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

CONTRACT AMENDMENT

AMENDMENT NUMBER:	CONTRACT NUMBER:	EFFECTIVE DATE OF AMENDMENT:	PROGRAM:
11	YH6-0014	October 1, 2000	ALTCS/DDD

CONTRACTOR'S NAME AND ADDRESS:

John L. Clayton, Director
DES/DDD Site Code 791-A
1789 W. Jefferson Street
Phoenix, AZ 85007

PURPOSE OF AMENDMENT: To extend the ALTCS/DDD contract for the period 10/1/00 - 9/30/01 and incorporate changes to contract requirements.

THE CONTRACT REFERENCED ABOVE IS AMENDED AS FOLLOWS:

A. EXTENSION OF CONTRACT: In accordance with Section D, Paragraph 62, Term of Contract and Option to Renew, this contract is extended for the period 10/1/00 - 9/30/01. DES/DDD's response affirming or declining the extension must be received by AHCCCSA by September 20, 2000.

B. CONTRACT RESTATEMENT: This amendment consists of a complete restatement of your contract with new or changed requirements indicated as discussed below.

C. CHANGES IN REQUIREMENTS: In accordance with Section E, Paragraph 19, Changes, various changes in contract requirements are indicated in this contract restatement. Throughout the document, DES/DDD will find sections of text which are underlined such as this. The text underlined in this manner represents a new or a changed requirement. Text which is lined through, ~~such as this~~, represents deletions to the contract document.

NOTE: Please sign, date and return both originals to:

Sharon Bercaw
AHCCCS Contracts and Purchasing
701 E. Jefferson
Phoenix, AZ 85034

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

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

CONTRACTOR: DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES SIGNATURE OF AUTHORIZED REPRESENTATIVE:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM SIGNATURE OF AHCCCSA CONTRACTING OFFICER:
TYPED NAME: JOHN L. CLAYTON	TYPED NAME: MICHAEL VEIT
TITLE: DIRECTOR	TITLE: CONTRACTS & PURCHASING ADMINISTRATOR
DATE:	DATE:

SECTION B - CAPITATION RATES

DES/DDD shall provide services as described in this contract. In consideration for the provision of services, DES/DDD will be paid in as shown below for the term October 1, 2000 through September 30, 2001.

CAPITATION RATES
(Per Member Per Month)

Capitation rates to be provided in a separate amendment.

Stated rates are payable to DES/DDD until such time new rates are established as described in Section D, Paragraph 36. Compensation and Paragraph 37. Annual Submission of Budget.

SECTION C - DEFINITIONS

A.A.C.	Arizona Administrative Code.
ABUSE (OF MEMBER)	Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.
ABUSE (BY PROVIDER)	Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.
ADHS	Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.
AGENT	Any person who has been delegated the authority to obligate or act on behalf of another person or entity.
AHCCCS	Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person, as defined in A.R.S. § 36-2902, et seq.
AHCCCSA	Arizona Health Care Cost Containment System Administration
ALTCS	The Arizona Long Term Care System (ALTCS), a program under AHCCCSA that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by A.R.S. § 36-2932.
AMPM	AHCCCS Medical Policy Manual.
BIDDERS' LIBRARY	A repository of manuals, statutes, rules and other reference material referred to in this document, located at the AHCCCS Office in Phoenix.
CAPITATION	Payment to contractor by AHCCCSA of a fixed monthly payment per person in advance for which the contractor provides a full range of covered services as authorized under A.R.S. § § 36-2931 and 36-2942.
CATS	Client Assessment and Tracking System, a component of the Administration's data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from DES/DDD.
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.
CYE	Contract Year Ending; Corresponds to federal fiscal year (Oct. 1 through Sept. 30). For example, Contract Year 01 is 10/1/00 - 9/30/01.
CONVICTED	A judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

CO-PAYMENT	A monetary amount specified by the Director that the member pays directly to a contractor or provider at the time covered services are rendered, as defined in R9-22-107.
COST AVOIDANCE	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by DES/DDD or before payment is made by DES/DDD. (This assumes DES/DDD can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party contracted provider render the service so that DES/DDD is only liable for coinsurance and/or deductibles.)
COVERED SERVICES	The health and medical services to be delivered by the Program Contractor as defined in R9-28-201.
CRS	Children's Rehabilitative Services as defined in R9-22-114.
DAYS	Calendar days unless otherwise specified.
DES/DDD	Department of Economic Security/Division of Developmental Disabilities.
DD	Developmentally disabled.
DIRECTOR	The Director of AHCCCS.
DME	Durable medical equipment, is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury as defined in R9-22-102.
DUAL ELIGIBLE	A member who is eligible for both Medicare and Medicaid.
EMERGENCY MEDICAL CONDITION	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. (42 USC 13960-2)
EMERGENCY MEDICAL SERVICE	Services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part, as defined in R9-22-102.
ENCOUNTER	A record of medical service, submitted by a contractor and processed by AHCCCS, that is rendered by a provider registered with AHCCCS to a member who is enrolled with a contractor on the date of service and for which the contractor incurs any financial liability, as defined by R9-22-117.
ENROLLMENT	The process by which an eligible person becomes a member of a contractor's plan as defined by R9-22-117.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment services for eligible persons or members less than 21 years of age as defined in R9-22, 102.
FFS	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
FFP	Federal financial participation (FFP) refers to the contribution that the federal government makes to the Title XIX program portion of AHCCCS as defined in

	42 CFR 400.203.
FIRST PARTY LIABILITY	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Administration, contractor, or member.
FFY	Federal Fiscal Year, October 1 through September 30.
FRAUD	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable state or federal law, as defined in 42 CFR 455.2.
HCBS	Home and community-based services, as defined in A.R.S. § § 36-2931 and 36-2939.
HCFA	Health Care Financing Administration, an organization within the U.S. Department of Health and Human Services which administers the Medicare and Medicaid and Children's Health Insurance Program.
HEALTH MAINTENANCE ORGANIZATION (HMO)	Various forms of plan organization, including staff and group models, that meet the HMO licensing requirements of the federal and/or state government and offer a full array of health care services to members on a capitated basis.
HOME	A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the state as a: health care institution defined in ARS § 36-401; residential care institution defined in ARS § 36-401; community residential facility defined in ARS § 36-551; or behavioral health service facility defined in A.A.C. 20, Articles 6, 7 and 8, as defined in R9-28-101.
IBNR	Incurred But Not Reported liabilities, for services rendered for which claims have not been received.
IHS	Indian Health Service, authorized as a federal agency pursuant to 25 U.S.C. 1661.
MANAGEMENT SERVICES SUBCONTRACTOR	A person or organization who agrees to perform any administrative service for DES/DDD related to securing or fulfilling DES/DDD's obligations to AHCCCSA under the terms of the contract.
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.
MEDICARE	A federal program authorized by Title XVIII of the Social Security Act, as amended.
MEMBER	An eligible person who is enrolled in the system, as defined in A.R.S. § 36-2931.
PAS	Pre-admission screening; is a process of determining an individual's risk of institutionalization at a NF or ICF-MR level of care as specified in R9-28-103.
PAY AND CHASE	Recovery method used by the Program Contractor to collect from legally liable first or third parties after the Program Contractor pays the member's medical bills. The

	service may be provided by a contracted or noncontracted provider. Regardless of who provides the service, pay and chase assumes that the Program Contractor will pay the provider, then seek reimbursement from the first or third party.
PCP	Primary Care Provider/ Practitioner, an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's or eligible person's health care, as defined in R9-22-102.
PMMIS	AHCCCSA's Pre-paid Medical Management Information System.
PRIOR QUARTER	The three month period immediately preceding the month in which the member applies for Title XIX benefits. If it is determined that the member would have been eligible had the member applied in the month in which services were provided, AHCCCSA may pay for unpaid Title XIX services on a fee-for-service basis. The Program Contractor is not liable for the prior quarter period.
PROGRAM CONTRACTOR	A person, organization or entity agreeing through a direct contracting relationship with AHCCCSA to provide the goods and services specified by this contract in conformance with stated contract requirements, AHCCCS statute and rules and federal law and regulations, as defined in A.R.S. § 36-2931.
QMB	Qualified Medicare Beneficiary, an individual who is entitled to Medicare Part A insurance, whose income does not exceed an income level established by the state, and whose resources do not exceed twice the maximum amount of resources that an individual may have to obtain benefits under that program, as defined in 42 U.S.C. 1396d.
REINSURANCE	A risk-sharing program provided by the Administration to contractors for the reimbursement of certain contract service costs incurred by a member or eligible person beyond a certain monetary threshold, as defined in R9-22-107.
RELATED PARTY	A party that has, or may have, the ability to control or significantly influence DES/DDD, or a party that is, or may be, controlled or significantly influenced by DES/DDD. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.
RFP	The Request For Proposals, a document prepared by AHCCCSA that describes the services required and that instructs prospective offerors how to prepare a response (proposal), as defined in R9-22-106.
RBHA	Regional Behavioral Health Authority, an organization under contract with ADHS to administer covered behavioral health services in a geographically specific area of the state. Tribal governments, through an agreement with ADHS, may operate a tribal regional behavioral health authority (TRBHA) for the provision of behavioral health services to Native American members living on-reservation.
SFY	State Fiscal Year, July 1 through June 30.
STATE PLAN	The written agreement between the State of Arizona and HCFA which describes how the AHCCCS program meets HCFA requirements for participation in the Medicaid program and the Children's Health Insurance program.
SUBCONTRACT	An agreement entered into by a contractor with any of the following: a provider of health care services who agrees to furnish covered services to a member; a marketing organization; or with any other organization or person who agrees to

perform any administrative function or service for a contractor specifically related to fulfilling the contractor's obligations to the Administration under the terms of this contract, as defined in R9-22-101.

SUBCONTRACTOR A person, agency or organization that a Program Contractor has contracted or delegated some of its management functions or responsibilities to provide covered services to its members; or 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.

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, eligible person or member, as defined in R9-22-110.

THIRD PARTY LIABILITY The resources available from an individual, entity or program that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an applicant, eligible person or member, as defined in R9-22-110.

TITLE XIX MEMBER Member eligible for Medicaid under Title XIX of the Social Security Act including those eligible under 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups.

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.

VENTILATOR DEPENDENT For the purposes of ALTCS eligibility, an individual who is medically dependent on a ventilator for life support at least 6 hours per day and has been dependent on ventilator support as an inpatient in a hospital, NF, or ICF-MR for 30 consecutive days, as defined in R9-28-102.

[END OF DEFINITIONS]

SECTION D - PROGRAM REQUIREMENTS

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SECTION D - PROGRAM REQUIREMENTS

PURPOSE AND APPLICABILITY:

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

The provisions of federal and state law, regulation, or rules referred to in this contract apply to DES/DDD and providers to the same extent as other terms apply to DES/DDD and providers as noted above. In the event that a provision of federal or state law, regulation, or rule is repealed or modified during the term of this contract, effective on the date the repeal or modification by its own terms takes effect:

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

AHCCCSA's Mission and Vision

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

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

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

ALTCS Guiding Principles

- *Member-centered case management*
  The member is the primary focus of the ALTCS program. The member, and family/significant others, as appropriate, are active participants in the planning for and the evaluation of services provided to them. Information and education about the ALTCS program, their choices of options and mix of services should be accurate and readily available to them.

- *Consistency of services*
  Services are mutually selected and to assist the member in attaining his/her goals(s) for achieving or maintaining their highest level of self-sufficiency. Service systems are developed to ensure a member can rely on services being provided as agreed to by the member and DES/DDD.

- *Accessibility of network*

Access to services is maximized when they are developed to meet the needs of the members. Service provider restrictions, limitations or assignment criteria are clearly identified to the member and family/significant others. Service networks are developed with DES/DDD's knowledge that a member's needs are not limited to normal business hours.

- *Least Restrictive Setting*
  Members are to be maintained in the least restrictive setting that is medically necessary and appropriate. To that end, members are afforded choice in remaining in their own home or choosing an alternative residential setting versus entering into an institution.

- *Collaboration with stakeholders*
  The appropriate mix of services will continue to change. Resources should be aligned with identified member needs and preferences. Efforts are made to include members/families, service providers and related community resources, to assess and review the change of the service spectrum. Changes to the service system are planned, implemented and evaluated for continuous improvement.

1. COVERED SERVICES

DES/DDD, either directly or through subcontractors, shall, at a minimum, be responsible for providing the following acute, long term, behavioral health and case management services in accordance with the *AHCCCS Medical Policy Manual (AMPM).* DES/DDD shall ensure that its providers are not restricted or inhibited in any way from communicating freely with members regarding the members' health care, medical needs and treatment options even if a service is not covered by AHCCCS or DES/DDD.

ACUTE CARE SERVICES

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

***Audiology*:** DES/DDD shall provide audiology services to members under age 21 including the identification and evaluation of hearing loss and rehabilitation of the hearing loss through other than medical or surgical means (i.e. hearing aids). Only the identification and evaluation of hearing loss are covered for members 21 years of age and older unless the hearing loss is due to an accident or injury-related emergent condition.

***Behavioral Health*:** DES/DDD shall provide behavioral health services as described in Section D, Paragraph 2, Behavioral Health Services. See also the *AMPM* for details on covered 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. DES/DDD shall refer children to the CRS program who are potentially eligible for services related to CRS covered conditions, as specified in R9-28-Article 2 and A.R.S. § 35-Ch. 3, § 2. Eligibility criteria and the referral process are described in the CRS Policy and Procedures Manual available in the Bidder's Library.

DES/DDD shall monitor referrals to CRS to ensure CRS covered services are provided in a timely manner to eligible members. Referral to CRS does not relieve DES/DDD of the responsibility for providing primary medical care and emergency services not covered by CRS to CRS eligible members. DES/DDD is also responsible for initial care of newborn members who are eligible for CRS. DES/DDD must require the member's Primary Care Provider (PCP) to coordinate their care with the CRS program. All services provided must be included in the member's medical record maintained by the PCP.

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

DES/DDD remains ultimately responsible for the provision of all covered services to its members. Therefore, if DES/DDD becomes aware that CRS has failed to meet the established appointment standards, or has failed to provide medically necessary CRS covered services, DES/DDD shall immediately notify AHCCCSA, Office of Managed Care, of the occurrence. In accordance with AHCCCS policy, DES/DDD may seek reimbursement from CRS for providing CRS Covered services, when CRS has failed to meet established appointment standards.

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

Dental: DES/DDD shall ensure that members under age 21 have direct access to dental providers. Members may also be referred by their PCPs. Members over age three and under 21 shall be screened annually by a dentist who will perform an evaluation and report findings and treatment to the member's PCP or DES/DDD. Members under age three shall be screened by their PCP and referred to a dentist when medically necessary. For members who are 21 years of age and older, DES/DDD shall provide emergency dental care, medically necessary dentures and dental services for transplantation services as specified in the *AMPM*. Dental standards may be found in the *AMPM,* Section 310.

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

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

Emergency services: DES/DDD shall have and/or provide the following at a minimum:
a. Emergency services facilities adequately staffed by qualified medical professionals to provide pre-hospital, emergency care on a 24-hour-a-day, 7-day-a-week basis, for an emergency medical condition as defined by AHCCCS Rule R9-22, Article 1. Emergency medical services are covered without prior authorization. DES/DDD is encouraged to contract with emergency service facilities for the provision of emergency services. DES/DDD 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. DES/DDD shall be responsible for educating members and providers regarding appropriate utilization of emergency room services including behavioral health emergencies. DES/DDD shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services

shall be whether a prudent layperson, similarly situated, would have requested such services. For purposes of this contract, a "prudent layperson" is a person who possesses an average knowledge of health and medicine.

b. All medical services necessary to rule out an emergency condition
c. Emergency transportation
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.
e. Compliance with federal guidelines in respect to coordination of post-stabilization care.

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

Family Planning: DES/DDD shall provide Family Planning services in accordance with the *AMPM*, Section 420, to members who choose to delay or prevent pregnancy. DES/DDD is responsible for annually notifying members of reproductive age (12-55 years) of the availability of Family Planning services.

Health Risk Assessment and Screening: DES/DDD shall provide these services for non-hospitalized members 21 years of age and older. These services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis and HIV/AIDS; nutritional assessment in cases when the member has a chronic, debilitating condition affected by nutritional needs: mammographies and prostate screenings; physical examinations and diagnostic work-ups; and immunizations. Assessment and screening services for members under age 21 are based on the AHCCCS EPSDT periodicity schedule.

Hospital: Inpatient services include semi-private accommodations for routine care, intensive and coronary care, surgical care, obstetrics and newborn nurseries, and behavioral health emergency/ crisis behavioral health services. If the member's medical condition requires isolation, private inpatient accommodations are covered. Nursing services, dietary services and ancillary services such as laboratory, radiology, pharmaceuticals, medical supplies, blood and blood derivatives, etc. are also covered. Outpatient services include any of the above services which may be provided on an outpatient or ambulatory basis (i.e. laboratory, radiology, therapies, ambulatory surgery, etc.). Observation services may be provided on an outpatient basis for up to 24 hours if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. Observation services include the use of a bed and periodic monitoring by hospital nursing staff and/or other staff to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability.

Immunizations: DES/DDD shall provide immunizations for adults (21 years of age and older) to include diphtheria-tetanus, influenza, pneumococcus, rubella, measles and hepatitis-B. EPSDT immunization requirements include diphtheria, tetanus, pertussis vaccine (DPT), oral/inactivated polio vaccine (OPV/IPV), measles, mumps, rubella vaccine (MMR), H. influenza, type B (HIB), hepatitis B (Hep B), and varicella vaccine.

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

Laboratory: Laboratory services for diagnostic, screening and monitoring purposes are covered when ordered by the member's PCP, other attending physician or dentist, and provided by a CLIA (Clinical

Laboratory Improvement Act) approved free standing laboratory or hospital laboratory, clinic, physician office or other health care facility laboratory.

Upon written request, DES/DDD may obtain laboratory test data on members from a laboratory or hospital based laboratory subject to the requirements specified in ARS § 36-2903 (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: DES/DDD shall provide pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care for members. Services may be provided by physicians, physician assistants or nurse practitioners certified in midwifery. Members may select or be assigned to a PCP specializing in obstetrics. Circumcisions are covered as described in the *AMPM*. Members anticipated to have a low-risk delivery may elect to receive labor and delivery services in their home from their maternity provider if this setting is included in allowable settings for DES/DDD, and DES/DDD has providers in its network that offer home labor and delivery services. Members anticipated to have a low-risk prenatal course and delivery may elect to receive maternity services of prenatal care, labor and delivery and postpartum care provided by licensed midwives if they are in DES/DDD's provider network. All licensed midwife labor and delivery services must be provided in the member's home since licensed midwives do not have admitting privileges in hospitals or AHCCCS registered free-standing birthing centers. Members receiving maternity services from a licensed midwife must also be assigned to a PCP for other health care and medical services.

DES/DDD shall allow women and their newborns to receive 48 hours of inpatient hospital care after a normal vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96 hour stay.
DES/DDD shall inform all ALTCS DES/DDD enrolled pregnant women of voluntary HIV testing and the availability of counseling if the test is positive. DES/DDD shall provide information in the member handbook to encourage pregnant women to be tested and instructions on where to be tested. Semi-annually, DES/DDD shall report to AHCCCS, Office of Medical Management, the number of pregnant women who have been identified as HIV/AIDS positive. This report is due no later than 30 days after the end of the second and fourth quarters.

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

Medically-Necessary Abortions: This service is covered for a member if the member suffers from a medical condition or disorder, physical injury, or illness caused by or rising from the pregnancy. This service is also covered for Title XIX members if the pregnancy is caused by rape or incest. Physician certification of the condition, disorder, illness or injury must be provided to DES/DDD. In addition, providers must submit to DES/DDD a Certificate of Medical Necessity for Pregnancy Termination and prior authorization is required. If the procedure is performed on an emergency basis, documentation must be submitted to DES/DDD within two working days. Additional documentation, outlined in the *AMPM*, is required for members under 18 years of age or member who are considered an incapacitated adult who seek medically necessary abortion due to rape or incest.

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

adjustments of purchased equipment are covered to make the equipment serviceable and/or when the repair cost is less than renting or purchasing another unit.

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

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

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

Prescription Medications and Pharmacy: Medications ordered by a PCP, attending physician or dentist and dispensed under the direction of a licensed pharmacist are covered subject to limitations related to prescription supply amounts, DES/DDD formularies and prior authorization requirements, as well as restrictions for immunosuppressant drugs addressed in AHCCCS medical policies for transplantations. Over the counter (OTC) medication may be prescribed when it is determined to be a lower cost alternative to a prescription medication.

Primary Care Provider (PCP): PCP services are covered when provided by a physician, physician assistant or nurse practitioner selected by, or assigned to, the member. The PCP provides primary health care and serves as a gate-keeper and coordinator in referring the member for specialty medical services, behavioral health and dental 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 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: DES/DDD shall provide occupational, physical and speech therapies. Therapies must be prescribed by the member's PCP or attending physician for an acute condition and the member must have the potential for improvement due to the rehabilitation.

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

Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs: These services are covered within limitations defined in the *AMPM*, for members diagnosed with specified medical conditions. Such limitations include whether the stage of the disease is such that the transplant can affect the outcome; the member has no other conditions which substantially reduce the potential for successful transplantation; and whether the member will be able to comply with necessary and required regimens of treatment. Bone grafts are also covered under this service. Services include: pre-transplant inpatient or outpatient evaluation; donor search; organ/tissue harvesting or procurement; preparation and transplantation services; and convalescent care. In addition, if a member receives a transplant covered by a source other than AHCCCS, medically

necessary non-experimental services are provided within limitations after the discharge from the acute care hospitalization for the transplantation. AHCCCS has contracted with transplantation providers for DES/DDD's use or DES/DDD may select its own transplantation provider. However, the quality of services must be equal to or exceed those of the AHCCCS provider and the rate paid can not exceed the AHCCCS provider's negotiated rate.

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

Triage/ Screening and Evaluation: These are covered services when provided by acute care hospitals, IHS facilities and urgent care centers to determine whether or not an emergency exists, assess the severity of the member's medical condition and determine services necessary to alleviate or stabilize the emergent condition. The provider must notify DES/DDD within 12 hours of the member's registration with the facility for emergency services. Supporting documentation for services rendered must be provided when reporting or billing a service. Triage/screening services must be reasonable, cost effective and meet the criteria for severity of illness and intensity of service.

LONG TERM CARE SERVICES

A more detailed description of services can be found in R9-28-Article 2 and Sections 1200 and 1300 of the *AMPM*.

Attendant Care: A service provided by a trained attendant for members who reside in their own homes and which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development.

Behavior Management: A service, specified in 9 A.A.C. 20, that primarily involves direct patient behavior management related to the behavioral health rehabilitative needs of the member.

Developmentally Disabled Day Care: Also known as Day Treatment and Training. A service available for members who need supervision, training, therapeutic activities and counseling, as appropriate, to develop skills in independent living, communication and socialization.

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

Environmental Modifications: Building modifications or items which allow members to function as independently as possible in their own homes.

Habilitation Services: A service encompassing the provision of training in independent living skills or special developmental skills; sensory-motor development; orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services.

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

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

Hospice: A program that provides care to terminally ill patients who have six months or less to live. A participating Hospice must meet Medicare requirements and have a written provider contract with DES/DDD.

Partial Care: Basic partial care and intensive partial care, specified in 9 A.A.C. 20, are services that provide structured, coordinated programs designed to provide therapeutic activities that promote coping, problem solving and socialization.

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

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

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

Supported Employment Services (ALTCS Transitional Program only): Provides for a variety of support services in order for a DD member to maintain a job. Services include a comprehensive assessment of the member to determine his/her appropriateness for services, plan development and ongoing job coaching and support services.

LONG TERM CARE - INSTITUTIONAL SETTINGS

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

Institution for Mental Disease (IMD): A Medicare certified hospital, a special hospital for psychiatric care, a behavioral health facility or a nursing care institution which has more than 16 treatment beds and provides diagnosis, care and specialized treatment services for mental illness or substance abuse for more than 50% of the patients is considered an Institution for Mental Diseases. Reimbursement for services provided in an IMD to persons between the ages of 22 through 64 years is limited to 30 days per inpatient admission, not to exceed a total of 60 days per contract year. For Title XIX members under age 22 and over age 65 there is no benefit limitation.

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

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

LONG TERM CARE - HCBS ALTERNATIVE RESIDENTIAL SETTINGS

Under the Home and Community-Based Services program, members may receive certain services while they are living in their own home. (See Section C for a definition of "home".) In addition, there are other alternative residential settings available to members. Members residing in these settings are responsible for the room and board payment. Medicaid funds can not be expended for room and board. Alternative residential settings include the following:

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

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

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

Behavioral Health Level I: A behavioral health service agency licensed by ADHS to provide a structured treatment setting with 24-hour supervision, on-site medical services and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services (other than psychiatric hospitalization) and when considered an alternative residential setting may provide mental health crisis stabilization and/or substance abuse detoxification.

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

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

Assisted Living Center, Unit Only *(formerly known as Supportive Residential Living Center)****:*** An ALTCS HCBS approved alternative residential setting composed of individual apartments licensed by ADHS to provide room, board and general supervision, as well as coordinate supportive living services to members on a 24-hour basis.

All approved ALTCS alternative residential settings are required to meet new ADHS licensing criteria.

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

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

2. BEHAVIORAL HEALTH SERVICES

DES/DDD shall provide medically necessary Title XIX (Medicaid) behavioral health services to all members in accordance with *AHCCCS policies* and AAC R9-28, Article 11. Covered services include:

a. Inpatient services
b. Individual, group and family therapy and counseling
c. Psychotropic medication
d. Psychotropic medication adjustment and monitoring
e. Partial care, basic and intensive
f. Emergency services
g. Behavior management
h. Psychosocial rehabilitation
i. Evaluation and diagnosis
j. Laboratory and radiology services for psychotropic medication regulation and diagnosis
k. Emergency and medically necessary transportation
l. Screening

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

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

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

There shall be procedures in place for ensuring that members' behavioral health services are appropriately provided, coordinated with the PCP and behavioral health providers, tracked by the case manager and documented in the member's record. DES/DDD shall also have procedures in place for ensuring communication occurs between the case manager, PCP and behavioral health providers and that care is coordinated with other agencies and involved parties. Quality management for behavioral health services must be included in DES/DDD's Quality Management Plan and shall meet the quality management requirements of AHCCCSA as specified in the *AMPM*, Chapter 1000.

3. AHCCCS MEDICAL POLICY MANUAL

The AHCCCS Medical Policy Manual (*AMPM*) is hereby incorporated by reference into the contract. DES/DDD is responsible for complying with the requirements set forth within. The *AMPM* with search capability and linkages to AHCCCS rules, Statutes and other resources is availability to all interested parties through the AHCCCS Home Page on the Internet (www.ahcccs.state.az.us). *AMPM* updates will be available through the Internet at the beginning of each month upon adoption by AHCCCSA. If required, DES/DDD may receive one hard copy of the *AMPM*, free of charge, from AHCCCSA, Office of Medical Management, Policy and Provider Network Unit.

4. THERAPEUTIC LEAVE AND BED HOLD

For therapeutic leave and bed hold policies, refer to the *AHCCCS Medical Policy Manual*, Section 1620-23.

5. ALTCS TRANSITIONAL PROGRAM

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

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

DES/DDD institutionalized members will continue to be considered institutional placement until the member is placed in an HCBS setting or expiration of the 90 day period, whichever occurs first. HCBS members will continue to be HCBS placed. DES/DDD compliance with this program will be monitored through AHCCCSA, Office of Managed Care and the Office of Medical Management.

6. CASE MANAGEMENT

Case management is the process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals eligible for ALTCS services. The process integrates the ALTCS member's and the case manager's review of the

member's strengths and needs resulting in the mutually agreed upon appropriate and cost effective acute and long term care services.

A Case manager is a person who is either a degreed social worker, licensed registered nurse, or a person with a minimum of two years experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities. Case managers shall not provide direct care services to members, but shall authorize appropriate services and/or refer members to appropriate services. Case managers shall spend at least 85% of their time on Title XIX ALTCS case management activities. Staffing must be sufficient to cover case manager absenteeism, turnover and out-of-state members. DES/DDD shall ensure that members and/or families are informed about the assignment of case managers and how to contact them. In the absence of the case manager, members and/or families must be given the opportunity to contact a back up staff person that will provide the necessary assistance. Case management orientation programs must include case management specific AHCCCS requirements as well as documentation of pertinent on-going training (e.g., cultural competency). DES/DDD must ensure that case managers are trained on the purpose of Unusual Incident Reports (UIR). Case managers shall be responsible for following procedures on reporting UIRs and tracking problem resolution involving ALTCS members.

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

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

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

a) Provide adequate information and teaching to assist the member/family in making informed decisions and choices;
b) Provide a continuum of service options that support the expectations and agreements established through the care plan process;
c) Integrate access to non-ALTCS services available throughout the community;
d) Advocate for the member and/or family/significant others as the need occurs;
e) Allow the member/family to identify their role in interacting with the service system;
f) Provide members with flexible and creative service delivery options;
g) Provide necessary information to providers about any changes in member's functioning to assist the provider in planning, delivering, and monitoring services;
h) Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the member.

DES/DDD shall ensure adequate staffing to meet case management requirements. ALTCS caseloads per case manager shall not exceed an average of 1:40. If caseloads exceed an average of 1:40, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCSA, to address caseload sizes. Non-users of service shall be reviewed by DES/DDD to determine if the member wishes to voluntarily withdraw from the ALTCS program. If the member declines long-term care services and requests acute care services only, the member's income must not exceed the SSI maximum (100% of the Federal Benefit Rate).

The Inventory for Client and Agency Planning (ICAP), which is DES/DDD's accepted tool for evaluating a client's overall functional level, shall be included in the initial assessment and upon any redetermination for

DD eligibility or as determined by the Individual Support Plan (ISP) team. Case managers must acquire sufficient evaluations and input from other professionals, i.e., physical therapist, nursing staff, vocational or educational staff, and incorporate the information into the service development process in order to ensure members needs are being met.

Case management for a member receiving behavioral health services must be provided in consultation/collaboration with a qualified behavioral health professional in those cases where the case manager does not meet the qualifications of a behavioral health professional as defined in R9-20. Case management in consultation with a behavioral health professional requires documentation of the initial consultation followed by quarterly consults between the ALTCS case manager and the behavioral health professional.

Case management of ventilator dependent members shall no longer require a team consisting of a licensed registered nurse and a social worker or case manager with a minimum of two years of experience in providing case management services. Member visits are completed in accordance to the setting in which the member resides. A list of ventilator dependent members who have been on a ventilator for 12 or more months as of the end of the federal fiscal year must be submitted to the Office of Medical Management to verify the receipt of an annual evaluation by a pulmonologist (see Attachment K).

The case manager shall be responsible for the transition of and discharge planning for members transferred to another program contractor or disenrolled from the ALTCS program. For members determined no longer eligible under DD criteria, AHCCCSA staff will perform an EPD PAS to see if the member meets EPD medical eligibility criteria. If so, the member will be disenrolled from DES/DDD and enrolled with an ALTCS EPD program contractor. In such situations, DES/DDD must continue to provide services until the date of disenrollment from DES/DDD. If an ALTCS member is disenrolled but remains eligible for AHCCCS acute care benefits, the case manager shall provide informational materials (available from AHCCCSA) to the member regarding available acute care health plans. The case manager shall obtain from the member his or her choice of health plans and convey this information to the AHCCCS Communication Center at 1-800-334-5283.

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

DES/DDD shall provide AHCCCSA a description of the internal monitoring of its case management program and shall include the aggregate results and analysis of this monitoring covering the previous 12 months. DES/DDD shall include those findings where improvement was indicated and the steps it has taken to resolve deficiencies.

The AHCCCS Administration is developing a report to monitor and compare DES/DDD on their timeliness of service implementation. In conjunction with this report, guidelines will be developed by AHCCCSA to require DES/DDD to self-audit specific aspects of HCBS implementation for members. These guidelines will be available by September 1, 2000.

Even though DES/DDD has up to 30 days to initiate services and place a new member, AHCCCSA's performance standard is two weeks. For future contract renewals, AHCCCSA will evaluate DES/DDD against the two-week standard. For details on Case Management requirements, see the *AMPM*, Chapters 1200, 1500, and 1600.

7. PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR)

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

8. QUALITY MANAGEMENT/ UTILIZATION MANAGEMENT

DES/DDD shall maintain an AHCCCSA-approved internal quality management/ utilization management system and plan in accordance with ALTCS Rules, the *AHCCCS Medical Policy Manual* and federal regulations found at 42 CFR 434.34 and Part 456; this RFP document does not contain all the QM/UM requirements. DES/DDD shall track all member problems and complaints (including non-QOC complaints) and provide trending and aggregation and analysis. The aggregation and analysis must incorporate the total ALTCS population served. DES/DDD shall respond to quality of care issues in accordance with the time limits specified in AHCCCSA correspondence concerning the individual issues and provide copies of any improvement plans specific to the case referred. DES/DDD shall make appropriate referrals of quality of care issues to licensure and regulatory agencies, but not limited to trended quality of care concerns.

DES/DDD shall ensure all children under age 21 receive required EPSDT screens and all medically necessary services in accordance with the *AHCCCS Medical Policy Manual*, Chapter 400.

DES/DDD shall participate in any annual study requested by AHCCCSA and shall cooperate in the collection of quality indicator data as needed, including chart reviews. AHCCCSA reserves the right to add required clinical indicators and set standards for compliance. The current ALTCS DD quality indicators identified by AHCCCSA include :

Annual:

- Pediatric immunization
- Number of members receiving childhood dental visits/services
- Program Monitoring in DD group homes
- Number of abuse and neglect unusual incident reports (UIR's)

Annual/Bi-annual as supported by the Core Indicator Process and developed by DES/DDD

- Number of individuals who choose where to live
- Number of individuals who choose their Support Coordinator
- Number of services that individuals did not receive which they felt were needed
- Number of female members who have an annual OB evaluation

Effective October 1, 2000, AHCCCS will require DES/DDD to adopt the Quality Improvement System for Managed Care (QISMC). AHCCCS expects DES/DDD to use the first year (October 1, 2000 – September 30, 2001) of adopting QISMC as an "implementation" year. There will be no expectation of initiation of QISMC related QI projects until after October 1, 2001. AHCCCS will work closely with DES/DDD during this implementation year and will work with DES/DDD to develop quality improvement projects that will meet the QISMC guidelines. Compliance with this requirement will become a part of the operational reviews after

October 1, 2001. AHCCCSA requests that DES/DDD develop performance improvement measurements that incorporate ongoing measurement and intervention. The measures would be demonstrable and indicate sustained improvement. The documentation of interventions instituted and the follow-up measurement from the baseline data is expected. DES/DDD is expected to have a written clinical performance indicator activity.

DES/DDD shall monitor activities related to the performance of the provider network. These activities shall include, but not be limited to, provider profiling in the areas of emergency room, hospital and pharmacy utilization. DES/DDD shall share provider profiling and utilization information on a regular basis with individual providers. DES/DDD shall comply with all medical audit provisions in AHCCCS Rule R9-28, Article 5.

DES/DDD will track, trend, and resolve all member problems and complaint data by provider, PCP, and case manager and maintain aggregation and analysis by district and from a statewide perspective

DES/DDD must choose measurable indicators from the Core Indicator Project and develop statewide interventions, timelines, and goals for each indicator which will support an integrated approach to continuous quality improvement. Include any additional focus areas of improvement that any of the Districts select.

Additional Requirements: DES/DDD shall conduct an annual case file review of the behavioral health care provided to its members. To meet this requirement, DES/DDD may independently perform the review, subcontract with ADHS or Regional Behavioral Health authorities or subcontract with a professional review organization. If applicable, DES/DDD shall have oversight responsibility to assure that the subcontractor performs the review as required and that results are accurate. DES/DDD shall ensure that reviews are conducted on a sample of member records for both children and adults served for each geographic service area based on a sampling methodology approved by AHCCCS.

DES/DDD shall submit a proposed sampling methodology and case file review guide to AHCCCSA, Office of Managed Care - Behavioral Health Unit, for review and approval no later than January 15, 2001. The sampling methodology and case file review guide shall be submitted to AHCCCS at least 30 days prior to implementation. The guide shall include, at a minimum:

A. Services are rendered by providers with qualifications appropriate to specific treatments ordered
B. Assessment, history and physical, progress notes support diagnosis
C. Treatment recommendations are appropriate to presenting problem and diagnosis; treatment recommendations meet accepted professional standards of care; treatment is timely; outcome of treatment met treatment objectives
D. Response to previous treatment is documented
E. Diagnostic modalities and tests are ordered as appropriate to the presenting problem; diagnostic tests are timely, are noted by the provider, and are acted upon by the provider
F. Follow-up is appropriate to diagnosis; follow-up activities scheduled; outreach efforts if appointment not kept; follow-up appropriate to diagnosis and treatment
G. Adverse outcomes: mortality during treatment; increased morbidity as evidenced by decreased functioning; readmission to an inpatient facility within 30 days of discharge

DES/DDD shall determine acceptable rates for compliance with each indicator and shall work with its subcontractors to identify the need for corrective action plans and follow-up evaluation.

9. VACCINE FOR CHILDREN PROGRAM

Federal legislation passed in 1993 (OBRA 93) amended Title XIX of the Social Security Act and created the Vaccine for Children (VFC) program which became effective 10/1/94. Through this program the federal and state governments purchase, and make available to providers free of charge, vaccines for AHCCCS children under age 19. Therefore, DES/DDD shall not utilize AHCCCS funding to purchase vaccines for members under the age of 19. Any provider licensed by the State to administer immunizations may register with ADHS as a "VFC provider" and receive free vaccines. DES/DDD shall comply with all VFC requirements and monitor its

providers to ensure that, if providing immunizations to AHCCCS members under the age of 19, the providers are registered with ADHS/VFC. (*AHCCCS Medical Policy Manual*, 430)

10. PHYSICIAN INCENTIVES

DES/DDD must comply with all applicable physician incentive requirements and conditions defined in 42 CFR 417.479(a). These regulations prohibit physician incentive plans that directly or indirectly make specific payments to a doctor or a physician group as an inducement to limit or refuse medically necessary services to a member. DES/DDD is required to disclose to AHCCCS the information on all physician incentive agreements listed in 42 CFR 417.479(h)(1) through 417.479(I) prior to initiation of a new contract, upon renewal, or upon request from AHCCCS or HCFA. Refer to the Office of Managed Care's Physician Incentive Plan (PIP) policies for details on providing required disclosures. In addition, per 42 CFR 417.479(h)(3), DES/DDD shall provide information on its physician incentive agreements to AHCCCS members who request them.

DES/DDD shall not enter into contractual arrangements that place providers at significant financial risk as defined in 42 CFR 417.479 unless specifically approved in advance by the Office of Managed Care. To obtain approval, the following must be submitted to the Office of Managed Care at least 45 days prior to the implementation of the contract:

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

11. PHYSICIAN REFERRALS

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

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

12. DENIALS OR REDUCTIONS OF SERVICES

When any covered service including HCBS services arranged by a case manager is denied, reduced, suspended or terminated, DES/DDD shall comply with the notice, appeal and continuation of benefits and appeals process specified in the Office of Managed Care Member Rights and Responsibilities Policy.

13. MEMBER HANDBOOK and MEMBER COMMUNICATIONS

All member informational materials (e.g. member handbooks, newsletters, brochures) prepared by DES/DDD shall be approved by AHCCCSA prior to distribution to members. Information shall be provided in English and a second language when 200 members or 5% of DES/DDD's enrolled population, whichever is greater, speak the same non-English language. DES/DDD is solely responsible for determining the necessity of this second-language requirement. All written communications shall be written at the fourth grade level. Suggested reference material to determine whether this requirement is being met are:

Fry Readability Index
PROSE, the Readability Analyst (Software developed by Education Activities, Inc.)
Gunning FOG Index
McLaughlin SMOG Index.

When there are program or service changes, DES/DDD will provide notification to the affected members at least 14 days before the change goes into effect.

DES/DDD shall produce and provide a Member Handbook to each member within 12 working days of enrollment. The Member Handbook shall be prepared in accordance with AHCCCSA rules for printed information and shallexplain, at a minimum, the following:

a. A table of contents
b. A description of all covered and non-covered services including a statement that the member is not liable for the debts of DES/DDD for covered services provided to the member by DES/DDD.
c. Operations of DES/DDD
d. How to contact Member Services and a description of its function
e. How to contact the case manager
f. How to select and change PCPs
g. Appointment procedures
h. What to do in case of an emergency including names, addresses and telephone numbers for members to call for instructions. In a life-threatening situation, the member handbook should instruct members to use the emergency medical services (EMS) available and/or activate EMS by dialing 9-1-1. The handbook must contain information on proper emergency service utilization.
i. Out-of-county and out-of-state moves
j. Grievance and request for hearing procedures, including a clear explanation of the member's right to file a grievance and to appeal any decision that affects the member's receipt of covered services.
k. Advance directives
l. Contributions the member can make towards his or her own health, member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by DES/DDD or AHCCCS. A sentence shall be included that stresses the importance of members keeping and not discarding their plastic AHCCCS ID card.
m. How to obtain emergency transportation and medically necessary transportation.
n. EPSDT services. A description of the purpose and benefits of EPSDT services, including the required components of EPSDT screenings and the provision of all medically necessary services to treat physical or mental illnesses discovered by the screenings. Screenings include a comprehensive history and developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screening and immunizations
o. Maternity and family planning services
p. Description of covered behavioral health services and how to access them
q. Coordination with Medicare and other potentially liable third parties

r. For members with Medicare coverage: indicate Medicare additional covered services, services not generally covered by Medicare, reference to the Medicare handbook "Other Things You Should Know About Medicare" which describes dual coverage (Medicare/Medicaid, QMB's, etc.)
s. Member's share of cost
t. The last revision date
u. Member's notification rights and responsibilities under *A.A.C.* R9-28, Article 12 and AHCCCS policy
v. A description of fraud and abuse including instructions on how to report suspected fraud or abuse. This shall include a statement that misuse of a member's identification card, including loaning, selling or giving it to others could result in loss of the member's eligibility and/or legal action against the member.
w. A statement that informs the member of their right to request information on whether or not DES/DDD has Physician Incentive Plans (PIP) that affect the use of referral services, the right to know the types of compensation arrangements DES/DDD uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with the PIP regulation.
x. Member's right to be treated fairly, regardless of race religion, sex, age, or ability to pay.
y. Detailed descriptions of all current residential placement options.
z. A description of all items and services for which prior authorization is required or not required.
aa. A description of how specialists are accessed.
bb. Information on self-referral process for certain services.
cc. A general description of how coordinated care works, including member responsibilities, appropriate utilization, and the PCP and case manager's role with the member in coordinating services.
dd. How to select and change PCPs and a list of available PCPs including names, addresses and phone numbers. This section shall include notice that, upon member request, DES/DDD will make information available regarding provider qualifications.
ee. How to obtain, without charge, a copy of the DES/DDD's provider directory.
ff. Information regarding prenatal HIV testing and counseling services.

Regardless of the format chosen by DES/DDD, the member handbook must be written in a type-style and size that can be easily read by members of varying degrees of visual impairment. At a minimum, the member handbook shall also contain the following questions and answers, along with the two paragraphs that follow.

Q. What if I have questions, problems, or complaints about DES/DDD?
A. If you have a question or problem, please call _____. If you have a specific complaint about your medical care, the Case Manager will help you.
Q. What if I am not happy with the help given to me by the Case Manager?
A. If you do not agree with the answer you receive, you may tell the Case Manager you want to file a written or oral grievance. The grievance must be filed no later than 60 days after the date of the action, decision, or incident.

DES/DDD will make a final decision within 45 days of getting your written grievance. A letter will be mailed to you stating our decision and the reason for the decision. The letter will tell you how you can appeal the decision if you are still unsatisfied. You must let us know you want to appeal within 15 days of being notified of our decision.

If you decide to appeal, we will send your request for appeal to AHCCCS. You will receive information from AHCCCS on how your appeal will be handled. AHCCCS will then decide if our decision was correct under the circumstances.

14. MEMBER SURVEYS

AHCCCSA may periodically conduct a survey of a representative sample of DES/DDD's membership. AHCCCSA will design a questionnaire to assess accessibility, availability and continuity of care with PCPs; communication between members and DES/DDD; and general member satisfaction with the ALTCS program. AHCCCSA will consider suggestions from DES/DDD for questions to be included in this survey. The results of these surveys will become public information and available to all interested parties upon request. In addition, unless waived by AHCCCSA, DES/DDD shall perform its own annual general or focused member survey. All such surveys must be approved in advance by AHCCCSA, Office of Managed Care. Results of the annual survey shall be communicated to AHCCCSA as soon as they are finalized. DES/DDD is required to include questions related to case manager performance on member surveys and to use personnel other than the case manager to administer the survey.

15. ENROLLMENT AND DISENROLLMENT

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

The effective date of enrollment with DES/DDD shall be retroactive to the effective date of ALTCS DD eligibility except when a member is enrolled with an acute health plan at the time of the ALTCS decision of approval. When this occurs, enrollment with DES/DDD will become effective the date the ALTCS enrollment action is processed by PMMIS (referred to as the "PMMIS update"). The disenrollment from the acute health plan will be effective the day before the DES/DDD effective enrollment date. Disenrollment from DES/DDD takes effect at the end of the month of discontinued ALTCS eligibility or, for ALTCS members who are no longer DD but remain ALTCS eligible, disenrollment from DES/DDD shall be effective no later than the end of the month in which an EPD PAS reassessment is completed. Exceptions to the disenrollment policy are discussed in ALTCS Eligibility Policy and Procedures Manual, Chapter 1600.

DES/DDD must continue to provide services until disenrollment from DES/DDD becomes effective. This includes reinstatement of ALTCS eligibility and DES/DDD enrollment pending a decision on the member's eligibility appeal with AHCCCSA.

16. REPORTING CHANGES IN MEMBERS' CIRCUMSTANCES

The ALTCS Member Change Report Form (DE-701) provides DES/DDD with a method for notifying the ALTCS eligibility offices and AHCCCSA of changes or corrections to the member's circumstances. This includes but is not limited to changes in residence, living arrangements, third party payers, share of cost, income or resources; a medical condition which could affect eligibility, or the member's death. See the ALTCS Eligibility Policy and Procedures Manual, chapter 1600.

17. OUT-OF-STATE PLACEMENT AND MEDICAL SERVICES

DES/DDD shall obtain prior written approval from AHCCCSA, Office of Medical Management, before placing a member outside of the state and notify AHCCCSA once placement has been completed. ALTCS members placed out-of-state by DES/DDD with AHCCCS approval are eligible for all ALTCS covered services. ALTCS members who are temporarily absent from Arizona without AHCCCSA approval are eligible for acute emergency

services only. Since absence from the state, even for a short period of time, will impact the covered services and may impact the member's eligibility for ALTCS. DES/DDD shall report all absences from the state to the ALTCS eligibility office for a determination of continued eligibility as specified in the ALTCS Eligibility Policy and Procedures Manual.

18. MAINSTREAMING OF ALTCS MEMBERS

To ensure mainstreaming of ALTCS members, DES/DDD shall take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental handicap, except where medically indicated. DES/DDD must take into account a member's culture, when addressing members and their concerns, and must take reasonable steps to encourage subcontractors to do the same. DES/DDD must also make interpreters available to members to ensure appropriate delivery of covered services.

Examples of prohibited practices include, but are not limited to, the following:

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

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

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

19. ADVANCE DIRECTIVES

DES/DDD shall maintain policies and procedures addressing directives for adult members that specify:

a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care must comply with federal and state law on advance directives for adult members. Requirements include:

1. Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to ARS § 36-3205.C.1)
2. Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections).

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

b. DES/DDD shall encourage subcontracted PCP's to comply with the requirements of subparagraph a.1. through 5. above. DES/DDD shall also encourage health care providers specified in subparagraph a. to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

20. PERFORMANCE MEASUREMENT

***EPSDT Participation**:* DES/DDD shall take affirmative steps to increase member participation in the EPSDT program to at least 80% of all enrolled members under the age 21 during CYE 2001. The participant rate is the number of children receiving at least one medical screen 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 federal periodicity schedule and the average period of eligibility. If DES/DDD's performance rates are higher than the statewide averages, but lower than the stated goals set forth in this contract, AHCCCSA may require DES/DDD to submit a corrective action plan.

AHCCCSA will measure participation levels through encounter data and will not use information from prior period coverage in evaluating DES/DDD's performance.

***EPSDT Immunizations**:* DES/DDD shall ensure members under age 21 receive age-appropriate immunizations as specified in the AHCCCS Medical Policy Manual. During CYE 2001, DES/DDD shall meet or exceed the following:

Immunization	Percentage of Members Immunized	Number of Doses
Diphtheria, Tetanus, Pertussis vaccine (DPT)	82%	4
Oral/Inactivated Polio Vaccine	88%	3
Measles, Mumps, Rubella Vaccine (MMR)	90%	1
H. Influenza, Type B (HIB)	90%	2
Hepatitis B (Hep B)	87%	3
Combined 3-Antigen Rate (4DPT, 3 OPV, 1MMR)	82%	8
Combined All Antigens	73%	13
Varicella Vaccine	67%	1

DES/DDD shall participate in an annual immunization audit based on random sampling to assess and verify the immunization status of two year old members. AHCCCSA will provide DES/DDD, within two weeks after the end of the contract year, the selected sample, specifications for conducting the audit, the AHCCCSA reporting requirements, and technical assistance. DES/DDD shall identify each child's PCP, conduct the assessment, and report to AHCCCSA in the required format all immunization data for the sampled two-year-old children no later than December 15 after the end of the contract year. If medical records are missing for more than 5% of the sample group, DES/DDD is subject to sanctions by AHCCCSA. AHCCCSA's External Quality Review contractor may conduct a study to validate DES/DDD's reported rates.

Annual Dental Visits: DES/DDD shall take affirmative steps to increase utilization of dental services for members under age 21. At least 55% of all enrolled members between the ages of 3 through 21 shall have at least one dental visit during CYE 2001. AHCCCSA will monitor utilization through reported encounter data. If DES/DDD's performance rates are higher than the statewide averages, but lower than the stated goals set forth in this contract, AHCCCSA may require DES/DDD to submit a corrective action plan.

21. STAFF REQUIREMENTS and SUPPORT SERVICES

DES/DDD shall have in place the organizational, management and administrative systems capable of fulfilling all contract requirements. At a minimum, the following staff are required:

a. An **Assistant Director (Program Administrator)** to oversee the entire operation of the DES/DDD Title XIX program.

b. A **Medical Director** who is an Arizona-licensed physician. The Medical Director shall be actively involved in all major clinical program components of DES/DDD. The Medical Director shall devote sufficient time to DES/DDD's operations to ensure timely medical decisions, including after-hours consultation as needed (see Paragraph 22).

c. A **Grievance Coordinator** to investigate member and provider complaints and grievances against DES/DDD and submit quarterly reports to AHCCCSA's Office of Legal Assistance.

d. A full-time **Financial Officer** to oversee the budget, accounting systems and financial reporting of DES/DDD.

e. A **Quality Management Coordinator** who is a registered nurse, physician or physician's assistant currently licensed in Arizona.

f. A **Behavioral Health Coordinator who** shall be a behavioral health professional as described in Health Services Rule R9-20. The Behavioral Health Coordinator shall devote sufficient time to assure DES/DDD's Behavioral Health program is implemented per AHCCCSA requirements.

g. An EPSDT Coordinator who is 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.

h. **Case Management Administrator/Manager/Supervisory staff** to oversee the case management functions

i. **Case Managers** to coordinate the provisions of services to clients in HCBS and institutional settings

j. **Provider Representatives** to coordinate communications between DES/DDD, subcontractors, other program contractors, and AHCCCSA

k. **Claims Processors/Encounter Administrator** to ensure the timely and accurate submission of encounter data, processing of original claims, claims corrections letters, resubmission and overall disposition of all claims

l. **Support Services Staff** to ensure the timely and accurate processing of support service reports and requests (e.g., telephone systems, MIS);

m. **Prior Authorization** staff to authorize medical care 24 hours per day, 7 days per week. This staff shall be directly supervised by an Arizona-licensed registered nurse, physician or physician's assistant.

n. **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.

o. Sufficient **clerical support staff** to conduct daily business

DES/DDD shall inform AHCCCSA, Office of Managed Care, in writing within seven days of learning of an intended resignation in any of the following key positions:

- Assistant Director
- ALTCS Program Administrator
- Medical Director
- Business Operations Administrator

- Managed Care Program Administrator
- EPSDT Coordinator
- Program Operations Administrator
- Quality Management Coordinator
- Case Management Administrator/Manager
- Behavioral Health Coordinator
- Grievance Coordinator

DES/DDD shall ensure that all staff have appropriate training, education and experience to fulfill the requirements of the position.

If DES/DDD subcontracts with other entities for acute medical care services, behavioral health services and other Long Term Care medical care services, it must ensure that the subcontractors perform in accordance with all AHCCCS requirements and that all staff have appropriate licenses and certifications.

22. MEDICAL DIRECTOR

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

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

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

23. WRITTEN POLICIES, PROCEDURES AND JOB DESCRIPTIONS

DES/DDD shall develop and maintain written policies, procedures and job descriptions for each functional area. DES/DDD shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions, as appropriate, in order to ensure all contract requirements are being met.

All policies and procedures shall be reviewed at least annually to ensure that DES/DDD's current practices reflect written policies. Review and/or revision dates shall be documented on the policy. Reviewed policies shall be dated and signed by DES/DDD's appropriate management. All medical and quality management/utilization management policies must be approved and signed by the Contractor's Medical Director.

Job descriptions for the following positions shall be reviewed at least annually to ensure that current duties performed by the employee reflect written requirements. Review dates shall be documented on the job descriptions.

- Assistant Director
- ALTCS Program Administrator
- Medical Director
- Business Operations Administrator
- Managed Care Program Administrator
- EPSDT Coordinator
- Program Operations Administrator
- Quality Management Coordinator
- Behavioral Health Coordinator
- Grievance Coordinator

24. PROVIDER MANUAL

DES/DDD shall develop, distribute and maintain a provider manual. DES/DDD shall document the approval of the provider manual by its Administrator and Medical Director and shall maintain documentation which verifies that the provider manual is reviewed at least annually. DES/DDD shall ensure and document that each provider (individual or group that submits claim and encounter data) is issued a copy of the provider manual. At a minimum, the provider manual must contain information on the following:

a. A table of contents
b. Introduction to DES/DDD which explains its organization and administrative structure
c. Provider responsibilities and DES/DDD's expectation of the provider such as gatekeeping activities, etc.
d. Overview of DES/DDD's Provider Services department and function
e. Listing and description of covered and non-covered services, requirements and limitations
f. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
g. Description of covered behavioral health services and how to access them
h. DES/DDD's policy regarding PCP assignments
i. Referrals to specialists and other providers
j. Grievance and procedures
k. Billing and encounter submission information
   - indicate which form, UB92, HCFA 1500, or Form C is to be used for services
   - indicate which fields are required for a claim to be considered acceptable by DES/DDD. A completed sample of each form shall be included
l. DES/DDD's written policies and procedures which affect the provider(s) and/or the provider network
m. Claims re-submission policy and procedure
n. Reimbursement information including reimbursement for members with other insurance or Medicare
o. Explanation of remittance advice
p. Prior authorization procedures

q. Claims medical review
r. Concurrent review
s. Fraud and abuse
t. AHCCCS appointment/ waiting time standards
u. Formulary information including updates when changes occur. (The formulary may be separate from the Provider Manual.)
v. EPSDT services, standards and forms
w. ADA requirements, as applicable
x. Cultural competency information
y. Eligibility verification

25. NETWORK DEVELOPMENT

DES/DDD shall develop and maintain a provider network and plan, including home and community based service providers and all subcontracted responsibilities (e.g., behavioral health services), that is sufficient to provide all covered services to ALTCS members. It shall ensure covered services are provided promptly and are reasonably accessible in terms of location and hours of operation. There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis. The development of home and community based services shall include provisions for the availability of services on a 7-day-a-week basis and for extended hours, as directed by member needs.

If a service or setting is not available or is inadequate, DES/DDD must submit with its response an action plan for the creation, recruitment or other activities designed to establish the service or setting.

Under the Balanced Budget Act of 1997, DES/DDD shall not discriminate with respect to participation in the AHCCCS program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification. This provision, however, does not prohibit DES/DDD from limiting provider participation to the extent necessary to meet the needs of DES/DDD's members. This provision also does not interfere with measures established by DES/DDD to control costs consistent with its responsibilities under this contract.

26. NETWORK MANAGEMENT

DES/DDD shall have policies and procedures in place that pertain to all service specifications described in the *AHCCCS Medical Policy Manual,* Chapter 1200. These include, but are not limited to, policies on how DES/DDD will:

a. Communicate with the network regarding contractual and/or program changes and requirements
b. Monitor and control network compliance with policies and rules of AHCCCSA and DES/DDD including compliance with all policies and procedures related to the grievance process and ensuring the member's care is not compromised during this 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 network capacity to ensure that there are sufficient providers to handle the volume of members
f. Ensure service accessibility, including monitoring appointment procedures standards, appointment waiting times, and service provision standards
g. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling.
h. Manage or share risk with providers

i. Provide training for its providers and maintain records of such training
j. Provide eligibility information and prior authorization 24 hours per day, 7 days per week.

DES/DDD shall comply with the provider network and staffing requirements described in the *AMPM*, Chapter 600 and the medical policy and standards related to care coordination described in Chapter 500. DES/DDD shall also submit to AHCCCSA, Office of Managed Care, quarterly updates on the provider network.

DES/DDD shall maintain files on all contracted service providers. At a minimum, these files shall contain: a current, signed contract; any contract amendments; current certificate of insurance; and copies of pertinent correspondence related to contract issues.

All material changes in DES/DDD's provider network must be approved in advance by AHCCCSA, Office of Managed Care. A material change is defined as one which affects, or can reasonably be foreseen to affect, DES/DDD's ability to meet the performance and network standards as described in this solicitation. The Office of Managed Care must be notified in writing of planned material changes in the provider network before the change process has begun, for example before issuing a 60-day termination notice to a provider. The written notification to AHCCCSA shall be made within one working day if the change is unexpected. AHCCCSA will assess proposed changes in DES/DDD's provider network for potential impact on members' health care and provide a written response to DES/DDD within 14 days of receipt of request. For emergency situations, AHCCCSA will expedite the approval process.

DES/DDD shall notify AHCCCSA, Office of Managed Care, 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, (2) DES/DDD's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services and (3) DES/DDD's plan to address and resolve any network deficiency.

27. PROVIDER REGISTRATION

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

28. PROVIDER AFFILIATION TAPE

DES/DDD shall submit information quarterly regarding its provider network. This information shall be submitted in the format described in the *Provider Affiliation Tape 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.

29. FEDERALLY QUALIFIED HEALTH CENTERS (FQHC)

DES/DDD is encouraged to use FQHCs in Arizona to provide covered services and must comply with the federal mandates in OBRA 89 and OBRA 90. This legislation gives FQHCs the option to require state Medicaid programs to reimburse the FQHC at 100% of reasonable costs for the services delivered. AHCCCSA and its contractors are required to comply with this legislation. The following payment methodology for reasonable cost reimbursement was implemented effective October 1, 1997.

If the FQHC elects reasonable cost reimbursement, the FQHC will receive a quarterly payment per Title XIX member per month from AHCCCSA. The initial capitation amount will be $1.75 per member per month (PMPM) statewide. In accordance with the Balanced Budget Act of 1997 and BBA Refinements Legislation, this additional reimbursement will be phased-out over a five year period beginning in contract year ending 2000:

Contract Year	Phase-Out Percentage	PMPM Amount
1997 through 1999	No phase-out	$ 1.75
2000	95%	$ 1.66
2001	95%	$ 1.66
2002	95%	$ 1.66
2003	90%	$ 1.58
2004	85%	$ 1.49
2005	0%	$ 0.00

DES/DDD is required to submit member month information for ALTCS members for each FQHC on a quarterly basis to AHCCCS Office of Managed Care. AHCCCSA will perform periodic audits of the member month information submitted. DES/DDD should refer to the Office of Managed Care's policy on FQHC reimbursement for further guidance.

The following FQHCs are currently recognized by HCFA:

Clinica Adelante, Inc.
El Rio Health Center
Lake Powell Medical Center
Mariposa Community Health Center, Inc.
Mountain Park Health Center
Sun Life Family Health Center
United Community Health Center, Inc.
Sunset Community Health Center (formerly Valley Health Center, Inc.)
Inter-Tribal Health Care Center
Native American Community Health Center, Inc.
Native Americans for Community Action Family Health Center
Chiricahua Community Health Centers, Inc.
Marana Health Center
Ajo Community Center
North Country's Community Health Center

Any additional clinics that become FQHCs at a later date will also be subject to the reimbursement methodology described above upon electing reasonable cost reimbursement with AHCCCSA.

30. APPOINTMENT STANDARDS

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

a. Emergency appointments the same day or within 24 hours of the member's phone call or other notification, or as medically appropriate
b. Urgent care appointments within two days
c. Routine care appointments within 21 days

For **specialty referrals**, DES/DDD shall be able to provide:

a. Emergency appointments within 24 hours of referral

b. Urgent care appointments within 3 days of referral
c. Routine care appointments within 30 days of referral

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

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

For **medically-necessary transportation,** DES/DDD shall require its transportation provider to schedule the transportation so that the member arrives no sooner than one hour before the appointment and does not have to wait more than one hour after making the call to be picked up after the appointment.

DES/DDD or its subcontractors shall actively monitor provider compliance with appointment standards through methods such as "mystery shopping" and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits. DES/DDD or its subcontractors 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.

DES/DDD shall have written policies and procedures about educating its provider network about appointment time requirements. Appointment standards shall be include in the Provider Manual.

31. FRAUD AND ABUSE

DES/DDD is responsible for reporting all cases of suspected fraud and abuse by subcontractors, members or employees. DES/DDD shall provide written notification of such incidents to AHCCCSA, Office of Program Integrity. DES/DDD shall develop programs to detect and prevent fraud and abuse and shall cooperate with AHCCCSA as requested to investigate fraud and abuse cases. DES/DDD is required to research potential overpayments identified by a fraud and abuse investigation or audit conducted by AHCCCSA. After conducting a cost benefit analysis to determine if such action is warranted, DES/DDD should attempt to recover any overpayments identified due to erroneous, false or fraudulent billings. For a full description of DES/DDD's responsibilities, see the *AHCCCS Health Plans and Program Contractors - Policy for Prevention, Detection and Reporting of Fraud and Abuse* which is available in the Bidders' Library and incorporated herein by reference.

DES/DDD shall participate in a fraud and abuse workgroup which will consist of representatives from acute care health plans, program contractors, AHCCCSA, the Attorney General's office, and the Health Care Financing Administration. The purpose of the workgroup is to explore ways to minimize the occurrence of fraud and abuse within the AHCCCS system and to recommend updates and revisions to the policy.

As stated in ARS § 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 population served in the long-term care program is very vulnerable, particularly in the area of abuse. DES/DDD shall develop specific controls to prevent and detect member abuse.

32. REPORTING REQUIREMENTS

AHCCCSA, under the terms and conditions of its waiver with HCFA, requires reports, encounter data, and other information from DES/DDD. DES/DDD will comply with all reporting requirements in a manner similar to all other program contractors. DES/DDD will be sanctioned if DES/DDD fails to comply with stated contractual reporting requirements. The submission of late, inaccurate, or otherwise incomplete reports shall constitute failure to report subject to the penalty provisions described in 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. DES/DDD shall comply with all changes specified by AHCCCSA. A listing of all standard reports and due dates can be found in Attachment K. Additional reports and data may be requested. Such requests will include a description of information requested and a due date.

DES/DDD 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. Also included in this requirement is DES/DDD's responsibility for continued reporting on performance measures.

DES/DDD shall comply with all financial reporting requirements contained in the *Reporting Guide for ALTCS Program 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 K.

33. DISSEMINATION OF INFORMATION

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

34. OPERATIONAL AND FINANCIAL REVIEWS

In accordance with HCFA requirements and AHCCCS Rule R9-28, Article 5, AHCCCSA will conduct regular operational and financial reviews for the purpose of (but not limited to) ensuring program compliance. The type and duration of the review will be solely at the discretion of AHCCCSA. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCSA will give DES/DDD at least three weeks advance notice of the scheduled Operational and Financial Review. AHCCCSA reserves the right to conduct reviews without notice. AHCCCSA may conduct a review without notice in the event DES/DDD undergoes a reorganization, or makes changes in three or more key staff positions within a 12-month period, or to investigate complaints received by AHCCCSA. DES/DDD shall comply with all other medical audit provisions as required by AHCCCSA.

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

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

The operations review is conducted by an AHCCCS review team comprised of staff from the Office of Managed Care, the Office of Medical Management and Legal Assistance. The team will evaluate DES/DDD's performance and compliance with AHCCCS policies, rules and the terms of this contract. The review will look at all aspects of operations including, but not limited to:

Case management	Quality management	Network management
Utilization management	Medical direction	Executive and financial management
Grievance process	Claims processing	Provider and member services
Encounter reporting	Behavioral health	Business Continuity Plan (Disaster Recovery)

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

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

35. PATIENT TRUST ACCOUNT MONITORING

DES/DDD shall have a policy regarding on-site monitoring of trust fund accounts for institutionalized members to ensure that expenditures from a member's trust fund comply with federal and state regulations. Suspected incidents of fraud involving the management of these accounts must be reported in accordance with Section D, Paragraph 31, Fraud and Abuse.

36. COMPENSATION

DES/DDD shall be reimbursed on a capitated basis using two cost-based rates: Ventilator and Non-Ventilator. These rates have been developed based on costs and encounter utilization information as reported by DES/DDD and are subject to change if AHCCCSA receives information which varies significantly from the information used to calculate the rates. Capitation payments will be made no later than the fifth working day of the month for which payment is due, dependent on the availability of sufficient state match funds.

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

The Ventilator rate includes the provision of an annual evaluation. Each ventilator dependent member shall have an annual evaluation by a pulmonologist to assess the prospects of weaning the member from dependency on the ventilator. A copy of this evaluation shall be promptly forwarded to AHCCCSA's Ventilator Dependent Coordinator.

Subject to the availability of funds, AHCCCSA shall make payments to DES/DDD in accordance with the terms of this contract provided that DES/DDD's performance is in compliance with the terms and conditions of this contract. Payment must comply with requirements of ARS Title 36. AHCCCSA reserves the option to make payments to DES/DDD by wire or NACHA (National Automated Clearing House Association) transfer and will provide DES/DDD at least 30 days notice prior to the effective date of any such change. Where payments are made by electronic funds transfer, AHCCCSA shall not be liable for any error or delay in transfer nor indirect or consequential damages arising from the use of the electronic funds transfer process.

All funds received by DES/DDD 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 DES/DDD for the services provided hereunder is the Arizona Health Care Cost Containment System Fund, as described in ARS §36-2913. An error discovered by the State with or without an audit in the amount of fees paid to DES/DDD will be subject to adjustment or repayment by DES/DDD making a corresponding decrease in a current DES/DDD payment or by making an additional payment by AHCCCSA to DES/DDD.

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

HIV-AIDS Supplement: On a quarterly basis, AHCCCSA shall utilize encounters to determine the number of members receiving approved HIV/AIDS drugs and calculate the amount of the supplemental payment. The rate of reimbursement for this separate per member per month payment is specified in Section B and is subject to review during the term of the contract. AHCCCSA reserves the right to recoup any amounts paid for ineligible members as determined through an encounter data review as well as an associated penalty for incorrect encounter reporting. Refer to the Office of Managed Care's HIV/AIDS supplemental payment and review policies for further details and requirements.

37. ANNUAL SUBMISSION OF BUDGET

DES/DDD shall submit to AHCCCSA, by July 31st of each renewal year, an estimate of the cost of serving members in each sub-program area for the prospective contract year. In addition, DES/DDD shall submit budget estimates of acute medical care costs, case management costs and the costs of serving Ventilator Dependent clients. This will include the cost of outpatient and day services as well as the cost of residential services. The cost estimates must be fully supported by documentation stating the nature of the costs and the methods and data used to develop the estimates. These cost estimates will be utilized by AHCCCS in preparation of the request of Federal Funds Expenditure Authority for the DES/DDD program in the AHCCCS HCFA-37.

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

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

DES/DDD shall ensure members have access to and receive behavioral health services as described in the AHCCCSA Behavioral Health Policy Manual.

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

DES/DDD receives legislative appropriations for DD Title XIX services. DES/DDD shall, by July 1st on an annual basis, transfer to AHCCCSA the total amount appropriated for the state match for Title XIX ALTCS expenditures. This transfer shall be made, in its entirety, prior to the first Title XIX disbursement. AHCCCSA shall deposit the monies transferred into an Intergovernmental Agreement (IGA) Fund of which AHCCCSA shall have sole disbursement authority.

When AHCCCSA draws FFP for qualifying DES/DDD disbursements, AHCCCSA will also withdrawal the appropriate state match from the IGA Fund and disburse both the FFP and the state match to DES/DDD. AHCCCSA shall only draw FFP when sufficient state match funds are available. If AHCCCSA determines that additional monies are required, AHCCCSA shall notify DES/DDD that additional monies must be deposited into the IGA Fund prior to making additional Title XIX disbursements. If at the end of a fiscal year, and after the close of any administrative adjustments as defined in ARS 35-190 - 191, monies remain in the IGA Fund, AHCCCSA shall notify DES/DDD and transfer these monies back to DES/DDD. If it is determined that excessive funds exist in the IGA Fund, DES/DDD may request a withdrawal of monies prior to the end of a state fiscal year and/or prior to the close of the administrative adjustment period.

38. FINANCIAL MANAGEMENT

Both AHCCCSA and HCFA require specific financial management and reporting standards to protect the financial integrity of spending under the ALTCS program. In addition, financial information must be available for DES/DDD to manage the program, to assess its own financial risk and to determine if members are receiving necessary services. At a minimum, DES/DDD's system shall:

a. Gather and report data on critical financial indicators (e.g., Incurred But Not Reported Claims)
b. Establish and maintain a financial information base to support current operations
c. Provide information regarding financial status, including all reporting mandated by law and accounting of medical expenditures, to internal management and AHCCCSA on a regular basis
d. Make records available for independent audit
e. Ensure that subcontractors are reimbursed promptly and correctly in accordance with AHCCCS Rule R9-28, Article 7, and R9-22, Article 7
f. Monitor institutional patient trust accounts

g. Monitor records in accordance with 42 CFR 483.10

In addition, DES/DDD's financial management systems must meet specific standards established by HCFA. These are specified in 45 CFR, Part 74, which is incorporated herein by reference.

39. REQUIRED FINANCIAL REPORTS

DES/DDD shall comply with all financial reporting requirements contained in the *Reporting Guide for Long-Term Care Program Contractors with the Arizona Health Care Cost Containment System.* The Guide, which may be found in the Bidders' Library, contains a complete listing of all monthly, quarterly and annual reporting requirements including due dates for each report.

40. FINANCIAL VIABILITY CRITERIA and PERFORMANCE MEASURES

AHCCCSA has established the following financial viability criteria and performance measures that DES/DDD shall adhere to. These standards are subject to change as AHCCCSA deems appropriate:

a. **Medical Expense Ratio** Standard: At least 85%

Total medical expense (net of reinsurance, TPL, HIV/AIDS Supplement) divided by total capitation

b. **Total Administrative Cost Percentage** Standard: No more than 10%
(Total administrative expenses, excluding income taxes, divided by total capitation + TPL + reinsurance + HIV/AIDS supplement.)

c. **Received But Unpaid Claims Days Outstanding** Standard: No more than 30 days
(Received but unpaid claims divided by the average daily medical expenses for the period, net of sub-capitation expense)

41. ADVANCES, DISTRIBUTIONS AND LOANS

DES/DDD shall not, without the prior written approval of AHCCCSA, make any advances to a related party, or any distribution, loan or loan guarantee to any entity, including another fund or line of business within its organization. Requests for prior approval shall be submitted to the Office of Managed Care.

42. ACCUMULATED FUND DEFICIT

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

43. 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 DES/DDD prior to modifying capitation rates. DES/DDD may request a review of a program change if it believes the program change was not equitable; AHCCCSA will not unreasonably withhold such a review.

If DES/DDD is in any manner in default in the performance of any obligation under this contract, 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. DES/DDD shall reimburse AHCCCSA and/or AHCCCSA may deduct from future monthly capitation for any portion of a month during which DES/DDD was not at risk due to, for example:

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

If a member is enrolled twice with DES/DDD, 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.

44. CLAIMS PAYMENT SYSTEM

DES/DDD shall develop and maintain a claims payment system capable of processing, cost-avoiding and paying claims in accordance with AHCCCS Rule R9-28, Article 7, a copy of which may be found in the Bidder's Library. In the absence of a subcontract provision to the contrary, claims submission deadlines shall be calculated from the date of service or the effective date of eligibility posting, whichever is later. Remittance advices accompanying DES/DDD'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 grievance rights. DES/DDD's claims payment system, as well as its prior authorization and concurrent review process, must minimize the likelihood of having to recoup already-paid claims. Any recoupment in excess of $50,000 per provider within a contract year must be approved in advance by AHCCCSA, Office of Managed Care.

In accordance with the Balanced Budget Act of 1997, unless a subcontract specifies otherwise, DES/DDD shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 90 days of receipt of the clean claim.

During the term of this contract, AHCCCSA anticipates requiring all program contractors to use a standardized electronic format for electronic claims processing between the program contractors and their providers. AHCCCSA plans to require the formats outlined in the Technical Interface Guidelines under *Claims Processing*, which is the format adopted by 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 DES/DDD.

DES/DDD must have procedures for either pre-payment or post-payment claims review that includes review of supporting documentation such as medical records, home health visit notes, in addition to authorizations. DES/DDD shall submit their policy and procedures for pre-payment or post-payment claims review to AHCCCS, Office of Managed Care, for review and approval.

45. HOSPITAL SUBCONTRACTING AND REIMBURSEMENT

DES/DDD shall reimburse hospitals for member care in accordance with AHCCCS Rule R9-22, Article 7. DES/DDD is encouraged to obtain contracts with hospitals in all other geographic service areas (GSAs).

For Out-of-State Hospitals*:* DES/DDD shall reimburse out-of-state hospitals in accordance with AHCCCS Rule R9-22, Article 7.

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

46. REINSURANCE

Reinsurance is a stop-loss program provided by AHCCCSA to DES/DDD for the partial reimbursement of covered medical services incurred, as described in this paragraph, for a member beyond an annual deductible. AHCCCSA is self-insured for the reinsurance program, which has an initial deductible level and a subsequent coinsurance percentage.

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

Catastrophic Reinsurance: The reinsurance program also includes a special Catastrophic Reinsurance program. This program encompasses members diagnosed with hemophilia, von Willebrand's Disease, and Gaucher's Disease. This program also 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. For additional detail and restrictions refer to the *AHCCCSA Reinsurance Claims Processing* and Medical Policy Manuals. There are no deductibles for catastrophic reinsurance cases. All catastrophic claims are subject to medical review by AHCCCSA.

HEMOPHILIA: When a member is deemed as being catastrophically eligible by AHCCCSA due to the specific diagnosis of hemophilia (ICD 9 286.0, 286.1, and 286.2). All medically necessary covered services provided during the contract year shall be eligible for reimbursement at 85% of DES/DDD's paid amount.

VON WILLEBRAND'S DISEASE: Catastrophic reinsurance coverage is available for all members diagnosed with von Willebrand's Disease (vWD) who are non DDAVP responders and dependent on Plasma Factor VIII. All medically necessary covered services provided during the contract year shall be eligible for 85% of DES/DDD's paid amount.

GAUCHER'S DISEASE: Catastrophic reinsurance coverage is available for members diagnosed with Gaucher's Disease classified as Type I, and are dependent on enzyme replacement therapy. Medically necessary covered services provided during the contract year shall be eligible for 85% of DES/DDD's paid amount.

Required Notice: DES/DDD shall notify AHCCCSA, Office of Medical Management, Reinsurance Unit, of the above cases identified for catastrophic non-transplant reinsurance coverage within 30 days of (a) initial diagnosis, (b) enrollment with DES/DDD, and (c) the beginning of each contract year for the above listed diseases. Catastrophic reinsurance will be paid for a maximum 30 day retroactive period from the date of notification to AHCCCSA.

TRANSPLANTS: Bone grafts and cornea transplantation services are not eligible for catastrophic reinsurance coverage but are eligible under the regular (non-catastrophic) reinsurance program. Catastrophic reinsurance coverage for transplants is limited to 85% of the AHCCCS contract amount for the transplantation services rendered, or 85% of DES/DDD's paid amount, whichever is less. 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, DES/DDD shall notify AHCCCSA, Office of Medical Management.

Encounter data will not be used to determine catastrophic reinsurance benefits for transplants. However, this does not relieve DES/DDD of the responsibility for submitting encounters for all catastrophic reinsurance services.

The initial claims for reimbursement under the catastrophic reinsurance program must be filed no later than June 30th of the year following the contract year. Catastrophic reinsurance claims that are submitted within this time limit and are denied or adjusted, may be corrected until September 30th of the year following the contract year. All catastrophic reinsurance claims must be submitted in accordance with the *AHCCCS Reinsurance Claims Processing Manual*.

Medical review on regular reinsurance cases will be determined based on statistically valid retrospective random sampling. The AHCCCSA, Office of Medical Management, will generate the sampling and notify DES/DDD of documentation needed for the retrospective review process to occur at DES/DDD's office. AHCCCSA will provide DES/DDD at least 45 days advance notice of any such review and all requested information shall be available on-site during the review. The DES/DDD representative shall be available to the Review Team at all times during AHCCCSA on-site review activities. While on-site, DES/DDD shall provide the Review Team with workspace, access to a telephone, electrical outlets and privacy for conferences. The results of the medical review sampling will be extrapolated to DES/DDD's entire regular reinsurance reimbursement population for the sampled timeframe. A partial recoupment of reinsurance reimbursements made to DES/DDD may occur based on the results of the medical review sampling. Reinsurance consideration will be given to inpatient facility contracts and hearing decisions rendered by the Office of Legal Assistance. Pre hearing settlements and/or hearing penalties discoverable during the review process will not be reimbursed under reinsurance.

47. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

By 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 two methods used in the coordination of benefits are cost avoidance and post-payment recovery. See also Section D, Paragraph 49, Medicare Services and Cost Sharing.

Cost Avoidance: DES/DDD shall cost-avoid all claims or services that are subject to third-party payment and may deny a service to a member if it knows that a third party (i.e. other insurer) will provide the service. However, if a third-party insurer (other than Medicare) requires the member to pay any copayment, coinsurance or deductible, DES/DDD is responsible for making these payments, even if the services are provided outside of DES/DDD's network. DES/DDD's liability for coinsurance and deductibles is limited to what DES/DDD would have paid for the entire service pursuant to a written contract with the provider or the AHCCCS fee-for-service rate, less any amount paid by the third party. (DES/DDD must decide whether it is more cost-effective to provide the service within its network or pay coinsurance and deductibles for a service outside its network. For continuity of care, DES/DDD may also choose to provide the service within its

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

If DES/DDD knows that the third party insurer will neither pay for nor provide the covered service, and the service is medically necessary, DES/DDD shall not deny the service nor require a written denial letter. If DES/DDD does not know whether a particular service is covered by the third party, and the service is medically necessary, DES/DDD shall contact the third party and determine whether or not such service is covered rather than requiring the member to do so. (See also Section D, Paragraph 49, Medicare Services and Cost Sharing.)

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

Postpayment Recoveries: Postpayment recovery is necessary in cases where DES/DDD was not aware of third-party coverage at the time services were rendered or paid for, or was unable to cost avoid. DES/DDD shall identify all potentially liable third parties and pursue reimbursement from them except in the circumstances below. DES/DDD shall not pursue reimbursement in the following circumstances unless the case has been referred to DES/DDD by AHCCCSA or AHCCCSA's authorized representative:

Uninsured/ underinsured motorist insurance
First and third-party liability insurance
Tortfeasors
Special Treatment Trusts recovery
Adoption recovery
Estate recovery
Worker's Compensation

DES/DDD shall report any cases involving the above circumstances to AHCCCSA's authorized representative should DES/DDD identify such a situation. See AHCCCS Rule R9-28, Article 9. DES/DDD shall cooperate with AHCCCSA's authorized representative in all collection efforts. In joint cases involving both AHCCCS fee-for-service or reinsurance and DES/DDD, 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 DES/DDD. 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. For total plan cases involving only payments from DES/DDD, DES/DDD is responsible for performing all research, investigation, the filing of liens and payment of lien-filing fees and other related costs. DES/DDD shall use the cover sheet as prescribed by AHCCCSA when filing liens.

DES/DDD 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 DES/DDD'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.)
c. Such recovery is not prohibited by state or federal law

Reporting: DES/DDD may be required to report case level detail of third-party collections and cost avoidance, including number of referrals on total plan cases. In addition, upon AHCCCSA's request, DES/DDD shall provide an electronic extract of the Casualty cases, including open and closed cases. Data elements include, but are not limited to: 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 DES/DDD. DES/DDD shall notify AHCCCSA's authorized representative within five working days of the identification of a third-party liability case with reinsurance. Failure to report reinsurance cases may result in one of the remedies specified in Section D, Paragraph 61. Sanctions. DES/DDD shall communicate any known change health insurance information, including Medicare, to AHCCCS Administration, Division of Member Services, not later than 10 days from the date of discovery using the AHCCCS Third-Party Coverage Form found in the Bidder's Library.

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

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

48. COPAYMENTS

DES/DDD is responsible for the collection of copayments from members in accordance with AHCCCS Rule R-9-28, Article 7 and Paragraph 36, Compensation. DES/DDD may not collect copayments for family planning and EPSDT services.

49. MEDICARE SERVICES and COST SHARING

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as "dual eligible". Generally, DES/DDD is responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within DES/DDD's network. However, there are different cost sharing responsibilities that apply to dual eligible members based on a variety of factors. DES/DDD is responsible for adhering to the cost sharing responsibilities presented in AHCCCS' *Medicare Cost Sharing* policy.

DES/DDD shall have no cost sharing obligation if the Medicare payment exceeds what DES/DDD would have paid for the same service of a non-Medicare member.

50. MEMBER SHARE OF COST

ALTCS members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the share of cost, have a share of cost in the amount of $0.00. Generally, only institutionalized ALTCS members currently have a share of cost; however, certain HCBS ALTCS members may be liable for a share of cost, particularly those who become eligible through a special treatment income trust. Generally however, HCBS placed members have no share of cost but may be assessed room and board by DES/DDD.

DES/DDD receives monthly capitation payments which incorporate an assumed deduction for the share of cost which members contribute to the cost of care. DES/DDD is responsible for collecting their members' share of

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

51. RECORDS RETENTION

DES/DDD 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. DES/DDD 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.

DES/DDD shall make available at its office at all reasonable times during the term of this contract and the period set forth in paragraphs a. and b. below any of its records for inspection, audit or reproduction by any authorized representative of AHCCCSA, State or federal government.

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

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

52. SUBCONTRACTS

DES/DDD shall be legally responsible for contract performance whether or not subcontracts are used. No subcontract shall operate to terminate the legal responsibility of DES/DDD to assure that all activities carried out by the subcontractor conform to the provisions of this contract. Subject to such conditions, any function required to be provided by DES/DDD pursuant to this contract may be subcontracted to a qualified person or organization. All such subcontracts must be in writing. See policy on claims processing by subcontracted providers in the Bidder's Library.

All subcontracts entered into by DES/DDD are subject to prior review and approval by AHCCCSA, Contracts and Purchasing, and shall incorporate by reference the terms and conditions of this contract. The following subcontracts shall be submitted to AHCCCSA Contracting Office for prior approval at least 30 days prior to the beginning date of the subcontract:

a. Automated data processing
b. Third-party administrators
c. Management Services (See also Section D, Paragraphs 53 & 54)
d. Model subcontracts for PCPs, attendant care, home health agencies, behavioral health providers, nursing facilities, alternative residential settings and dental services

e. Capitated or other risk subcontracts requiring claims processing by the subcontractor must be submitted to AHCCCSA, Office of Managed Care.

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

DES/DDD shall maintain a fully executed original of all subcontracts which shall be accessible to AHCCCSA within two working days of request by AHCCCSA. A subcontract is voidable and subject to immediate cancellation by AHCCCSA in the event any subcontract pertinent to "a" through "e" above is implemented without the prior written approval of AHCCCSA. All subcontracts shall comply with the applicable provisions of federal and State laws, regulations and policies.

DES/DDD shall not include covenant-not-to-compete requirements in its provider agreements. Specifically, DES/DDD shall not contract with a provider and require that the provider not provide services for any other AHCCCS contractor.

DES/DDD must enter into a written agreement with any provider DES/DDD reasonably anticipates will be providing services on its behalf more than 25 times during the contract year. Exceptions to this requirement include the following:

a. If a provider who provides services more than 25 times during the contract year refuses to enter into a written agreement with DES/DDD, DES/DDD shall submit documentation of such refusal to AHCCCS Office of Managed Care within seven days of its final attempt to gain such agreement.
b. If a provider performs emergency services such as an emergency room physician or an ambulance company, a written agreement is not required.

These and any other exceptions to this requirement must be approved by AHCCCS Office of Managed Care.

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

a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor. b. Identification of the name and address of the subcontractor.
c Identification of the population, to include patient capacity, to be covered by the subcontractor.
d. The amount, duration and scope of medical services to be provided, and for which compensation will be paid.
e. The term of the subcontract including beginning and ending dates, methods of extension, termination and re-negotiation.
f. The specific duties of the subcontractor relating to coordination of benefits and determination of third-party liability.
g. A provision that the subcontractor agrees to identify Medicare and other third-party liability coverage and to seek such Medicare or third-party liability payment before submitting claims to DES/DDD.
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 42 CFR Part 456, as implemented by AHCCCSA.
j. A provision stating that a merger, reorganization or change in ownership of a subcontractor that is related to or affiliated with DES/DDD 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 DES/DDD 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 DES/DDD to suspend, deny, refuse to renew or terminate any subcontractor in accordance with the terms of this contract and applicable law and regulation.

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

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

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

DES/DDD shall promptly advise AHCCCSA, the Office of Managed Care, in writing of the subcontractor's non-compliance and of corrective actions taken.

53. MANAGEMENT SERVICES and DISTRIBUTION OF FUNDS

All proposed management services subcontracts, MIS subcontracts, corporate cost allocation plans, proposals to adjust management fees, and proposals for the distribution of funds which may affect plan equity must be approved in advance by AHCCCSA, Office of Managed Care. AHCCCSA will not approve a request for a distribution of funds that will result in negative plan equity. Cost allocation plans must be submitted with the proposed management fee agreement. AHCCCSA reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If the fees or allocations are determined to be unjustified or excessive, amounts may be subject to repayment to DES/DDD. In addition, DES/DDD may be placed on monthly financial reporting and financial sanctions may be imposed.

54. MANAGEMENT SERVICES SUBCONTRACTOR FINANCIAL AUDITS

All management services subcontractors are required to have an annual financial audit. A copy of this audit shall be submitted to AHCCCSA, Office of Managed Care, within 120 days after the subcontractor's fiscal year end.

55. RELATED PARTY TRANSACTIONS

Any proposed subcontract involving a related party or entity requires prior approval from AHCCCSA, Office of Managed Care. The minimum information required on ownership and control in related party transactions is set by federal law (42 CFR 455.100 through 455.106) and DES/DDD shall disclose all required information, justify

all related party transactions reported, and certify the accuracy and completeness of the disclosures made. DES/DDD shall demonstrate that transactions occurring between the provider and a related party-in-interest are reasonable, will not adversely affect the fiscal soundness of DES/DDD, and do not present a conflict of interest.

56. REQUESTS FOR INFORMATION

AHCCCSA may, at any time during the term of this contract, request financial or other information from DES/DDD. Upon receipt of such requests for information, DES/DDD shall provide complete information as requested no later than 30 days after the receipt of the request unless otherwise specified in the request itself.

57. DATA MANAGEMENT

DES/DDD shall have the capability for all required technical interfaces with AHCCCSA. Refer to the *AHCCCS Technical Interface Guidelines* in the Bidder's Library for further information. A copy of these guidelines will be provided to DES/DDD upon contract award.

58. DATA EXCHANGE REQUIREMENT

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

AHCCCSA may require DES/DDD to provide to AHCCCSA original evidence of service rendered and PCP assignments in a form appropriate for electronic data exchange. DES/DDD shall be provided with a security code for use in all data transmissions. DES/DDD agrees that by using its security code, it certifies that any data transmitted is accurate and truthful, to the best of its knowledge.

Electronic Data Interchange (EDI): In addition to the requirements outlined in Section D, Paragraph 44, Claims Payment System, DES/DDD will be required to comply with all administrative simplification provisions resulting from the Health Insurance Portability and Accountability Act (HIPAA). The administrative simplification section standardizes electronic transaction formats and code sets; establishes national identifiers for providers, employers, health plans, and individuals; and sets standards for security and privacy. Each of these provisions will be published as one or more Final Rules in the Federal Register. Implementation of these provisions will be required two years after the effective date of each provision's final rule as published by the Department of Health and Human Services.

59. ENCOUNTER DATA REPORTING

The accurate and timely reporting of encounter data is crucial to the success of the ALTCS program. AHCCCSA uses encounter data to:

Pay reinsurance benefits
Set fee-for-service and capitation rates
Determine disproportionate share payments to hospitals
Evaluate quality of care through quality indicators developed with encounter data

DES/DDD shall submit encounter data electronically to AHCCCSA for covered services whenever DES/DDD or the subcontractor incurs a financial liability. Formatting and specific requirements for encounter data are described in *AHCCCS Encounter Reporting User Manual* and *AHCCCS Technical Interface Guidelines,* copies of which may be found in the Bidders' Library. Data must be organized into the PMMIS AHCCCSA-supplied formats. The *Encounter Record Submission Standards* are included herein as Attachment C.

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 DES/DDD. Further information regarding the Encounter Submission Tracking Report may be found in *The Encounter User's Manual.*

60. SPECIALTY CONTRACTS

The Director of AHCCCSA may at any time negotiate or contract on behalf of DES/DDD and AHCCCSA for specialized hospital and medical services such as organ transplants. If the Director has contracted for such specialized services, DES/DDD may be required to include such services within its delivery networks and make contractual modifications necessary to carry out this section. Specialty contracts shall take precedence over all other contractual arrangements between DES/DDD and its providers. If DES/DDD's specialty contracts are less costly than those of AHCCCSA, AHCCCSA may allow DES/DDD to continue using its specialty contractors.

61. SANCTIONS

If DES/DDD violates any provision stated in law, AHCCCS Rules, AHCCCS policies and procedures or this contract, AHCCCSA may suspend, refuse to renew or terminate this contract or any related subcontracts in accordance with the terms of this contract and applicable law and regulations. AHCCCSA may, in addition to these remedies, impose sanctions in accordance with the provisions of this contract, applicable law and regulations to include sanctions due to noncompliance with any federally required reporting or performance criteria related to this contract. Written notice will be provided to DES/DDD specifying the sanction to be imposed, the grounds for such sanction and either the length of suspension or the amount of payment to be withheld. DES/DDD may appeal the decision to impose a sanction in accordance with AHCCCS Rule R9-28, Article 6.

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

62. TERM OF CONTRACT and OPTION TO RENEW

The initial term of this contract shall be October 1, 1996 through September 30, 1997. In addition, this contract may be renewed, not to exceed a total contracting period of five years. 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. 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 DES/DDD, unless within that time DES/DDD 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 16, Disputes, and administered accordingly.

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

63. GRIEVANCE PROCESS AND STANDARDS

DES/DDD shall have in place a written grievance and request for hearing policy for members and providers which defines their rights regarding any adverse action by DES/DDD. This written policy shall be in accordance with applicable federal and state law and AHCCCS Rules and policies including, but not limited to, AHCCCS grievance and request for hearing policy requirements, the Alternative Resolution Process and the Member Rights and Responsibilities. DES/DDD shall maintain a complaint log pertaining to its program, services and provision of care. Refer to Attachment E for a complete description of the grievance process requirements.

64. QUARTERLY GRIEVANCE REPORT

A Quarterly Grievance Report shall be submitted to AHCCCSA, Office of Legal Assistance and must be received no later than 45 days after the end of each quarter.

65. CULTURAL COMPETENCY

DES/DDD shall have a Cultural Competency Plan which meets the requirement of the AHCCCS Cultural Competency Policy, a copy of which is available in the Bidder's Library. DES/DDD must identity a staff member responsible for the cultural competency plan and inform the Office of Managed Care of that person's identity and if that person changes.

66. TRANSITION ACTIVITIES

DES/DDD shall comply with the *AMPM*, the *Office of Managed Care Member Transition for Annual Enrollment Choice* and *Other Plan Changes and the Office of Managed Care Change of Program Contractors* policies standards for member transitions between Program Contractors, to or from an AHCCCSA contractor, upon eligibility termination and upon termination or expiration of a contract. Also, see Paragraph 15, Enrollment and Disenrollment. DES/DDD shall develop and implement policies and procedures which comply with AHCCCS medical policy to address transition of all ALTCS members. The Enrollment Transition Information form must be completed for all ALTCS members and transmitted to the receiving Program Contractor. Appropriate medical records and case management files of the transitioning member shall also be transmitted. Special consideration should be given to, but not limited to, the following:

1. Home-based members with significant needs such as enteral feedings, oxygen, wound care, and ventilators;
2. Members who are receiving ongoing services such as behavioral health, dialysis, home health, pharmacy, medical supplies, transportation, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition; and
3. Members who have received prior authorization for services such as scheduled surgeries, or out-of-area specialty services.

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

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

67. MEDICAID IN THE PUBLIC SCHOOLS

Pursuant to an Intergovernmental Agreement with the Arizona Department of Education, AHCCCS will begin paying participating school districts for specifically identified Medicaid services provided to Medicaid eligible children. The Medicaid service shall be identified in a child's Individualized Education Plan as a medically necessary service for children with special educational needs. In the first phase, AHCCCS shall directly reimburse school districts for speech, physical and occupational therapies with dates of service beginning July 1, 2000. The Administration's intent is to add other Medicaid reimbursable services in the future.

To ensure that there is coordination of care, the Administration shall require that a participating school district notify the primary care provider that Medicaid services are being provided to the child in a school-based setting. If a child is enrolled with DES/DDD and a request is made for a school-based Medicaid covered service, DES/DDD shall evaluate the request on the same basis as any request for a covered service. The determination by DES/DDD to provide the service shall include consideration of whether the school-based services are sufficient to meet the child's needs.

[END OF SECTION D]

SECTION E - CONTRACT CLAUSES

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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 DES/DDD are violations of the contract and of applicable law. Such changes, including unauthorized written contract amendments, shall be void and without effect, and DES/DDD shall not be entitled to any claim under this contract based on those changes.

3. ORDER OF PRECEDENCE

The parties to this contract shall be bound by all terms and conditions contained herein. For interpreting such terms and conditions the following sources shall have precedence in descending order: The Constitution and laws of the United States and applicable federal regulations; the terms of the HCFA 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 amendments; 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. ASSIGNMENT AND DELEGATION

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

7. COMPLIANCE WITH APPLICABLE LAWS, RULES AND REGULATIONS

The materials and services supplied under this contract shall comply with all applicable federal, state and local laws, and DES/DDD shall maintain all applicable licenses and permits.

8. PAYMENTS

DES/DDD shall be paid as specified in the contract. Payment must comply with requirements of ARS Title 35. AHCCCSA reserves the option to make payments to DES/DDD by wire or NACHA transfer and will provide DES/DDD at least 30 days notice prior to the effective date of any such change.

9. ADVERTISING AND PROMOTION OF CONTRACT

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

10. PROPERTY OF THE STATE

Any materials, including reports, computer programs and other deliverables, created under this contract are the sole property of AHCCCSA. DES/DDD is not entitled to a patent or copyright on those materials and may not transfer the patent or copyright to anyone else. DES/DDD shall not use or release these materials without the prior written consent of AHCCCSA.

11. 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.

12. RIGHT OF OFFSET

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

13. NON-EXCLUSIVE REMEDIES

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

14. AUDITS AND INSPECTIONS

DES/DDD shall comply with all provisions specified in applicable AHCCCS Rule R9-28, Article 5 and AHCCCS policies and procedures relating to the audit of DES/DDD's records and the inspection of its facilities. DES/DDD shall fully cooperate with AHCCCSA staff and allow them reasonable access to DES/DDD's staff, subcontractors, members, and records.

At any time during the term of this contract, DES/DDD's or any subcontractor's books and records shall be subject to audit by AHCCCSA and, where applicable, the federal government, to the extent that the books and records relate to the performance of the contract or subcontracts.

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

15. EFFECTIVE DATE

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

16. DISPUTES

The exclusive manner for DES/DDD to assert any claim, grievance, dispute or demand against AHCCCSA shall be in accordance with AAC Title 9, Chapter 28, Article 8. Pending the final resolution of any disputes involving this contract, DES/DDD 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.

17. RIGHT TO INSPECT PLANT OR PLACE OF BUSINESS

AHCCCSA may, at reasonable times, inspect the part of the plant or place of business of DES/DDD or subcontractor which is related to the performance of this contract, in accordance with ARS §41-2547.

18. INCORPORATION BY REFERENCE

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

19. CHANGES

AHCCCSA may at any time, by written notice to DES/DDD, make changes within the general scope of this contract. If any such change causes an increase or decrease in the cost of, or the time required for, performance of any part of the work under this contract, DES/DDD may assert its right to an adjustment in compensation paid under this contract. DES/DDD must assert its right to such adjustment within 30 days from the date of receipt of the change notice. Any dispute or disagreement caused by such notice shall constitute a dispute within the meaning of Section E, Paragraph 16, 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 DES/DDD, unless within that time DES/DDD notifies AHCCCSA in writing that it refuses to

sign the amendment. If DES/DDD provides such notification, AHCCCSA will proceed in accordance with Section E, Paragraph 16, Disputes.

20. TYPE OF CONTRACT - Firm Fixed-Price

21. 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 (602) 417-4577.

22. WARRANTY OF SERVICES

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

23. NO GUARANTEED QUANTITIES

AHCCCSA does not guarantee DES/DDD any minimum or maximum quantity of services or goods to be provided under this contract.

24. CONFLICT OF INTEREST

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

25. DISCLOSURE OF CONFIDENTIAL INFORMATION

DES/DDD 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 DES/DDD by AHCCCSA.

26. SUSPENSION OR DEBARMENT

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

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

SECTION F - LIST OF ATTACHMENTS

*** NOTE: Attachments A, C, E, K and L are included. All other Attachments are incorporated by reference.**

ATTACHMENT A: MINIMUM SUBCONTRACT PROVISIONS

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

"*Contract*: means any contract between DES/DDD and a third party for the performance of any or all services or requirements specified under DES/DDD's contract with AHCCCS.

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

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

1. 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 contract.

2. RECORDS AND REPORTS

The Contractor shall maintain all forms, records, reports and working papers used in the preparation of reports, files, correspondence, financial statements, records relating to quality of care, medical records, prescription files, statistical information and other records specified by AHCCCSA for purposes of audit and program management. 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 shall properly reflect each service provided and all net costs, direct and indirect, of labor, materials, equipment, supplies and services, and other costs and expenses of whatever nature for which payment is made to the Contractor. Such material shall be subject to inspection and copying by the state, AHCCCSA and the U.S. Department of Health and Human Services during normal business hours at the place of business of the person or organization maintaining the records.

The Contractor agrees to make available at the office of the Contractor, at all reasonable times, any of its records for inspection, audit or reproduction, by any authorized representative of the state or federal governments.

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

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

b. Records which relate to 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 the state, shall be retained by the Contractor until such disputes, litigation, claims or exceptions have been disposed of.

The Contractor shall provide all reports requested by AHCCCSA, and all information from records relating to the performance of the Contractor which AHCCCSA may reasonably require. The Contractor reporting requirements may include, but are not limited to, timely and detailed utilization statistics, information and reports.

3. LIMITATIONS ON BILLING AND COLLECTION PRACTICES

The Contractor shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services. This provision shall not apply to patient contributions to the cost of services delivered by nursing homes.

4. ASSIGNMENT AND DELEGATION OF RIGHTS AND RESPONSIBILITIES

No payment due the Contractor under this contract may be assigned without the prior approval of AHCCCSA. No assignment or delegation of the duties of this contract shall be valid unless prior written approval is received from AHCCCSA.

5. APPROVAL OF CONTRACTS, AMENDMENTS OR TERMINATIONS

This contract is subject to prior approval by AHCCCSA. DES/DDD shall notify AHCCCSA in the event of any proposed amendment or termination during the term hereof. Any such amendment or termination is subject to the prior approval of AHCCCSA. Approval of the contract may be rescinded by the Director of AHCCCSA for violation of federal or state laws or rules.

6. WARRANTY OF SERVICES

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

7. SUBJECTION OF CONTRACT

The terms of this contract 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.

8. AWARDS OF OTHER CONTRACTS

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

9. INDEMNIFICATION BY CONTRACTOR

The Contractor agrees to hold harmless the state, all state officers and employees, AHCCCSA and other appropriate state agencies, and all officers and employees of AHCCCSA and all AHCCCS eligible persons in the event of nonpayment to the Contractor. The Contractor shall further indemnify and hold harmless the state, AHCCCSA, other appropriate state agencies, AHCCCS contractors, and their agents, officers and employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the State, AHCCCSA or its agents, officers or employees, or AHCCCS contractors, through the intentional conduct, negligence or omission of the Contractor, its agent, officers or employees.

10. MAINTENANCE OF REQUIREMENTS TO DO BUSINESS AND PROVIDE SERVICES

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

11. COMPLIANCE WITH LAWS AND OTHER REQUIREMENTS

The Contractor shall comply with all federal, State and local laws, rules, regulations, standards and executive orders governing performance of duties under this contract, without limitation to those designated within this contract.

12. SEVERABILITY

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

13. VOIDABILITY OF CONTRACT

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

14. CONFIDENTIALITY REQUIREMENT

Confidential information shall be safeguarded pursuant to federal and state laws including, but not limited to, 42 CFR Part 431, Subpart F, ARS §36-107, 36-2903, 41-1959 and 46-135, and AHCCCS and/or ALTCS Rules.

15. GRIEVANCE PROCEDURES

Any grievances filed by the Contractor shall be adjudicated in accordance with AHCCCS Rules.

16. TERMINATION OF CONTRACT

AHCCCSA may, by written notice to the Contractor, terminate this contract 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 Contractor, or any agent or representative of the Contractor, 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 Contractor; 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 contract 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 Contractor in providing any such gratuities to any such officer or employee.

17. PRIOR AUTHORIZATION and UTILIZATION REVIEW

DES/DDD and the Contractor shall develop, maintain and use a system for Prior Authorization and Utilization Review which is consistent with AHCCCS Rules and DES/DDD's policies.

18. NON-DISCRIMINATION REQUIREMENTS

If applicable, the Contractor shall comply with:

a. The Equal Pay Act of 1963, as amended, which prohibits sex discrimination in the payment of wages to men and women performing substantially equal work under similar working conditions in the same establishment.

b. Title VI of the Civil Rights Act of 1964, as amended, which prohibits the denial of benefits of, or participation in, contract services on the basis of race, color, or national origin.

c. Title VII of the Civil Rights Act of 1964, as amended which prohibits private employers, state and local governments, and educational institutions from discriminating against their employees and job applicants on the basis of race, religion, color, sex, or national origin.

d. Title I of the Americans with Disabilities Act of 1990, as amended, which prohibits private employers and state and local governments from discriminating against job applicants and employees on the basis of disability.

e. The Civil Rights Act of 1991, which reverses in whole or in part, several recent Supreme Court decisions interpreting Title VII.

f. The Age Discrimination in Employment Act (ARS Title 41-1461, et seq.); which prohibits discrimination based on age.

g. State Executive Order 99-4 and Federal Order 11246 which mandates that all persons, regardless of race, color, religion, sex, age, national origin or political affiliation, shall have equal access to employment opportunities.

h. Section 503 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination in the employment or advancement of the employment of qualified persons because of physical or mental handicap.

i. Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination on the basis of handicap in delivering contract services.

19. COMPLIANCE WITH AHCCCS RULES RELATING TO AUDIT AND INSPECTION

The Contractor shall comply with all applicable AHCCCS Rules and Audit Guide relating to the audit of the Contractor's records and the inspection of the Contractor's facilities. If the Contractor is an inpatient facility, the Contractor shall file uniform reports and Title XVIII and Title XIX cost reports with AHCCCSA.

20. CERTIFICATION OF TRUTHFULNESS OF REPRESENTATION

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

21. CERTIFICATION OF COMPLIANCE - ANTI-KICKBACK and LABORATORY TESTING

By signing this contract, the Contractor 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 therefrom. If the Contractor 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 Health Care Financing Administration.

22. CONFLICT IN INTERPRETATION OF PROVISIONS

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

23. ENCOUNTER DATA REQUIREMENT

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

24. 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. Contractor may not reimburse providers who do not comply with the above requirements.

25. INSURANCE

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

The Contractor shall maintain for the duration of this contract a policy or policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Contractor agrees that any insurance protection required by this contract, or otherwise obtained by the Contractor, shall not limit the responsibility of Contractor to indemnify, keep and save harmless and defend the State and AHCCCSA, their agents, officers and employees as provided herein. Furthermore, the Contractor 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.

26. FRAUD AND ABUSE

If the Contractor discovers, or is made aware, that an incident of potential fraud or abuse has occurred, the Contractor shall report the incident to DES/DDD, who shall proceed in accordance with the *AHCCCS Health Plans and Program Contractors Policy for Prevention, Detection and Reporting of Fraud and Abuse*. Incidents involving potential member eligibility fraud should be reported to AHCCCSA, Office of Managed Care, Member Fraud Unit. All other incidents of potential fraud should be reported to AHCCCSA, Office of the Director, Office of Program Integrity. (See AHCCCS Rule R9-22-511.)

ATTACHMENT C: ENCOUNTER SUBMISSION STANDARDS and SANCTIONS

DES/DDD shall exchange data with AHCCCSA in accordance with the AHCCCS Technical Interface Guidelines. DES/DDD is responsible for any incorrect data, delayed encounter data submission any penalty applied due to error, omission, deletion, or erroneous insert caused by data it submitted. Any data that does not meet the standards required by AHCCSA shall not be accepted by AHCCCSA. DES/DDD is responsible for identifying any inconsistencies immediately upon receipt of data from AHCCCSA. If any unreported inconsistencies are subsequently discovered, DES/DDD shall correct its records at its own expense.

DES/DDD 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 DES/DDD'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

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

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

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

When DES/DDD notifies AHCCCSA in writing that the resolution of a pended encounter depends on AHCCCSA rather than DES/DDD, 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 DES/DDD's notification and asks DES/DDD to research the issue and provide additional substantiating documentation, or if AHCCCSA disagrees with DES/DDD's claim of AHCCCSA error. If a pended encounter being researched by AHCCCSA is later determined not to be caused by AHCCCSA error, DES/DDD may be sanctioned retroactively.

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

Encounter Validation Studies

Per HCFA requirement, AHCCCSA will conduct encounter validation studies of DES/DDD's encounter submissions, and sanction DES/DDD 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 DES/DDD'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.

The following reflects AHCCCSA's encounter validation study process and sanction policy as of 10/1/97. AHCCCSA may revise study methodology, timelines, and sanction amounts based on agency review or as a result of consultations with HCFA. DES/DDD 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 DES/DDD in writing of the sanction amounts and of the selected data needed for encounter validation studies. DES/DDD will have 90 days to submit the requested data to AHCCCSA. In the case of medical records requests, DES/DDD'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 DES/DDD to select a statistically valid sample for a study, DES/DDD 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. All encounters must be received by AHCCCSA no later than 240 days after the end of the month in which the service was rendered, or the effective date of enrollment with DES/DDD, whichever is later. For all encounters for which timeliness is evaluated, a sanction per encounter error extrapolated to the population of encounters may be assessed if the encounter record is received by AHCCCSA more than 240 days after the date determined above. It is anticipated that the sanction amount will be $1.00 per error extrapolated to the population of encounters; however, sanction amounts may be adjusted if AHCCCSA determines that encounter quality has changed, or if HCFA changes sanction requirements. DES/DDD 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 HCFA changes sanction requirements. DES/DDD 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 HCFA changes sanction requirements. DES/DDD 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 DES/DDD's encounters for encounter validation studies, subsequent encounter submissions for the period being studied will not be considered.

AHCCCSA may review all of DES/DDD'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 DES/DDD'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 DES/DDD for review and comment. DES/DDD 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 DES/DDD's documentation and may revise study results if warranted. Written final results of the study will then be sent to DES/DDD and communicated to HCFA, and any sanctions will be assessed.

DES/DDD may file a written challenge to sanctions assessed by AHCCCSA not more than 35 days after DES/DDD 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 grievance pursuant to Article 8 of AHCCCS Rules. Sanction amounts will be deducted from DES/DDD's capitation payment.

Encounter Adjustments/Voids

DES/DDD is required to submit adjusted or voided encounters in the event that claims are subsequently adjusted or denied after the initial encounter submission. This includes adjustments for inaccuracies identified by fraud and abuse audits or investigations conducted by AHCCCSA or DES/DDD. DES/DDD shall refer to the Encounter User's Manual for further instructions regarding adjustments to encounters.

ATTACHMENT E: GRIEVANCE AND REQUEST FOR HEARING PROCESS AND STANDARDS

The Contractor shall have in place a written grievance and request for hearing policy for members and providers which defines their rights regarding any adverse action by the Contractor. The Contractor shall also ensure compliance with 9 A.A.C. R9-28-Article 12 and the Members' Rights and Responsibilities Policy. The written grievance and request for hearing policy shall be in accordance with applicable federal and State laws and AHCCCS Rules and policy including, but not limited to, AHCCCS Rules R9-28-514; R9-28-507(C); R9-28-801; and R9-28-1201. The grievance policy shall include the following provisions:

a. The grievance and request for hearing procedure will be provided all subcontractors at time of contract, and to non-contracting providers within 10 days of the date of receipt of the claim. For non-contracting providers, the grievance and request for hearing procedure may be mailed with the remittance advice provided the remittance is sent within 45 days of receipt of claim.

b. Specific individual(s) are appointed with authority to require corrective action to administer the grievance and request for hearing policy.

c. A log is maintained for all grievances containing sufficient information to identify the complainant, date of receipt, nature of the grievance and the date grievance is resolved. Separate logs must be maintained for provider and member grievances. The logs must contain sufficient information to identify the complainant, date of receipt, nature of the grievance and the date grievance is resolved.

d. Within five working days of receipt, the complainant is informed by letter that the grievance has been received. The letter must also be in a second language when 200 members or 5% of the Contractor's population, whichever is greater, speak the second language.

e. Each grievance is thoroughly investigated using the applicable statutory, regulatory and contractual provisions as well as the Contractor's policies and procedures, ensuring that facts are gathered from all parties.

f. All documentation received and mailed by Contractor during the grievance and request for hearing process is dated upon date of receipt.

g. All grievances are filed in a secure, designated area and are retained for five years following the final decision, judicial appeal or close of a grievance.

h. A copy of the Contractor's final decision will be either hand-delivered or delivered by certified mail to all parties. The final decision shall be mailed to all other individuals by regular mail. The date of the final decision shall be the date of the notice. The final decision must include, and describe in detail, the following:
   1. the nature of the grievance
   2. the issues involved
   3. the reasons supporting the Contractor's decision including references to applicable statute, rule and procedure
   4. the complainant's right to request a hearing regarding the Contractor's decision to AHCCCSA by filing the appeal to the Contractor no later than 35 days after the date of the Contractor's final decision. This must also be written in a second language, if applicable.

i. If the member requests a hearing, all supporting documentation must be received by the AHCCCSA, Office of Legal Assistance no later than five working days from the date the Contractor receives the request or from the date of the oral or written request from AHCCCSA, Office of Legal Assistance. The appeal file must contain a cover letter that includes:
   1. complainant's name
   2. complainant's AHCCCS ID number
   3. complainant's address
   4. phone number (if applicable)
   5. date of receipt of grievance and request for hearing
   6. summary of the Contractor's actions undertaken to resolve the grievance and basis thereof

j. The following material shall be included in the appeal file:
   1. written request of the complainant asking for the appeal

2. copies of the entire file which include the investigations and/or medical records; and the Contractor's grievance decision
3. other information used by the Contractor to resolve the grievance and that would be necessary to AHCCCSA to resolve the grievance.

k. The Contractor may attempt to use alternative resolution procedures to resolve disputes presented to the Contractor verbally or in writing. If the Contractor elects to use an alternative resolution process, it must be administered and completed within 10 days from receipt of the dispute. If the matter is not resolved to the complainant's satisfaction within the 10 day period, the dispute must then be adjudicated using the grievance standards contained above. However, the Contractor must render the written grievance decision within a maximum of 30 days from the date of the initial filing of the grievance or dispute unless a longer period was agreed to by the parties involved.

l. For all disputes where an alternative resolution is proposed, the Contractor maintain a separate log, complying with paragraphs c. and g. above.

ATTACHMENT K: CHART OF DELIVERABLES

BEHAVIORAL HEALTH

REPORT	DATE DUE	SEND TO:
Sample of Case Manager and PCP records	By Request (At time of O&FR)	Behavioral Health Mgr. (OMC)
Case file review sampling methodology and guide	January 15	Behavioral Health Mgr. (OMC)

CLINICAL CONDITIONS

REPORT	DATE DUE	SEND TO:
Annual Pulmonologist Report (for Ventilator Dependent only-for members who have been on a ventilator for 12 or more months as of the end of September)	November 1	ALTCS Manager (OMM)
Non-transplant catastrophic reinsurance-covered diseases	Within 30 days of the start of the contract year, enrollment with DES/DDD, and when newly diagnosed	Reinsurance Manager (OMM/FFS)

CONTRACTS

REPORT	DATE DUE	SEND TO:
Initial contracts with AHCCCS and any amendments and renewals	Within 60 days of receipt from AHCCCS	Contracts & Purchasing Administrator (DBF)
Request to assign any right or delegate any duty	Approval required prior to assignment	Contracts & Purchasing Administrator (DBF)
Subcontracts for: • Automated Data Processing • Third Party Administrators • Management Services • Model Subcontracts for PCP's, attendant care, home health agencies, behavioral health providers, nursing facilities, alternative residential settings, dental services, or as specified in contract • Capitated or other risk subcontracts requiring claims processing by the subcontractors	30 days prior to start date	Contracts & Purchasing Administrator (DBF)
Advertisements or published information for commercial benefit	Prior approval required	Contracts & Purchasing Administrator (DBF)
Management Services subcontractor audit	Within 120 days after subcontractors fiscal year end	Contracts & Purchasing Administrator (DBF)

ENCOUNTERS

REPORT	DATE DUE	SEND TO:
Encounter Data	As required in AHCCCS Encounter Manual	Encounter Unit (OMC)
Encounter Data Validation Studies	Annually as requested	Encounter Unit (OMC)

EXECUTIVE MANAGEMENT

REPORT	DATE DUE	SEND TO:
Network Plan	November 15	ALTCS Operations Manager (OMC)
Resignation and addition of any key staff	Within 7 days of learning of resignation	ALTCS Operations Manager (OMC)
All physician incentive agreements	Upon signing of agreement	ALTCS Financial Manager (OMC)
Physician Incentive Plan (PIP) reporting	Annually by October 1st of each contract year	ALTCS Financial Manager (OMC)
Changes to Fraud and Abuse Plan	When changes are made, prior to distribution	Office of Program Integrity (OPI)
All incidents of suspected fraud and abuse	Upon learning of the incident	As directed in AHCCCS Fraud and Abuse Policy
Modifications of Operational & Financial Review Corrective Action Plan	Prior to implementation of modification	ALTCS Operations Manager (OMC)
Proposed merger, reorganization or ownership change	Prior approval required	ALTCS Operations Manager (OMC)
Related party subcontracts	Prior approval required	ALTCS Operations Manager (OMC)

FINANCE

REPORT	DATE DUE	SEND TO:
Quarterly Financial Statement	60 days after quarter end	ALTCS Financial Mgr. (OMC)
HIV/AIDS Protease Inhibitor	60 days after quarter end	ALTCS Financial Mgr. (OMC)
FQHC Member Month Information	60 days after quarter end	ALTCS Financial Mgr. (OMC)
Draft Audited Financial Statement	90 days after year end	ALTCS Financial Mgr. (OMC)
Draft Management Letter	90 days after year end	ALTCS Financial Mgr. (OMC)
Final Audited Financial Statement	120 days after year end	ALTCS Financial Mgr. (OMC)
Final Management Letter	120 days after year end	ALTCS Financial Mgr. (OMC)
Annual Disclosure Statement	120 days after year end	ALTCS Financial Mgr. (OMC)

Annual Reconciliation	120 days after year end	ALTCS Financial Mgr. (OMC)
Advances, Distributions, Loans	Prior approval required	ALTCS Financial Mgr. (OMC)
Claims recoupments exceeding $50,000 per provider within a contract year	Prior approval required	ALTCS Financial Mgr. (OMC)
Reinsurance claims	Within 12 months from the date of service	As per AHCCCS Reinsurance Manual
Corporate cost allocation plans, adjustment in management fees, fund distributions affecting equity	Prior approval required	ALTCS Financial Mgr. (OMC)
Summary of contract rates for long term care and home and community based services (format to be provided by AHCCCS)	December 1	ALTCS Financial Mgr. (OMC)

GRIEVANCE AND REQUEST FOR HEARINGS

REPORT	DATE DUE	SEND TO:
Quarterly Grievance Report	45 days after the end of each quarter	Administrative Assistant (OLA)
Request for Hearing Files	5 working days from the date appeal is received	Office of Legal Assistance

MEMBER SERVICES/CASE MANAGEMENT

REPORT	DATE DUE	SEND TO:
Annual Member Survey	Prior to Distribution	ALTCS Operations Manager (OMC)
Member Handbook	Upon any changes. Prior to Distribution	ALTCS Operations Manager (OMC)
All Member Informational Materials (Newsletters, Brochures, etc.)	Prior to Distribution	ALTCS Operations Manager (OMC)
Institutional placement outside the state	Prior approval required	ALTCS Manager (OMM)
Changes or corrections to member's circumstances (income, living arrangements, TPL, services, etc.)	ALTCS member change report Form (DE-701) requirements	Division of Member Services or local ALTCS Office
Case Management Plan	November 15	ALTCS Manager (OMM)
Targeted Case Management Plan	November 15	ALTCS Manager (OMM)
Case management internal monitoring process, results, and continuous improvement strategies	December 1	ALTCS Manager (OMM)

NETWORK MANAGEMENT

REPORT	DATE DUE	SEND TO:
Quarterly Network Update	1st of Jan., Apr., July & Oct.	ALTCS Operations Manager (OMC)

All material changes in provider network	In advance of the change	ALTCS Operations Manager (OMC)
Unexpected major network changes	Within 1 day of change	ALTCS Operations Manager (OMC)
Provider who refuses to sign a contract (if providing more than 25 services in the contract year)	Document refusal within 7 days of final attempt to gain contract	ALTCS Operations Manager (OMC)
Quarterly Provider Affiliation Tape	As per page 6 in the Provider Affiliation Tape User Manual	ISD Operations at 801 East Jefferson
Provider limitations, restrictions, and/or priority assignments	Within 10 days of change	ALTCS Operations Manager (OMC)

THIRD PARTY LIABILITY

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

QM/UM

REPORT	DATE DUE	SEND TO
ALTCS QM/UM Evaluation	November 15	ALTCS QM Manager (OMM)
ALTCS QM/UM Plan	November 15	ALTCS QM Manager (OMM)
ALTCS Inpatient Hospital Showings	15 days after the end of each quarter. (15th of Jan., Apr., July & Oct.)	ALTCS QM Manager (OMM)
ALTCS Maternity Care Plan	December 1	ALTCS QM Manager (OMM)
ALTCS EPSDT Participation Plan (including dental)	December 1	ALTCS QM Manager (OMM)
ALTCS HIV Report (includes AIDS)	100 days after the end of each contract year	ALTCS QM Manager (OMM)
ALTCS Pregnancy Termination	Must be sent by the end of every month, even if there are no terminations. Terminations are to be reported by the end of the month after the month of termination.	ALTCS QM Manager (OMM)

Quarterly EPSDT Progress Report	40 days after the end of each quarter	ALTCS QM Manager (OMM)
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	AHCCCS Chief Medical Officer

ATTACHMENT L: TARGETED CASE MANAGEMENT

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

1. TARGETED CASE MANAGEMENT SERVICES FOR NON-ALTCS RECIPIENTS

The case management responsibilities as described in Chapter 1300 of the *AHCCCS Medical Policy Manual* shall apply to DES/DDD recipients enrolled with an AHCCCS acute care contractor (non-ALTCS members). DES/DDD shall submit to AHCCCSA, in writing, an updated plan describing the implementation of Targeted Case Management.

DES/DDD shall ensure adequate staffing to meet case management requirements. If case management staffing is not adequate to meet the needs of the recipients, DES/DDD shall develop and implement a corrective action plan, approved in advance by AHCCCSA, to address caseload sizes. "Case manager" means a person who is either a degreed social worker, licensed registered nurse, or one with a minimum of two years experience in providing case management services to EPD or developmentally disabled (DD) persons. Staffing must be sufficient to cover case manager absenteeism and turnover. AHCCCSA will determine compliance through the Case Management Services Review.

The Inventory for Client and Agency Planning (ICAP), which is DES/DDD's accepted tool for evaluating a client's overall functional level, shall be included in the initial assessment and upon any redetermination for DD eligibility or as determined by the Individual Support Plan (ISP) team. Case managers shall acquire, as available, input from other professionals, i.e., physical therapist, nursing staff, vocational or educational staff, and incorporate the information into the service plan development process.

DES/DDD shall ensure that recipients and/or families are informed about the assignment of case managers and how to contact them. In the absence of the case manager, recipients and/or families must be given the opportunity to contact a back up staff person that will provide the necessary assistance.

DES/DDD shall provide AHCCCSA a description of the internal monitoring of its case management program and shall include the aggregate results and analysis of this monitoring covering the previous 12 months. DES/DDD shall include those findings where improvement was indicated and the steps it has taken to resolve deficiencies.

2. PAYMENT

Payment to DES/DDD for targeted case management services must not duplicate payments made to public agencies or private entities under other program for this same purpose and will be made by AHCCCSA on a capitated basis as a pass through of federal funds received by AHCCCSA.

Subject to the availability of funds, AHCCCSA will make payments to DES/DDD in accordance with the terms of this amendment provided that DES/DDD's performance is in compliance with the terms and conditions of this amendment.

DES/DDD will be paid monthly on a capitated basis. This payment will be based on the number of recipients matched as of the first of each month. The capitation payment will be made no later than 10 working days after receipt of the DES/DDD data transmission.

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

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

Where payments are made by electronic funds transfer, AHCCCSA shall not be liable for any error or delay in transfer nor indirect or consequential damages arising from the use of the electronic funds transfer process. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by DES/DDD. All funds received by DES/DDD pursuant to this contract shall be separately accounted for in accordance with generally accepted accounting principles.

3. ON-SITE REVIEWS

In accordance with AHCCCS Rule R9-28-513, AHCCCSA will conduct an operational review targeted case management services every year for the purpose of, but not limited to, ensuring program compliance. The type and duration of the review will be solely at the discretion of AHCCCSA and will include, but not be limited to, Case Management Services Review. The reviews will identify areas where improvements can be made and make recommendations accordingly, monitor DES/DDD's progress towards implementing mandated programs and provide DES/DDD with technical assistance if necessary. Except in cases where advance notice is not possible or advance notice may render the review less useful, AHCCCSA will give DES/DDD at least weeks advance notice of the date of the on-site review. AHCCCSA may conduct a review in the event DES/DDD undergoes a reorganization or makes changes in three or more key staff positions within a 12-month period.

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

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

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

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

4. ANNUAL SUBMISSION OF BUDGET

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

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

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

5. SANCTIONS

If DES/DDD violates any provision stated in law, AHCCCS Rules, AHCCCS policies and procedures, or this contract, AHCCCSA may imposesanctions in accordance with the provisions of this contract, applicable law and regulations. Written notice will be provided to DES/DDD specifying the sanction to be imposed, the grounds for such sanction and the amount of payment to be withheld.