprehensive EPSDT Plan including Dental	Annually on December 15th	Section D, Paragraph 24	DHCM/CQM
EPSDT Progress Report including Dental - Quarterly Update	15 days after the end of each quarter	*AMPM*, Chapter 400	DHCM/CQM
Quality Management Plan and Evaluation	Annually on December15th	*AMPM*, Chapter 900	DHCM/CQM

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
Monthly Pregnancy Termination Report	End of the month following the pregnancy termination	*AMPM*, Chapter 400	DHCM/CQM
Maternity Care Plan	Annually on December 15th	*AMPM*, Chapter 400	DHCM/CQM
Sterilization	Immediately following procedure	*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 2nd and 4th quarter of each contract year	*AMPM*, Chapter 400	DHCM/CQM
Performance Improvement Project Proposal (initial/baseline year of the project)	Annually on December15th	*AMPM*, Chapter 900	DHCM/CQM
Performance Improvement Project Re-measurement Report	Annually on December 15th	*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 23	DHCM/CQM
Pediatric Immunization Audit	As requested	Section D., Paragraph 24	DHCM/CQM

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
DHCM Medical Management			
Quarterly Inpatient Hospital Showing	15 days after the end of each quarter	State Medicaid Manual and the *AMPM*, Chapter 1000	DHCM/MM
Utilization Management Plan and Evaluation	Annually on December 15th	Section D, Paragraph 23	DHCM/MM
UM Quarterly Report	45 Days after the end of each quarter	Section D, Paragraph 23	DHCM/MM
HIV Specialty Provider Lists	Annually on December 15th	*AMPM*, Chapter 300	DHCM/MM
Transplant Report	15 days after the end of each month	*AMPM*, Chapter 1000	DHCM/MM

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
Office of Program Integrity			
Provider Fraud/Abuse Report	Immediately following discovery	Section D, Paragraph 62	Office of Program Integrity Manager
Eligible Person Fraud/Abuse Report	Immediately following discovery	Section D, Paragraph 62	Office of Program Integrity Manager

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
Office of the Director			
Prescription Drug Utilization Report	Quarterly, within 45 days of end of the quarter	*AMPM*	Pharmacy Program Administrator

REPORT	*WHEN DUE*	*SOURCE/REFERENCE*	*SEND TO:*
As Required/Needed			
Contract Termination Reports	5 days after the end of each month	Section D, Paragraph 1	Financial Manager
Nursing Facility Stay	When a member has been residing in a nursing facility for 75 days	Section D, Paragraph 10, Nursing Facility	Division of Member Services Assistant Director
Key Position Change	Within 7 days after an employee leaves and as soon as new hire has taken place	Section D, Paragraph 16	DHCM Assistant Director
Third Party Liability Updates	Within 10 days of discovery	Section D, Paragraph 58	TPL Administrator
Third Party Liability Case Identification	Within 10 days of discovery	Section D, Paragraph 58	TPL Administrator
Certificate of Insurance	Within 10 days of contract award	Section E, #25	Contract Manager

[END OF ATTACHMENT F]

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

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 ACOM *Enrollee Grievance 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, the appeals process, enrollee rights, the grievance system requirements and timeframes, shall be in each prevalent non-English language occurring within the subcontractor's service area and in an easily understood language and format. The 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 and requests for hearing.
2. Information explaining the grievance, appeal, and fair hearing procedures and timeframes. This information shall include a description of the circumstances when there is a right to a hearing, the method for obtaining a hearing, the requirements which govern representation at the hearing, the right to file grievance and appeals and the requirements and timeframes for filing a grievance, appeal, or request for hearing.
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 standard appeals and expedited appeals may be extended up to 14 days if the enrollee requests the extension or if the Contractor establishes a need for additional information and that the delay is in the enrollee's interest.

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

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

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

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

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

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

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

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

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

17. The definition of a standard authorization request. 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 [42 CFR 438.210(d)(1)]. The Notice of Action must comply with the advance notice requirements when there is a termination or reduction of a previously authorized service OR when there is a denial of an authorization request and the physician asserts that the requested service/treatment is a necessary continuation of a previously authorized service.

18. The definition of an expedited authorization request. For expedited authorization decisions, the 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. [42 CFR 438.210(d)(2)]

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

20. That the Contractor shall notify the requesting provider of the decision to deny or reduce a service authorization request. The notice to the provider need not be written.

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

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

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

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

25. That the Contractor 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 standard service authorization request and within three business days from receipt of an expedited service authorization request unless an extension is in effect. For service authorization decisions, the Contractor shall also ensure that the Notice of Action provides the enrollee with advance notice and the right to request continued benefits for all terminations and reductions of a previously authorized service and for denials when the physician asserts that the requested service/treatment which has been denied is a necessary continuation of a previously authorized service. As described below, the Contractor may elect to mail a Notice of Action no later than the date of action when:
    a. The Contractor receives notification of the death of an enrollee;
    b. The enrollee signs a written statement requesting service termination or gives information requiring termination or reduction of services (which indicates understanding that the termination or reduction will be the result of supplying that information);
    c. The enrollee is admitted to an institution where he is ineligible for further services;

d. The enrollee's address is unknown and mail directed to the enrollee has no forwarding address;
e. The enrollee has been accepted for Medicaid in another local jurisdiction;

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

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

28. That benefits shall continue until a hearing decision is rendered if: 1) the enrollee files an appeal before the later of a) 10 days from the mailing of the Notice of Action or b) the intended date of the 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.

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

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

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

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

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

34. That if the enrollee files a request for hearing the Contractor must ensure that the case file and all supporting documentation is received by the AHCCCSA, Office of Administrative Legal Services(OALS) as specified by OALS. The file provided by the Contractor must contain a cover letter that includes:
    a. Enrollee's name
    b. Enrollee's AHCCCS I.D. number
    c. Enrollee's address
    d. Enrollee's phone number (if applicable)
    e. Date of receipt of the appeal
    f. Summary of the Contractor's actions undertaken to resolve the appeal and summary of the appeal resolution

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

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

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

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.

[END OF ATTACHMENT H(1)]

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

The Contractor shall have in place a written claim dispute policy for providers. 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 challenging claim payments, denials or recoupments must be filed in writing with the Contractor no later that 12 months from the date of service, 12 months after the date of eligibility posting or within 60 days after the date of the payment, denial or recoupment of a timely claim submission, whichever is later.

3. Specific individuals are appointed with authority to require corrective action and with requisite experience to administer the 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 a written 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 overturned, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.

10. If the Provider files a request for hearing, the Contractor must ensure that all supporting documentation is received by the AHCCCSA, Office of Administrative Legal Services, no later than

five business days from the date the Contractor receives the provider's written hearing request. 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.

[END OF ATTACHMENT H(2)]

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

[END OF ATTACHMENT I]

ATTACHMENT L: COST SHARING COPAYMENTS

I. EXEMPT POPULATIONS (REGARDLESS OF RATE CODE)

The following populations are **exempt from copayments for ALL services ($0 copay):**

- All members under the age of 19, including all KidsCare members
- All Pregnant Women
- All ALTCS enrolled members
- All persons with Serious Mental Illness receiving RBHA services
- All members who are receiving CRS services
- SOBRA Family Planning Services Only members

Additionally, **no member** may be asked to make a copayment for family planning services or supplies.

II. STANDARD COPAYMENTS APPLY TO THE TITLE XIX WAIVER GROUP

Services to this population may <u>not</u> be denied for failure to pay copayment.

The standard copayments apply to the Title XIX Waiver Group, including RBHA General Mental Health and Substance Abuse service members. The standard copayments are as follows:

Service	***Copayment***
Generic Prescriptions or Brand Name if generic not available	$ 0 per Rx
Brand Name Prescriptions when generic is available	$ 0
Non Emergency Use of ER	$ 1
Physician Office Visits	$ 1

III. STANDARD COPAYMENTS APPLY TO THE FOLLOWING POPULATIONS

Services to this population may <u>not</u> be denied for failure to pay copayment.

- AHCCCS for Families with Children
- Supplemental Security Income with and without Medicare

Service	***Copayment***
Generic Prescriptions or Brand Name if generic not available	$ 0
Brand Name Prescriptions when generic is available	$ 0
Non Emergency Use of ER	$ 1
Physician Office Visits	$ 1

IV. OTHER CO-PAYS

HIFA Parents (Parents of KidsCare and SOBRA Children)

- Copayment is not mandatory
- **EXCEPTION: Native American Contractor Enrolled Parents are exempt from any copayment**

Service	***Copayment***
Generic Prescriptions or Brand Name if generic not available	$ 0
Brand Name Prescriptions when generic is available	$ 0
Non Emergency Use of ER	$ 1
Physician Office Visits	$ 0

[END OF ATTACHMENT L]